# Ashford and St. Peter's Hospitals NHS Foundation Trust

# St Peter's Hospital

## Inspection report

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## Ratings

### Overall rating for this service

Requires Improvement

# Our findings

## Overall summary of services at St Peter's Hospital

**Requires Improvement** 

We carried out an unannounced focused inspection because we had concerns about the safety and quality of services.

Prior to our inspection we received information of concern from several sources. The information related to the culture in surgery and anaesthetics division and suggested patients were not being safely discharged from care in the medical care division.

This was a focused inspection and we rated the domains of safe and well led for medical care and surgery at St Peters Hospital. We also looked at some aspects of the effective and responsive domains for medical care.

Because this was a focused inspection the overall rating for the trust stayed the same. We rated the domains of safe and well-led. Our rating for surgery went down because we rated safe and well led as requires improvement. Our rating of medical care remained the same we rated safe and well led as good.

Our rating for the hospital went down because:

- Nursing staff numbers were consistently below planned levels.
- Staff were not up to date with mandatory safeguarding training.
- The environment on the wards and in theatres did not always meet national guidance.
- There was a significant number of senior surgical staff who felt disengaged and disenfranchised and the strategies to address this appeared to be lacking impact.

However:

- Staff understood how to protect patients from abuse and harm most of the time, and managed safety well. They controlled infection risks and managed medicines well.
- Staff assessed risks to patients, acted on them and kept good care records.
- Staff managed safety incidents well and learned lessons from them. They collected safety information and used it to make improvements and were committed to continuous improvement.
- Staff understood the services vision and values, and how to apply them in their work. They were clear about their roles and accountabilities.
- Staff were focused on the needs of patients receiving care. They treated patients with compassion and kindness, respected their privacy and dignity and took account of their individual needs. Services engaged well with patients and the community to plan and manage services.

**How we carried out the inspection**

# Our findings

During the inspection we visited medical and surgical services. We looked at the environment, observed staff huddles, patient handovers and patient care. We spoke with 76 members of staff including doctors all grades of nurses, allied health professionals, consultants, anaesthetists and senior leaders. We spoke with two patients who attended the hospital for surgery and two patients on the medical wards. We reviewed 22 patient's records including medicine charts. We looked at a range of policies, procedures and other documents relating to the running of the service.

We reviewed data for this inspection from November 2020 – October 2021.

You can find further information about how we carry out our inspections on our website: https://www.cqc.org.uk/what-we-do/how-we-do-our-job/what-we-do-inspection.

# Surgery

**Requires Improvement** ↓

Our rating of this location went down. We rated it as requires improvement because:

- Nursing staff numbers were consistently below planned levels.
- Staff were not always up-to-date with mandatory training.
- The theatre environment had damage to the walls, flooring and fittings. This was an infection control risk.
- Several items of medical equipment was out of date for servicing. This meant staff could not be sure equipment was safe to use.
- Staff did not always feel respected, supported and valued. The culture in the theatres was unhappy and staff felt disengaged. Staff did not feel listened to.

However:

- Staff had access to training in key skills, understood how to protect patients from abuse, and managed safety well. The service controlled infection risk well. Staff assessed risks to patients, acted on them and kept good care records. They managed medicines well. The service managed safety incidents well and learned lessons from them.
- Leaders ran services well using reliable information systems and supported staff to develop their skills. Staff understood the service's vision and values, and how to apply them in their work. They were focused on the needs of patients receiving care. Staff were clear about their roles and accountabilities. The service engaged well with patients and the community to plan and manage services and all staff were committed to improving services continually.

## Is the service safe?

**Requires Improvement** →←

Our rating of safe stayed the same. We rated it as requires improvement.

### Mandatory training

**The service provided mandatory training in key skills to all staff. However, they did not always make sure everyone completed it.**

Nursing staff received mandatory training. However, this was not always kept up-to-date. For example, nursing staff across the general surgery, anaesthetics, critical care and theatres (GS-ACT) division were 76% compliant. Nursing staff in the specialist surgery and musculoskeletal (SSM) division were 80% compliant. Allied health professionals across the two divisions were on average 76% compliant with mandatory training.

Medical staff received mandatory training. However, this was not always kept up-to-date. For example, medical staff on average across the two divisions were 63% compliant with mandatory training.

The SSM division had an overall compliance rate of 74% for mandatory training completion. The GS-ACT division had an overall compliance rate of 78% for mandatory training completion. Staff had struggled to complete mandatory training

during the pandemic because when patient demand was high in the hospital, mandatory training was cancelled to keep patients safe. Consequently, this reflected in mandatory training compliance not being at the trust target rate. Managers told us they recognised the importance of improving mandatory training compliance and had plans to monitor performance through monthly divisional meetings.

The trust told us planned mandatory training had been significantly reduced in the last year due to the Covid-19 pandemic. The trust told us they refocussed training efforts in line with national directives and guidance to support intensive care.

Mandatory training was comprehensive and met the needs of patients and staff. The service had an education, learning and development policy. Staff received training aligned to the Core Skills Training Framework (CSTF) outlined by Skills for Health. Staff received additional training on sepsis management which included use of sepsis tools and care bundles. Clinical staff completed training on recognising and responding to patients with mental health needs, learning disabilities, autism and dementia. Refresher training was delivered at ward level on a specific topic. These were called "tea trolley training". For example, Kingfisher ward had recently received tea trolley training on pressure ulcer management.

Managers monitored mandatory training and alerted staff when they needed to update their training. Mandatory training compliance was monitored and reported during the monthly divisional harms meeting. Where compliance was below the target rate, the ward manager completed an action plan. Managers alerted staff when they needed to complete mandatory training through email reminders and through team meetings.

### Safeguarding

**Staff understood how to protect patients from abuse. Staff had training on how to recognise and report abuse and they knew how to apply it. However, staff safeguarding training was not always kept up-to-date.**

Nursing staff received training specific for their role on how to recognise and report abuse. However, nursing staff safeguarding training was not always kept up-to-date. For example, nursing staff in the GS-ACT division were 69% compliant with adult safeguarding training and 75% compliant with children's safeguarding.

Medical staff received training specific for their role on how to recognise and report abuse. However, medical staff safeguarding training was not always kept up-to-date. For example, medical staff in the GS-ACT division were 56% compliant with adult safeguarding training and 50% compliant with children's safeguarding.

However, staff knew how to identify adults and children at risk of, or suffering, significant harm. Staff understood the process to report a safeguarding concern and who to inform if they had concerns. Staff demonstrated a good understanding of trust's safeguarding policy and gave examples of when they would report a safeguarding concern. Staff were positive about support received from the safeguarding team in the trust.

### Cleanliness, infection control and hygiene

**The service controlled infection risk well. Staff used equipment and control measures to protect patients, themselves and others from infection. They kept equipment and the premises visibly clean. The service used systems to identify and prevent surgical site infections.**

# Surgery

Ward areas were clean and had suitable furnishings which were clean and well-maintained. Clinical areas were visibly clean and clutter free. The service completed daily checklists to demonstrate cleaning was complete and up-to-date. All cleaning records were complete and up-to-date. Staff cleaned equipment after patient contact and used “I am clean” stickers on equipment to show when it was last cleaned.

The service generally performed well for cleanliness. Surgical wards had good compliance with cleanliness audits. For example, the most recent results showed Robin ward had 98% compliance and Falcon ward had 97%.

Staff used records to identify how well the service prevented infections. The service completed regular infection prevention and control audits in all areas of the division. The most recent audit for Swan ward demonstrated 68% compliance and main theatres had 77% compliance with infection prevention and control measures. Staff developed action plans as a result of the audit.

The service monitored infection prevention and control in high impact interventions such as catheter and cannula use. Audit results generally showed good compliance with infection prevention and control measures for high impact interventions. However, some wards had lower compliance results.

Staff worked effectively to identify and treat surgical site infections. The service monitored surgical site infection (SSI) rates. The service’s results showed surgical site infection rates were higher than the trust target and national benchmarks for all specialties, apart from breast surgery. The service had led a number of learning sessions for staff to improve knowledge and reporting on SSIs.

Staff followed infection control principles including the use of personal protective equipment (PPE). Staff wore the right level of personal protective equipment. Staff had easy access to PPE such as masks, gowns and gloves. There was sufficient access to antibacterial hand gels, handwashing and drying facilities. Staff were bare below the elbow and washed their hands appropriately. The service completed hand hygiene audits each month. Staff were trained to complete these audits. The service showed good compliance with hand hygiene through these audits.

The service completed audits on aseptic non-touch technique performed by staff. For example, the most recent audit demonstrated 100% compliance for both Robin and Falcon ward, Kingfisher ward showed 95% compliance.

The service managed COVID-19 infection prevention and control measures well. For example, staff wore appropriate PPE. Patients were encouraged to wear face masks where able. Patients were tested regularly for COVID-19 during their stay at hospital.

The service had a ‘North Star’ objective to “End health and care acquired infections for the team, patients and the community we serve". A ‘North Star’ objective is a long-term, high-level aspiration goal to motivate staff. Staff were aware of this objective and how it related to their role in infection prevention and control.

### Environment and equipment

**The design, maintenance and use of facilities, premises and equipment did not always keep people safe. However, staff managed clinical waste well.**

The design of the environment followed national guidance. The environment layout was in line with health building notes guidance. For example, surgical ward areas had a mixture of single rooms and bays, each with access to toilet and washing facilities. All areas had separate dirty and clean utility. The service had suitable facilities to meet the needs of patients’ families.

However, the environment in the theatres and recovery areas required attention to repair or replace damaged flooring, walls and fittings. There were significant holes in walls and floors which had temporarily been patched up using tape. These posed an infection risk as they could not be cleaned effectively. After our inspection the chief executive told us the trust estate team produced a report detailing all maintenance issues in order of priority to be completed. Planned time and cost for completion of maintenance had been agreed.

The service completed environment risk assessments. This supported staff to identify environmental risks in their area and identify actions to address them. The service completed 'Perfect Ward' audits which evaluated the ward environment. The service performed well in these audits.

The service had enough suitable equipment to help them to safely care for patients. However, a number of these were overdue servicing. Equipment was serviced by an external provider. The services' policy was to have a sticker on equipment to indicate when it last underwent servicing and when it was next due. In theatres and recovery, a significant number of items of equipment were overdue servicing. Staff could not be sure that equipment was safe to use. After our inspection the chief executive told us they have reviewed the full asset register of equipment in the theatres. The service have risk assessed and prioritised equipment which required servicing.

The service had recently commissioned an independent review into medical device management. The outcome of the review found similar themes to what we saw on inspection. For example, equipment out of date. The service had a medical device engineering audit schedule. The most recent audit of the theatres also found equipment that was past its service due date. Both of these reviews recommended actions to improve compliance.

The service had developed an action plan to address concerns about theatre equipment servicing. This action plan identified that 61 out of 269 medical devices were overdue servicing. The service had put a plan to complete these servicing check by the end of January 2022.

Staff received training on medical devices. This meant staff were competent to use equipment safely.

Staff logged equipment faults with the trust's estates team in line with trust policy. Staff told us the estates team were generally responsive to equipment faults.

Staff carried out daily safety checks of specialist equipment. Resuscitation equipment was visible and accessible. Resuscitation trolleys were kept on all surgical wards and in theatres. Trolleys had tamper evident tags. The contents of the trolleys were checked and records were complete. Anaesthetic equipment was available and fit for purpose and checked in line with guidance.

Patients could reach call bells and staff responded quickly when called. Patients reported that staff were responsive to call bells, this was corroborated during observations.

Staff disposed of clinical waste safely. Waste was segregated with separate colour coded arrangements for general waste and clinical waste. Sharps, such as needles, were disposed of in line with national guidance. Staff followed the trust's policy on control of substances hazardous to health.

### Assessing and responding to patient risk

**Staff completed and updated risk assessments for each patient and removed or minimised risks. Staff identified and quickly acted upon patients at risk of deterioration.**

# Surgery

Patients received risk-based pre-operative assessments to ensure they were safe for surgery at St. Peter's hospital. For emergency surgery staff used of American Society of Anaesthesiologists (ASA) physical status classification system to predict risks for that patient before surgery.

Staff completed risk assessments for each patient on admission or arrival, using a recognised tool. Patient records showed staff compliance with completing risk assessments. Risk assessments included Malnutrition Universal Screening Tool (MUST), falls, venous thromboembolism (VTE) and pain. The service completed regular audits to monitor compliance with MUST and VTE completion and there was good compliance.

The service monitored on the day cancellation numbers for surgeries. Patients cancelled on the day due to non-clinical reasons such as 'list planning issues' or 'admin/secretarial error' were mostly rebooked within less than 28 days. Two patients were booked within 31 days.

Staff used a nationally recognised tool to identify deteriorating patients and escalated them appropriately. Staff used the National Early Warning System (NEWS) to identify deteriorating patients. Observations and NEWS scores were displayed using an electronic display system behind the reception desk at each surgical ward. This meant all staff had oversight of the NEWS scores of patients on the ward. Staff demonstrated how they escalated patients appropriately in line with the trust's policy.

However, staff did not always complete regular observations of patients within required timescales. The service completed regular audits to determine compliance with observation timescales. For example, for observations during the day in October, Kingfisher ward had 74% compliance, Falcon had 68% compliance and Heron ward has 70% compliance. When compliance rates fell below the average the ward manager had to produce an action plan to improve compliance.

Staff knew about and dealt with any specific risk issues. Staff understood how to identify the signs of sepsis and the management of sepsis in line with national guidelines. Staff understood how to recognise and manage pressure ulcers.

Staff undertook the World Health Organisations (WHO) '5 steps to safer surgery' checklist in theatres and undertook audits to measure compliance. Staff consistently undertook all five steps of the checklist. WHO completion audit showed good compliance with completion with a rate above 90% in October 2021.

The service had a policy which defined local safety standards for invasive procedures. This was in line with national safety standards for invasive procedures.

Staff shared key information to keep patients safe when handing over their care to others. Handover between surgical wards and theatre teams was comprehensive and identified patient risks.

### Nurse staffing

**The service had enough nursing and support staff with the right qualifications, skills, training and experience to keep patients safe from avoidable harm and to provide the right care and treatment. Managers regularly reviewed and adjusted staffing levels and skill mix, and gave bank and agency staff a full induction.**

Managers accurately calculated and reviewed the number and grade of nurses, nursing assistants and healthcare assistants needed for each shift in accordance with national guidance. The ward manager could adjust staffing levels daily according to the needs of patients. Staffing levels were calculated based on the number of patients, their complexity and taking national guidance into account. Staffing levels were adjusted as necessary to support other areas

in the division who required more staffing to provide safe care. This was in line with the trust's escalation policy for safe staffing. In theatres when there were staff absences on the day or bank and agency shifts were not filled, staff on administrative duties or training were moved into theatre to provide safe levels of staffing. The service also provided help across the trust's two hospital sites. For example, staff from Ashford Hospital theatres supported St. Peter's theatres and vice versa.

The service had enough nursing and support staff to keep patients safe in the theatres. Theatres had reducing vacancy rates. The number of nurses and healthcare assistants (HCA) matched the planned numbers. The service did not run lists with nursing staff below the Association for Perioperative Practice (AFPP) guidelines. For the local anaesthetic theatre lists there was a minimum of two scrub nurses and one anaesthetic trained nurse. For the general anaesthetic list there was a minimum of two scrub nurses, one circulating nurse, one anaesthetic trained staff member and one recovery nurse.

However, on the surgical wards nurses and healthcare assistants actual numbers did not always match the planned numbers. For example, during our inspection Kingfisher ward had one less HCA for the early and middle shift and one less registered nurse for the middle shift. For September 2021 the surgical wards had planned 186 full time equivalent (FTE) hours for nurses. However, the actual FT hours was 161. There had been three incident reports in the last six months which related to lack of qualified staffing. Staff told us staffing was an issue, but the service was actively recruiting to vacant posts.

The service used bank and agency nurses. For example, in October 2021 the service used 36 whole time equivalent (WTE) hours of bank staff and 41 WTE for agency.

Managers limited their use of bank and agency staff and requested staff familiar with the service. The service offered additional shifts to current staff as extra bank shifts. The service used frequent agency staff but requested the same individuals each time, which meant they were familiar with the service and had received a full trust induction.

The board had oversight of staffing for the service. Staffing was discussed during the people committee, modern healthcare committee and through workforce reports submitted to the board.

### Medical staffing

**The service had enough medical staff with the right qualifications, skills, training and experience to keep patients safe from avoidable harm and to provide the right care and treatment. Managers regularly reviewed and adjusted staffing levels and skill mix.**

The service had enough medical staff to keep patients safe. Medical staff rotas were organised and planned to keep patients safe. The medical staff matched on duty the planned number. The service had a good skill mix of medical staff on each shift and reviewed this regularly.

The service had low vacancy rates, low turnover rates and low rates of bank and locum use for medical staff.

The service always had a surgical registrar on call during evenings and weekends. This member of staff was identified and named on the staff rota for the theatres. There had been three incident reports in the last six months which related to lack of medical consultant presence during weekday and lack of medical staffing.

# Surgery

The service had a review against the Royal College of Anaesthetists (RCoA) standards for medical staffing. This found the service generally met the standards. For example, the service had sufficient doctors available to simultaneously cover commitments to obstetrics, critical care and emergency theatres.

The Care Quality Commission had received information of concern before inspection about the anaesthetic rota. We were told anaesthetic rotas were not clear and staff felt they did not know who the duty anaesthetist was. We reviewed the last three month's rotas. These were clear and identified which anaesthetist was covering which theatre and on-call anaesthetists were named for each day.

### Records

**Staff kept detailed records of patients' care and treatment. Records were clear, up-to-date, stored securely and easily available to all staff providing care.**

Patient notes were comprehensive, and all staff could access them easily. Eight patient records all had dates, the name and grade of the person reviewing the patient, and diagnosis management plans. Staff could find the most up-to-date information about patients when they needed it. Patient records showed that nursing and clinical assessments were carried out before, during and after surgery and that these were documented correctly.

The service completed an audit of patient records. The audit generally showed compliance with medical record completion. Where elements of the records fell below the target the service identified actions to improve compliance.

When patients transferred to a new team, there were no delays in staff accessing their records. We saw multidisciplinary team input in the notes. Relevant staff had access to patient notes to record their observations and management plans related to their speciality. For example, we saw pain management and dietitians on Robin ward.

Patient records were paper based. Records were stored securely in locked trollies in line with trust policy.

### Medicines

**The service used systems and processes to safely prescribe, administer, record and store medicines. However, we identified some areas for improvement.**

Staff followed systems and processes to prescribe, administer, record and store medicines safely. Staff completed medicines records accurately and kept them up-to-date. Medicine administration records showed patients were given their medicines in a timely way, as prescribed, and records were fully completed including any allergies to medicines.

Medicines were stored securely in locked rooms, fridges and cupboards. The service monitored medicines safety as part of the 'Perfect Ward' audit. The results from audits in October showed good compliance with processes to prescribe, administer, record and store medicines safely.

Staff reviewed each patient's medicines regularly and provided advice to patients and carers about their medicines. However, on some wards previous editions of reference sources were available and staff were not aware of some trust guidelines on the trust intranet. Following the inspection, the trust highlighted to staff how to access trust guidelines.

# Surgery

Staff stored and managed all medicines and prescribing documents safely. The trust pharmacy team attended the theatres and wards regularly to review stock levels and order more where necessary. Medicines were in date and stored appropriately. Staff carried out daily checks on controlled drugs and medicine stocks to ensure that medicine stocks were managed correctly. Controlled drugs stock levels were correct and the controlled drug registers were completed correctly.

The service audited medicines records. The service had 89% compliance with indication recording and 97% compliance with maximum dose recording for as required medicines.

Staff followed national practice to check patients had the correct medicines when they were admitted, or they moved between services. Pharmacy staff visited the ward from Monday to Friday. However, a clinical pharmacy service was not provided at weekends.

The service audited medicines reconciliation rates within twenty-four hours of admission. The latest audit result showed the service had on average 78% compliance with medicines reconciliation rates within twenty-four hours. The patient records audit showed that there was poor compliance in medicines reconciliation record completion. Staff had developed an action plan to improve compliance.

Staff learned from safety alerts and incidents to improve practice. We saw a notice board in Kingfisher ward relating to a medicines incident where gentamycin was given to the wrong patient. The board displayed the learning from this incident so all staff could read it. Staff on the ward received additional “tea trolley” training on this topic to improve practice.

### Incidents

**The service managed patient safety incidents well. Staff recognised and reported incidents and near misses. Managers investigated incidents and shared lessons learned with the whole team and the wider service. When things went wrong, staff apologised and gave patients honest information and suitable support. Managers ensured that actions from patient safety alerts were implemented and monitored.**

Staff knew what incidents to report and how to report them. Staff raised concerns and reported incidents, serious incidents and near misses in line with trust policy. Staff understood how to report incidents on the trust’s electronic reporting system.

The service had no never events on any wards. The service had reported no never events or serious incidents in the last year. A never event is a serious incident that is wholly preventable as guidance, or safety recommendations providing strong systemic protective barriers, are available at national level, and should have been implemented by all healthcare providers. They have the potential to cause serious patient harm or death, has occurred in the past and is easily recognisable and clearly defined.

Managers investigated incidents thoroughly. Patients and their families were involved in these investigations. Three serious incident root-cause-analysis investigations were complete, comprehensive and identified learning actions to ensure an incident of this type did not occur again.

Staff received feedback from investigation of incidents. Incidents were discussed at monthly divisional harms meetings for General surgery, anaesthetics, critical care and theatres (GS-ACT) and monthly harm free care and quality metrics review meetings for specialist surgery and musculoskeletal (SSM). Learning across the divisions were shared during this meeting and ward managers fed this back to staff on their wards.

# Surgery

The service followed the trust's Learning from Deaths Policy. The service held regular mortality and morbidity meetings, by speciality, to discuss learning from deaths. However, these were in the form of presentations and were not minuted, attendance was not recorded and learning actions identified did not have a person assigned to them. This was not in line with the Royal College of Surgeons guidelines.

Staff met to discuss the feedback and look at improvements to patient care. There was evidence that changes had been made as a result of feedback. For example, on Kingfisher ward the service had recently had a serious incident regarding a patient who developed a deep tissue injury. Staff met to discuss this incident during a team meeting and had additional "tea trolley" training. This learning and additional training had contributed to a decrease in pressure ulcer injuries on Kingfisher ward.

Staff understood the duty of candour. They were open and transparent, and gave patients and families a full explanation if and when things went wrong. We were given examples where duty of candour was carried out. We saw duty of candour carried out following serious incidents.

## Is the service well-led?

**Requires Improvement** ↓

Our rating of well-led went down. We rated it as requires improvement.

### Leadership

**Leaders had the skills and abilities to run the service. They understood and managed the priorities and issues the service faced. They were visible and approachable in the service for patients and staff. They supported staff to develop their skills and take on more senior roles.**

The service had leadership at ward level which included ward and theatre managers and matrons. These individuals fed upwards to the leaders of the triumvirates. The triumvirate included a divisional director, divisional chief nurse and associate director of operations. These individuals fed upwards to the medical director and chief nurse. Surgery services were split into two divisions these included: General surgery, anaesthetics, critical care and theatres (GS-ACT) and specialist surgery and musculoskeletal (SSM).

Leaders understand the challenges to quality and sustainability and could identify actions needed to address them. Leaders identified staffing as a current challenge and had immediate and long-term strategies to improve staffing levels. These included active recruitment including overseas.

Leaders had relevant skills, knowledge and experience. Leaders at all levels of the service demonstrated relevant skills, knowledge and experience to run the service. Staff were complimentary of their local leaders on the ward and found they were always visible and approachable. Staff found senior staff in the triumvirate visible and approachable.

However, theatre staff told us local leadership were not always visible and approachable. Staff said that they rarely saw the trust executive team in the department. The trust told us that during the Covid-19 pandemic the executive team did not carry out their usual walkabouts to visit staff, because of the infection risk. However, the executive team spoke to staff in monthly trust wide live "Virtual Team Talks". The trust told us these sessions were well attended by staff. However, despite these measures staff told us they felt the executive team were not visible.

# Surgery

The service supported staff to upskill and develop to take on senior roles as part of their strategy to improve staffing. The service had a nursing vacancy rate of 13%. The service had a 14% turnover rate for nursing staff. The service was actively recruiting to help reach established staffing numbers. The service had mechanisms to provide all staff at every level with the development they needed. This included high-quality appraisal and career development conversations which occurred yearly. Appraisals were completed yearly and generally these were up-to-date for all staff. However, Falcon ward had 72% compliance with completion of appraisals and the theatre team had 77% compliance. The trust told us appraisal completion had been significantly reduced in the last year due to the Covid-19 pandemic. This was in line with national directives and guidance.

### Vision and Strategy

**The service had a vision for what it wanted to achieve and a strategy to turn it into action, developed in response to the COVID-19 pandemic.**

The service had recently had a divisional restructure. They did not have a formalised strategy for the GS-ACT and SSM divisions. However, during the pandemic period and since the restructure the service had been following the trust strategy.

The vision and strategy for the GS-ACT and SSM divisions were embedded in the trust's vision. The trust had a clear vision and a set of values, with quality and sustainability as the top priorities. The trusts vision was "to provide an outstanding experience and best outcome for patients and the team".

The trust had robust and realistic strategic objectives underpinning these visions which prioritised quality and sustainability. For example, "quality of care" and "modern healthcare". The trust values the '4Ps' include patients first, personal responsibility, passion for excellence and pride in our team.

The GS-ACT division had an interim strategy which was based on the prevention of harm, patient care, safety and infection prevention. The SSM division had an interim strategy to keep patients safe and focused on the 'North Star' trust objective around infection prevention.

All staff knew and understood what the vision, values and strategy are, and what their role is in achieving them.

### Culture

**Not all staff felt respected, supported and valued. However, staff were focused on the needs of patients receiving care. The service promoted equality and diversity in daily work, and provided opportunities for career development. The service had an open culture where generally staff could raise concerns without fear.**

The culture of the service differed between the ward and theatre areas. While the staff on surgical wards reported that the culture made them feel valued, included and respected this was not the same for all staff in the theatre and recovery areas.

The Care Quality Commission had received information of concern prior to inspection about the culture in the theatres. Our findings during inspection corroborated many of the concerns previously raised. For example, we found a significant number of staff in theatres who felt disengaged and unhappy. Staff perceived there was a lack of consultation about changes to service provision and ways of working. The triumvirate told us they had to change services rapidly in response to the pandemic often without consultation. However, staff told us there was a lack of consultation before the pandemic period.

# Surgery

Following the inspection the trust sent evidence showing how staff were consulted during major strategy and re-organisation. This included their organisational change policy. The trust sent us records of senior consultant attendance at regular meetings around Getting It Right First Time (GIRFT) collaborations. However, these interventions had not been effective in engaging the consultant body in a way that was meaningful to them. This was reflected in feedback from staff.

We found there had been action taken to address behaviour and performance of staff that is inconsistent with the vison and values, regardless of seniority. However, this was not always effective. For example, we were told there was a formal complaint about one individual. We were told this was not resolved, the individual did not apologise to the member of staff who complained and staff were told the reason this individual showed poor behaviours was because they were going through “personal issues”. Staff did not feel this was resolved effectively.

We had information of concern about racist and bullying behaviour prior to our inspection. During our inspection we found no evidence to corroborate these concerns. All staff we spoke to, including those with particular protected characteristics under the Equality Act, felt they were treated fairly and equally. Equality and diversity was promoted within and beyond the organisation. For example, all the policies had an equality impact assessment. The trust produced an annual equality report with actions they have taken so far and future actions. The trust supported development and adaptation of ethnic minority and overseas nurses. For example, the trust ran regular meetings and career development sessions.

We had information of concern that incidents and deaths were not being reported prior to our inspection. Prior to the inspection the executive team provided us with assurance that all incidents and deaths had been reported. During our inspection we found no evidence to corroborate these concerns. Generally, the culture encouraged openness and honesty at all levels within the organisation. Generally, staff told us they were encouraged to raise concerns. Leaders and staff understood the importance of being able to raise concerns without fear of retribution. The service took appropriate learning and action as a result of concerns and incidents raised. The service had access to the trust freedom to speak up guardian and local ambassadors.

The executive team and divisional leaders had developed an action plan and introduced a number of ways to improve the culture and give staff the opportunity to speak out and share their experiences. For example, staff were given an opportunity to discuss concerns with the executive team during “team talk” discussions. Staff could also submit their feedback through an online tool called “Unmask your stories”. Samples of the stories shared by staff were included in the GS-ACT newsletter. The trust had sent communications to staff to highlight ways of raising concerns and to feedback issues and learning raised during the “team talk” discussions. The service led a project on workforce transformation which addressed concerns raised by staff. The service had also implanted a staff survey working group to respond to the results of the staff survey. However, these had not been effective and lacked the impact required for change.

After our inspection the chief executive told us that the theatre teams have started to work with an external provider to address the concerns raised. The trust is continuing progress with their action plan and will be continuing to support theatre teams with managing change, team building and leadership development.

In the ward areas relationships between staff were positive and there was strong teamwork and collaboration. The culture centred on the needs and experience of people who use services. All staff told us they felt positive and proud to work for the service.

# Surgery

There was a strong emphasis on the safety and well-being of staff. Staff had access to employee assist programs and the trust had developed a wellbeing centre which was an open and light area. This had sofas for staff to use to relax and gym equipment.

### Governance

**Not all leaders operated effective governance processes, throughout the service and with partner organisations. Staff at all levels were clear about their roles and accountabilities and had regular opportunities to meet, discuss and learn from the performance of the service.**

Ward sisters had a monthly meeting with the divisional chief nurse to provide service updates for example finance and learning from recent incidents. Actions were added to a log with lead individuals assigned.

Ward managers and matrons met each month as part of a divisional harms meeting review. The purpose was to discuss harms data and share learning. Six sets of meeting minutes, followed the same agenda and were comprehensive. Learning identified from these meetings were fed back to staff during ward team meetings. Meeting minutes evidenced discussion of learning.

Leaders from each division met monthly for a divisional board meeting. Meeting minutes were comprehensive and showed discussion of current safety issues within the division. Actions were identified and recorded on a log with lead individual assigned. Actions were followed up during the following divisional board meeting.

We saw evidence from learning from mortality reviews was seen at board level through a quality of care committee board report presented to the board.

Generally, the service had effective structures, processes and systems of accountability to support the delivery of the strategy and good quality services. Staff had clear lines of accountability which ensured safety and quality issues were reported in a timely way to the right individual. Each ward had a list of link and champion individuals who staff could access for additional advice.

However, not all levels of governance and management functioned effectively and interacted with each other appropriately. For example, in theatres and recovery a significant number of items of equipment were overdue servicing with an external servicing company. This indicated a local governance issue as we did not find corroborating evidence on the surgical wards.

### Management of risk, issues and performance

**Leaders and teams used systems to manage performance effectively. They identified and escalated relevant risks and issues and identified actions to reduce their impact.**

The service had robust arrangements for identifying, recording and managing risks, issues and mitigating actions. Risks were sent to the divisional triumvirate for approval to add to the risk register. The risk register was reviewed on monthly basis at the divisional board meetings. Risks were updated and reviewed on a regular basis. The services risks on the risk register included: “potential inability to provide high quality patient care due to vacant nursing posts” and “Priority patients not being operated upon within four weeks”. The risk register had recorded mitigating actions and each risk was given a risk level. There was alignment between the recorded risks and what staff said was “on their worry list”.

# Surgery

There were processes to manage current and future performance. The service had a systematic programme of clinical and internal audit to monitor quality. The service submitted audit results for the trusts "quality, experience, workforce and safety monthly triangulation and predictor dashboard". This dashboard rated each wards performance and required action plans when performance was below target.

The service had comprehensive assurance systems, and performance issues were escalated appropriately through clear structures. Each ward had their performance reviewed during a monthly divisional harms meeting. Performance issues were escalated during this meeting and the ward manager was required to produce an action plan when performance was below expectations.

### Information Management

**The service collected reliable data and analysed it. Staff could find the data they needed, in easily accessible formats, to understand performance, make decisions and improvements. The information systems were integrated and secure.**

The service had a holistic understanding of performance. This integrated people's views with information on quality. The service reported into the trusts "quality, experience, workforce and safety monthly triangulation and predictor dashboard". This included information such as patient experience, audits, workforce data and harm data. Each score was rated and combined to give an overall score for the ward and theatre area. This information was used to measure improvement, not just give assurance, as it displayed the trend.

The data in this dashboard for October indicated that Swan and Falcon wards were rated as amber which meant the team had to create an action plan to address the issue identified. The rest of the theatre areas and wards were rated either yellow or green. Green indicated no immediate action was required and yellow indicated a review of current actions to address issues. This information was displayed in ward areas to ensure staff had sufficient access to the information.

The service had effective arrangements to ensure that the information used to report on quality and performance is accurate, valid, reliable, timely and relevant. The service had a data quality policy to support this.

The service had robust arrangements to ensure integrity and confidentiality of identifiable data in line with data security standards. The service had an information governance policy. Staff received information governance training to ensure patient information remained confidential. The service had not had any reportable breaches in confidential information in the last year.

### Engagement

**Leaders and staff actively and openly engaged with patients, and local organisations to plan and manage services. They collaborated with partner organisations to help improve services for patients. However, not all staff felt they were actively engaged in discussion over strategies and service reorganisation.**

People's views and experiences were gathered to shape and improve the services and culture. The service engaged with patients through compliments and complaints. Complaints data was reviewed at the monthly divisional harms meeting. When complaints were above average the ward or theatre area had to complete an action plan to identify learning or service improvements.

# Surgery

Staff were actively engaged with, so they understood key information which was relevant to their everyday work. Staff had regular team meetings and handovers. During which key information such as patient and service risks and incidents were discussed. The GS-ACT division had recently started a monthly newsletter to provide useful information and updates to staff. However, staff in the theatres reported that they did not feel involved in decision-making to shape services and culture. Staff felt that there was a lack of discussion over strategies and service reorganisation.

There were positive and collaborative relationships with external partners to build a shared understanding of challenges within the system and the needs of the relevant population, and to deliver services to meet those needs. The service had collaborated effectively during the pandemic period with local independent health hospitals to reduce the elective surgery backlog. There was transparency and openness with independent health hospitals about performance which meant the service could be honest about what they needed.

### Learning, continuous improvement and innovation

**All staff were committed to continually learning and improving services. They had a good understanding of quality improvement methods and the skills to use them. Leaders encouraged innovation.**

Leaders and staff were committed to continuous learning, improvement and innovation. The SSM division ran additional training days for their ward managers and deputies. Topics included in these training days included: red blood cell transfusion and a review of spinal case notes. Staff received simulation training in theatre emergency and human factors training.

Both the GS-ACT and SSM division have a robust local clinical audit schedule, this supports staff to identify learning actions to improve the service effectiveness and efficiency. Audits undertaken include renal colic, virtual fractures clinic clinical effectiveness and rapid COVID-19 testing on theatre efficiency.

The SSM division had conducted work on staff behaviours to reinforce divisional behaviour values such as: treat others with respect, being supportive of colleagues and working collaboratively.

The service participated in a recognised accreditation schemes. The GS-ACT division had recently created audits to review aspects of clinical safety in theatres using standards set by the RCoA. The aim of this work was to identify any problems and work to solve them using quality improvement methodology. Staff had support from the quality improvement team during this work. The service has used this information as part of their work to gain Anaesthesia Clinical Services Accreditation (ACSA).

Staff received training in quality improvement methods. Staff used quality improvement methods to run projects. For example, staff used quality improvement tools to improve the number of falls on Kingfisher ward. The trust had a quality improvement internet page for staff to access resources, support and ideas related to quality improvement.

The service effectively participated in and learning from incidents, including those related to mortality. Learning was shared effectively to make improvements. For example, on Kingfisher ward there had been learning from medicines incidents. Following learning and training, medicines incidents on the ward had reduced.

# Surgery

## Areas for improvement

Action the trust MUST take is necessary to comply with its legal obligations. Action a trust SHOULD take is because it was not doing something required by a regulation, but it would be disproportionate to find a breach of the regulation overall, to prevent it failing to comply with legal requirements in future, or to improve divisions.

**Action the trust MUST take to improve:**

- The service must ensure that damage to flooring, walls and fittings in the theatre and recovery areas is repaired (Regulation 12(2)(d)).
- The service must ensure all medical devices are serviced regularly (Regulation 12(2)(e)).

**Action the trust SHOULD take to improve:**

- The trust should ensure patient physiological observations are completed on time (Regulation 12).
- The service should ensure that staff can access current guidelines and reference sources when handling medicines (Regulation 12).
- The trust should ensure medicines reconciliation is completed within 24 hours (Regulation 12).
- The service should ensure all staff are up-to-date with their safeguarding adults and safeguarding children training (Regulation 13).
- The service should ensure all staff are up-to-date with their mandatory training (Regulation 18).
- The service should take action so staffing numbers matches the planned numbers on the ward areas.
- The service should consider the culture in theatres and how to address issues in a way that will produce effective and embedded improvement.
- The service should consider a formalised way to record mortality and morbidity meetings.

# Medical care (including older people's care)

**Good** ➔➔

Our rating of medical care remained the same.

- Staff had training in key skills, understood how to protect patients from abuse and harm most of the time, and managed safety well. The service controlled infection risk well. Staff assessed risks to patients, acted on them and kept good care records most of the time. They managed medicines well. The medical division managed safety incidents well and learned lessons from them.
- Staff provided good care and treatment most of the time, gave patients enough to eat and drink, and gave them pain relief when they needed it. Managers made sure staff were competent. Staff worked well together for the benefit of patients and had access to good information. Key services were available seven days a week.
- Leaders ran services well using reliable information systems and supported staff to develop their skills. Staff understood the vision and values, and how to apply them in their work. Staff felt respected, supported and valued. They were focused on the needs of patients receiving care. Staff treated patients with compassion and kindness, respected their privacy and dignity and took account of their individual needs. Staff were clear about their roles and accountabilities. The service engaged well with patients and the community to plan and manage services. Staff collected safety information and used it to improve the division and all staff were committed to improving divisions continually.

However:

- Nursing staff numbers were consistently below planned levels.
- Safeguarding training was not always at an appropriate level and senior doctors' training was out of date. Staff did not always make sound judgements around people's safeguarding needs. Staff did not feel supported because safeguarding teams did not visit the wards.
- Staff did not always record patient observations on time during the day.
- Staff did not always manage naso-gastric tubes in line with national guidance, food and nutrition charts were not always accurately completed.

## Is the service safe?

**Good** ↑

Our rating of safe improved. We rated it as good

### Mandatory Training

**The division provided mandatory training in key skills to all staff and made sure everyone completed it.**

Nursing staff received and kept up-to-date with their mandatory training. The mandatory training was comprehensive and met the needs of patients and staff. Ninety per cent of staff had completed mandatory training.

Senior staff were trained in advanced life support. Compliance was 85% with senior staff trained in advanced life support and other staff trained in intermediate life support. All middle grade doctors had completed simulated life support training

# Medical care (including older people's care)

Clinical staff completed training on recognising and responding to patients living with dementia. Over 80% of staff had received dementia in clinical practice training. Managers completed "Best Interest" assessments for people who lacked capacity and were unable to make decisions about their care. The trust monitored compliance of this.

Managers monitored mandatory training and alerted staff when they needed to update their training. Clinical practice educators (CPE) monitored training completion. However, the trust was in the process of transferring data from one digital system to another and completion figures did not always reflect completion dates. The CPE manually monitored compliance to ensure trust targets were met which was time consuming

The trust made sure that new staff received an educational development plan and orientation manual which outlined clear objectives and key information about the hospital which included contact details of managers and CPE assessors.

The trust had implemented mandatory 'Preventing Harms' training in August 2021 to make sure new members of staff were competent in pressure ulcer and falls prevention, malnutrition universal screening tool (MUST) use and Venus-thromboembolism (VTE) care and assessment.

### Safeguarding

**Staff understood how to protect patients from abuse and the division worked well with other agencies to do so most of the time. Staff had training on how to recognise and report abuse but did not always make appropriate referrals. The safeguarding lead did not offer face to face support on the wards, not all doctors were trained to the appropriate level or up-to-date with safeguarding training.**

Nursing staff received training specific for their role on how to recognise and report abuse. Training was delivered via e-learning. Records confirmed that all nurses were trained at child and adult safeguarding level 2. However, there was no evidence that nurses had trained at level 3 safeguarding and we saw examples where staff did not always consider people's needs holistically. For example, the use of safeguarding referrals as a support mechanism for teenagers whose carer was in hospital.

Medical staff received training specific for their role on how to recognise and report abuse. Overall, most doctors had completed their level two adult safeguarding training online. However, training records for senior registrars and consultants in the division showed that 51% were not compliant with safeguarding training. Also, there was no evidence that any doctors were trained at level 3. The Adult Safeguarding: Roles and Competencies for Health Care Staff (2018) national guideline states "Registered health care staff who engage in assessing, planning, intervening and evaluating the needs of adults where there are safeguarding concerns should be trained at level 3".

After the inspection the trust advised that safeguarding training for doctors compliance was recognised as a challenge. The trust had planned to roll out level 3 safeguarding training for staff in April 2021. However, due to the COVID-19 pandemic this had been delayed because staff had been relocated. Leaders advised us that there was a recovery plan and this issue had been recorded on the trust's risk register.

Staff gave examples of how to protect patients from harassment and discrimination, including those with protected characteristics under the Equality Act. Staff told us that if they had concerns, they would speak to the doctors and the safeguarding lead although they could not give us any examples.

Staff knew how to make a safeguarding referral and who to inform if they had concerns. However, staff did not always make appropriate referrals as they did not identify all adults at risk of neglect, abuse suffering, or significant harm. Staff told us that since the COVID-19 pandemic they did not complete safeguarding referral forms because the safeguarding

team reviewed the details, completed the safeguarding referral and followed the patients up. This does not conform to the national guidance which states, “competent staff should be able to “undertake regular documented reviews of own (and/or team) safeguarding practice as appropriate to role (in various ways, such as through audit, case discussion”. However, after the inspection the trust advised that this was a temporary measure during the pandemic to enable staff more time to care for patients and that in fact the care group had reverted to senior ward staff completing the safeguarding referrals.

Since COVID-19 the safeguarding lead did not visit the wards. Staff discussed referrals’ via the telephone which meant the safeguarding lead did not review the patient paper record in full, with other members of the multi-professional team. Clinical staff told us they preferred speaking to the safeguarding team in person as this made them feel more supported in their decision making around safeguarding.

Staff identified all adults at risk of, or suffering significant harm most of the time, and worked with other agencies to protect them. The CQC received several safeguarding notifications from third-party community teams regarding unsafe discharges and pressure ulcers. These highlighted missed opportunities by ward staff to make adequate safeguarding referrals. This implied that patients were sent home without the appropriate care package, when we raised this with the trust they investigated all of the concerns raised. After the inspection we were assured by the trust that they had robust systems to refer pressure ulcers to safeguarding if required. All pressure ulcers were reported via the trusts internal incident reporting system. These were are then reviewed by the tissue viability team to ensure they are investigated thoroughly.

Staff worked collaboratively with specialist teams to assess patients safeguarding needs, for example the dementia and psychiatric liaison team. Staff received support from the Learning Disabilities Liaison Service provided by a mental health trust. A learning disabilities nurse (LD) and a nursing associate provided support for both inpatient and outpatient services for patients with a learning disability. The LD nurse attended the wards and supported decisions made in the best interests of patients.

### Cleanliness, infection control and hygiene

**The division controlled infection risk well most of the time. Staff used equipment and control measures to protect patients, themselves and others from infection. They kept equipment and the premises visibly clean.**

Ward areas were clean and had suitable furnishings which were clean and well-maintained. The division performed well for cleanliness. Staff completed monthly a Quality Experience Workforce and Safety monthly triangulation audit (QEWS) and infection control was recorded using a digital application which prompted staff to input data and take photos of any risks. Half yearly data confirmed cleanliness performance met trust targets most of the time.

Cleaning records were up-to-date and demonstrated that all areas were cleaned regularly. Housekeepers worked alongside clinical staff in all ward areas. Cleaning record sheets were displayed in all areas and confirmed that cleaning was completed on a regular basis.

Staff followed infection control principles including the use of personal protective equipment (PPE). The trust had guidelines on what and when to wear appropriate PPE which was available at workstations throughout all wards. Staff always wore masks and when caring for patients, used face visors, aprons and gloves.

Staff were ‘bare below the elbows’. Wards completed monthly hand hygiene audits records confirmed that trust targets were met over 90% of the time. Hand decontamination gel was available at the entrance to all wards and at the entrance to each bay.

Staff cleaned equipment after patient contact and labelled it to show when it was last cleaned. Staff limited opportunities for cross contamination. They had access to decontamination antibacterial wipes which they used after patient contact.

The service learned from instances of COVID-19 infections to make sure outbreaks were well managed. In October 2021 there were four probable healthcare acquired COVID cases in the trust. These were cases confirmed 8-14 days after patient admission. There were seven definite healthcare acquired COVID cases in the trust. These were cases confirmed 15 days or more after admission. This placed the trust in the top 15 performing trust nationally. The trust used a number of new technologies to achieve low rates of healthcare associated COVID. These included use of filter air purifiers on the wards, UVC light disinfection and decontamination in both clinical and non-clinical areas.

### Environment and equipment

**The design, maintenance and use of facilities, premises and equipment kept people safe. Staff were trained to use them. Staff managed clinical waste well.**

Patients could reach call bells and staff responded quickly most of the time. The wards were busy, and often below the agreed staff numbers, but we observed staff responding to call bells as soon as possible.

The design of the environment did not always follow national guidance. This was because the hospital had been built over 50 years ago. For example, there was lack of workspace: all staff used the same limited number of phones and computers at the nurses station to communicate which meant confidential patient information could be overheard during handovers. This was not in line with NHS England's (Health Building Note 00-03) Clinical and clinical support spaces (2021). Ward bays caring for people with dementia were not all designed or laid out in line with current best practice for example the University of Stirling standards for dementia design. Only one bay, which had appropriate flooring and coloured walls and equipment to help dementia patients navigate the area safely. However, after the inspection the chief executive told us that the trust's ambition is to improve the environment, but trust spending had been capped as part of a national initiative created by the COVID-19 pandemic.

Staff carried out daily safety checks of specialist equipment. Staff made sure that emergency resuscitation equipment was checked daily. Checklists were kept on the appliances and confirmed daily checks were completed.

The division had enough suitable equipment to help them to safely care for patients. Each bay had blood pressure monitoring equipment, and piped air and oxygen. All beds were electrically operated and had pressure relieving mattresses to reduce the risk of pressure sores.

Staff disposed of clinical waste safely. Waste bins were colour coded so staff could segregate clinical and domestic waste. Staff knew about the colour coded system. Sharps bins were available in all bays.

Staff completed medical device training on equipment used in patient care. Staff training was aligned to the trust's "Medical Device Training Policy". Staff were trained to use medical devices, observation monitoring and resuscitation equipment.

### Assessing and responding to patient risk

**Staff completed and updated risk assessments for each patient and removed or minimised risks most of the time. Staff identified and acted upon patients at risk of deterioration.**

# Medical care (including older people's care)

Staff used a nationally recognised tool to identify deteriorating patients and escalated them appropriately. Staff completed National Early Warning Score (NEWS) charts to record patient observations. Scores were completed and concerns escalated to the doctors. However, staff did not always complete observations on time. The division's performance for monitoring patients observations averaged 70% failing to meet the trust's target of 90% in most audits.

Staff completed risk assessments for each patient on admission, using a recognised tool, and reviewed this regularly, including after any incident. Staff knew about and dealt with most specific risk issues. Staff completed and updated a patient risk assessment booklet throughout the patient's stay. This prompted staff to consider various common risks. Audits that identified lack of compliance to updating the various aspects of the document were fedback to the divisional leads and fedback to staff via daily staffing huddles, the monthly 'harms free' care meetings and the 'Medicine Division Newsletter' published monthly. However, we reviewed 14 sets of patient records and seven had incomplete waterlow scores, which are used to assess pressure ulcers.

Staff did not always records conversations with healthcare professionals, patients, and families about care in future emergencies. The trust introduced ReSPECT which stands for Recommended Summary Plan for Emergency Care and Treatment in May 2021. The ReSPECT process creates a summary of personalised recommendations for a person's clinical care in a future emergency in which they do not have capacity to make or express choices. A trust audit confirmed that of resuscitation documentation found 47% of audited notes did not record conversations between healthcare professionals patients and families.

Shift changes and handovers included all necessary key information to keep patients safe. Staff used the Situation Background Assessment Risk (SBAR) tool to receive patients being admitted. Handover sheets were designed in an SBAR format and all staff caring for patients were responsible for updating an electronic SBAR so that handovers were accurate and informed the plan of care.

Staff understood the signs of sepsis and acted upon the symptoms when identified. Digital NEWS scores highlighted potential risks. Nursing staff escalated concerns to doctors and used a 'sepsis care bundle' to treat patients showing signs of sepsis

The division had 24-hour access to mental health liaison and specialist mental health support. Staff arranged, psychosocial assessments and risk assessments for patients thought to be at risk of self-harm or suicide. Staff worked collaboratively with the psychiatric and dementia teams. The Dementia Policy advised staff that hospital was not the best place to diagnose dementia and assessments should be arranged in the community setting. Staff referred patients to the community frailty hub for ongoing assessment of their cognitive impairment. However, patients with cognitive impairment often had extended hospital stays which meant they did not always receive care in the most appropriate setting.

Staff shared key information to keep patients safe when handing over their care to others. Staff used standardised referral forms when referring patients to the dietitian, specialist nursing, dementia and psychiatric liaison teams. These forms prompted staff to include all the patient's history and detailed reason for referral.

Staff made sure that people with dementia were identifiable to staff, so they were aware of the associated risks. Patients who were at risk of falls, wore yellow socks and had yellow blankets on their beds. This highlighted their extra needs to all staff caring for them. However, since COVID-19 staff did not complete a 'This is Me' passport which is a communication aid which families and carers help to complete so that staff understand all the patient's needs. After the inspection, the chief executive advised us that the Safeguarding and Learning Disabilities Committee has oversight on the progress of this and will reporting this in their December meeting.

# Medical care (including older people's care)

## Nurse staffing

**The division did not always have enough nursing and support staff with the right qualifications, skills, training and experience to keep patients safe from avoidable harm and to provide the right care and treatment. However, managers regularly reviewed and adjusted staffing levels and skill mix to meet the needs of the patients and accessed bank and locum staff to keep patients safe.**

The division did not always have enough nursing and support staff to keep patients safe. The division monitored staffing. The trust's Quality Experience Workforce and Safety monthly triangulation audit (QEWS) confirmed that most ward staffing failed to meet the trust's target of 90% during the past six months and there were times when some medical wards staffing averaged 70%. Staff told us that their biggest challenge was managing workloads due to poor staffing. Staffing challenges were recorded on the trust's risk register. After the inspection the chief executive told us that the trust took a multifaceted approach to managing their staffing challenges which included a sourcing staff from overseas as part of their comprehensive recruitment strategy.

Managers told us that a cohort of 48 new health care professionals were due to start by the end of the year and that the trust plans to continue to recruit from overseas.

Managers accurately calculated and reviewed the number and grade of nurses, nursing assistants and healthcare assistants needed for each shift in accordance with national guidance. The trust produced a quarterly workforce report which confirmed the use of a nationally recognised staff planning tool. However, staff sickness and staff vacancy rates were high during the COVID-19 pandemic and staff turnover had increased.

The number of nurses and healthcare assistants rarely matched the planned numbers. The ward manager adjusted staffing levels daily according to the needs of patients most of the time. Matrons met daily to redeploy staff to areas where the workforce was depleted. The quarterly workforce report confirmed that several wards had a depleted workforce which average 24%. This meant staff were redeployed on a regular basis and the impact of this was lack of continuity of care for patients.

The service had reducing sickness rates. Managers trust wide had experienced challenges during the last year due to staff having to self-isolate because of their exposure to the COVID-19 virus or because they were shielding due to pre-existing health conditions.

The division had a high vacancy rate for registered health care professionals. The trust had recruited its newly qualified cohort of students and was sourcing additional clinical staff from overseas. The current vacancy rate for qualified staff averaged 17% and varied from ward to ward, for example Cedar ward had a -28% vacancy rate yet Chestnut had a 36% vacancy rate. The division had a high vacancy rate for unregistered support staff with a varying rate which averaged 25% across ten wards. The effect of this was that staff had less time to care for patients.

The divisions turnover rate did not meet the trust's target of 12%. Five wards had a rate over 19% and three over 12%. Managers collected staffing data which was shared with the trust's governance team who used the data to complete the quarterly workforce report, and the information was shared at board level.

The division use of bank and agency nurses used on the wards was high. The trust monitored the use of bank and agency and the trust spend on staff cover had increased by a third from May 2021 to October 2021. The trust told us that

there had been an increase in the use of bank and agency staff due to the opening of escalation areas and further wards to increase capacity, also to cover the increase in sickness. Ward managers were instructed to complete return to work interviews and support teams with their well-being. Also, staff were referred to Occupational Health as deemed necessary.

Managers made sure all bank staff understood the service. The division had its own pool of staff who registered with the bank nursing department and applied to work extra shifts. This meant they were familiar with the environment.

### Medical staffing

**The division had enough medical staff with the right qualifications, skills, training and experience to keep patients safe from avoidable harm and to provide the right care and treatment. Managers regularly reviewed and adjusted staffing levels and skill mix and gave locum staff a full induction.**

The division had enough medical staff to keep patients safe most of the time although medical staffing did not always match the planned numbers. However, the division had reducing vacancy rates. The trust monitored medical staffing and the vacancy rate had improved from September 2021. After the inspection the chief executive told us that there were 2.4 whole time equivalent (WTE) vacancies in medicine, one of which has recently been filled and recruitment to the other post was at shortlisting stage. The remaining 0.4 WTE is a chief registrar post which is 40% non-clinical.

Sickness rates for medical staff were reducing. The division had experienced challenges during the last year due to staff having to self-isolate because of their exposure to the COVID-19 virus or because they were shielding due to pre-existing health conditions. Although sickness rates from May 2021 to October 2021 had reduced by 30%.

The division had an increased rate of bank and locum staff. Records confirmed that managers used bank staff to backfill shifts and the use of locums had increased by a third from May 2021 to October 2021.

Managers could access locums when they needed additional medical staff. Managers made sure locums had a full induction to the division before they started work. The division provided locums with a full orientation and induction and the covering doctors completed a competency assessment.

The division had a good skill mix of medical staff on each shift most of the time and reviewed this regularly. However, doctors told us that due to the acuity of patients with complex medical and social histories there were times when they felt they needed extra medical staff on the wards. Junior staff told us they felt supported by their senior colleagues during the week, although at weekends this was more challenging.

The division always had a consultant on ‘remote’ call during evenings and weekends. Records confirmed patients were reviewed within 24 hours of admission. However, this was not always by a consultant. Consultant ward rounds were completed daily during the week.

### Records

**Staff kept detailed records of patients’ care and treatment. Records stored securely and easily available to all staff providing care. However, not all records were clear, correctly updated or filed in order.**

Patient notes were comprehensive, and all staff could access them. However, paper records were in use and they were not always fully completed or filed contemporaneously in line with trust policy. We reviewed 14 sets of paper medical records and noted that there were various gaps in documentation ranging from incomplete recording of patients contact details and next of kin to lack of entries on gaining patient consent. This was not in line with the Records Management

Code of Practice (2021) which provides a framework for consistent records management and reflects the professional obligations of registered healthcare professionals. After the inspection the trust submitted evidence of a completed patient record audit which highlighted gaps in record keeping. For example, the audit highlighted poor recording of evidence of patients involvement in decision making. The outcomes were used to create and inform a trust-wide action plan.

Nursing records were kept at the end of the patient's bed and contained records of patients' assessments such as observations, nutrition, pressure ulcer and nutritional observation charts. Staff kept nursing records in a blue folder to ensure they were not on view to visitors.

Staff completed electronic patient records of observations, diagnostic tests, including blood and diagnostic imaging results. Access was password protected. Also, staff had access to an electronic patient admissions board and could see which patients were on a ward at any time.

Medical records were stored securely in line with the trust's "Records Management Policy" in key coded cabinets which were kept at the nursing station. These records contained all notes from assessments and interventions completed by doctors and other members of the multidisciplinary teams.

When patients transferred to a new team, there were no delays in staff accessing their records. Patients' and GP's received timely information about their patients' care and treatment. Discharge notifications were completed by doctors and nurses and a was printed prior to discharge. Discharge notifications were given to the patient at the point of discharge and GP's received the information electronically.

### Medicines

**The division used systems and processes to safely prescribe, administer, record and store medicines.**

Staff followed systems and processes when safely prescribing, administering, recording and storing medicines. Medicine administration records showed patients were given their medicines in a timely way, as prescribed, and records were fully completed including any allergies to medicines

Staff reviewed patients' medicines regularly and provided specific advice to patients and carers about their medicines. However, on some wards previous editions of reference sources such as the intravenous handbook were available for use or the critical medicines list and were not available. After the inspection the chief executive told us that the trust identified that the "Critical Medicines list" required updating and expanding. The updated document was provided after the inspection and, the managers highlighted to staff how to access trust guidelines. Following our inspection, the trust advised us IV medication handbooks were being removed from all clinical areas and they had distributed communications on an electronic resource for all IV medication preparations. The trust said they would complete follow up checks to ensure these actions were completed.

Staff completed medicines records accurately and kept them up to date. Staff used hard-copy medicines administration charts' to record administration of medication and an audit of 14 patients records confirmed these were accurately completed.

# Medical care (including older people's care)

Staff stored and managed medicines and prescribing documents in line with the provider's policy. Staff carried out daily checks on controlled drugs and medicine stocks to ensure that medicines were reconciled correctly. Controlled drugs stock levels were correct and the controlled drug registers were completed correctly. However, we found a few medicines lacked revised expiry dates following a change of storage, such as salbutamol nebuliser solution once opened or glucagon once removed from the fridge.

Staff followed current national practice to check patients had the correct medicines when they were admitted or moved through services. Staff completed a medicine e-learning module to make sure they understood the correct process. A pharmacist reviewed all medical prescriptions, including antibiotics to identify and minimise the incidence of prescribing errors and to ensure antibiotics were used appropriately. Pharmacy staff visited the ward from Monday to Friday 8am to 4pm; a ward pharmacist service was not provided at weekends An "on call" pharmacist was accessed remotely at weekends for medication queries but there was no face to face patients reviews over the weekend. This had the potential to lead to delays in the administration of long term medication for people with chronic disease or illness.

The division had systems to ensure staff knew about safety alerts and incidents, so patients received their medicines safely. The alerts were placed on the trust's intranet and cascaded via ward managers and matrons and staff received alerts via email.

### Incidents

**The division managed patient safety incidents well. Staff recognised and reported incidents and near misses. Managers investigated incidents and shared lessons learned with the whole team and the wider division. When things went wrong, staff apologised and gave patients honest information and suitable support. Managers ensured that actions from patient safety alerts were implemented and monitored.**

Staff knew what incidents to report and how to report them. Staff raised concerns and reported incidents and near misses in line with trust policy. Staff completed a digital incident reporting form which was reviewed by the matrons. A trust central team supported staff and delivered training on roles and responsibilities for the effective management of reporting and investigating incidents. This was monitored by the divisional chief nurse via speciality governance meetings and the "Ward Accreditation Programme".

Staff reported serious incidents clearly and in line with trust policy. Serious incidents were reported via an electronic reporting system. Alerts were sent to matrons who reviewed the details and allocated the incident to key staff for investigation. Serious incident review panels completed 72 hours reviews to ensure learning from incidents was fedback to staff in a timely manner.

Managers investigated incidents thoroughly. Patients and their families were involved in these investigations. The division had no "never" events. Never Events are serious, preventable safety incidents that should not occur if the available preventative measures are implemented.

Staff received basic feedback from investigation of incidents that occurred internally. Staff told us they did not always know the full outcome of investigations, but they received an acknowledgement. Managers met to discuss the feedback and look at improvements to patient care. Staff received feedback via staff handovers which included a 'topic of the week'. For example, the trust's performance regarding pressure care.

Managers debriefed and supported staff after any serious incident. Relevant learning was shared through ward meetings and events. The trust had a regular learning event where serious incident (SI) investigations were presented, and learning shared across the organisation. Actions following an SI was added to incident reporting system and allocated to the relevant staff for action and monitoring.

Managers shared learning with their staff about never events and serious incidents that happened elsewhere. The division held monthly staff meetings, held weekly 'hot topic' updates, and produced the divisions newsletter which highlighted key themes and practice changes to reduce future risk. For example, nasogastric tubes, pressure ulcers and falls were all reported on in the October 2021 version.

The patient safety team held daily safety huddle and the division had a plan to reduce the number of overdue incidents which was supported by the safety team. There were 319 open incidents which included five serious incidents and two deaths. The number of overdue incident reports by department were included in the speciality governance data and escalated on a weekly basis to the triumvirates. The numbers were discussed as part of the divisional chief nurse meetings with the ward managers. Leaders told us that the division has an action plan to ensure incidents are closed in a timely manner. Overall, the trust most recent incident reporting rate was 46.6 per 1000 bed days which is evidence of an adequate safety reporting culture.

Changes had been made as a result of feedback. The division made sure that practice was updated as a result of feedback. For, example, the addition of alarms to patient air flow purifiers to alert staff if the equipment was malfunctioning.

Staff understood the duty of candour. They were open and transparent and gave patients and families a full explanation when things went wrong. Staff practised in line with the trust's "Being Open" policy which was based on the Health and Social Care Act 2008 (regulated activities) Regulations 2014: Regulation 20 Duty of Candour. Staff understood their ethical responsibility to be open and honest and people received verbal and written apologies.

## Is the service effective?

**Inspected but not rated**

Because this was a focused inspection we did not rate effective.

### Nutrition and hydration

**Staff gave patients enough food and drink to meet their needs and improve their health. They used special feeding and hydration techniques when necessary although the management of nasogastric tubes did not always follow national guidance. Nutrition records were not always completed correctly to ensure all patients received nutrition and hydration reviews.**

Staff made sure patients had enough to eat and drink, including those with specialist nutrition and hydration needs. Staff took time to encourage people with complex needs to eat and drink most of the time. Some staff were concerned about the management of nasogastric (NG) tubes. NG tubes are used to administer nutrition to people who are unable to eat normally. They reported training and observation competency tests were not always performed in line with national guidance. We saw one case where an NG tube had not been managed in line with national guidance "Time to put patient safety first" (BAPEN 2020). Records showed varying degrees of training and competency checks throughout the division. NG tube compliance was not recorded on the directorate risk register.

# Medical care (including older people's care)

Specialist support from staff such as dietitians and speech and language therapists was available for patients who needed it. Dietitians visited the wards daily Monday to Friday to receive referrals and review patients. Speech and language therapist reviews were requested when patients had communication or swallowing problems.

Staff used a nationally recognised screening tool to monitor patients at risk of malnutrition. Staff used the Malnutrition Universal Screening Tool (MUST) scoring tool. This was reviewed on a weekly basis for long stay patients. The ward audit scores measuring MUST completion and an accurate MUST score, showed compliance between 95 - 98%. However, records we reviewed showed gaps in MUST documentation; for example, weight or dietary needs not recorded at every review and prior to discharge. The CQC received information of concern regarding lack of MUST assessments. The impact of this is that staff missed opportunities to nourish some patients. As a result of NHS England 'Reducing the Burden' Letters of March 2020 and January 2021 the division reduced mandatory training of assessing nutrition called 'MUST'. The nurse staff training rate was 36% in November 2021. However, the clinical practice educators in the division were supporting staff to reach the trust target of 90%. The trust planned a campaign for January 2022 concentrating on embedding nutrition and MUST assessments.

Staff did not always fully and accurately complete patients' fluid and nutrition charts where needed. Fluid balance assessment status was not always updated. Fifty per cent of records reviewed showed updates were missing. Managers said audit data for this was not accurate as not all patients audited required a fluid balance chart; they planned to audit five patients with a fluid balance chart on a quarterly basis.

## Is the service responsive?

**Inspected but not rated**

Because this was a focused inspection we did not rate responsive.

### Access and flow

**People could access the service when they needed it and received the right care promptly most of the time. Waiting times from referral to treatment and arrangements to admit, treat and discharge patients were not always in line with national standards.**

Managers and staff were not always able to make sure patients did not stay longer than they needed to. This was because staffing levels and the acuity of patients made the discharge process time consuming and complex and within the community there was a lack of social care beds for people with complex mental health needs. This meant there were numerous examples of medically fit patients who were "stranded" on medical wards waiting for discharge documentation to be completed. Also, patients suspected of having dementia were stranded on medical wards which was not a suitable place to care for their needs. We were given examples of patients being stranded for 30 days which meant they were not in the best place to meet their needs and protect their human rights.

The division faced daily challenges to make sure discharges were timely and safe. Ward managers and matrons attended daily meetings to monitor the number of delayed discharges and knew which wards had the highest number most of the time. The discharge team managed complex discharges. There was a daily "medically fit call" where staff discussed the challenges with the divisional management team around patients who are medically fit for discharge. However,

managers we spoke to did not always have complete oversight of how many medically fit patients were stranded in the division or how long they had been stranded for. At the time of our visit there were 63 stranded patients within the division. This affected the trust's ability to manage patient flow and the trust experienced capacity issues at peak times because of this.

Managers and staff worked hard to make sure that they started discharge planning as early as possible. Discharge planning documents were started prior to discharge by the doctors caring for the patient. However, staff told us this was not always completed before a patient was ready for discharge. This meant that staff moved medically fit patients to the discharge lounge whilst they awaited the completed documentation because they needed to create capacity.

Staff planned most patients' discharge carefully. However, for those with complex mental health and social care needs there were reported gaps in the process. The CQC received several enquiries from third party organisations about missed opportunities by staff to complete safeguarding referrals' with some patients left alone without support. The trust had recognised there were issues with unsafe discharges in the past and had implemented a pilot discharge improvement programme 'Alliance 16' in partnership with the local authority and adult social care so that it could monitor and reduce the length of hospital stays for medically fit patients. During the reporting period there were 64 failed discharges incidents reported internally. These figures did not include the failed discharges reported by community teams.

The service moved patients only when there was a clear medical reason or in their best interest most of the time. However, due to capacity issues we were told there were times when patients were moved to free up beds. For example, the recently opened Discharge Lounge at St. Peter's Hospital provided seven days a week service, working from 8.00am to 9.00 pm Monday-Friday and 9.00am to 5pm at weekends and public holidays. Since opening in October 2021 staff told us it was commonplace for the area to be opened at night and staffed by a bank nurse and support worker to care for patients waiting to go home to free space on the wards.

After the inspection the chief executive clarified the trust's actions to oversee and manage discharges for medically fit patients. The trust recently introduced a digital platform, inpatient patient treatment list (PTL), to enhance access to information around patient discharge for which training was provided to all ward teams. Since the inspection, the division has clarified access arrangements to the PTL with all ward areas, matrons and discharge teams to ensure staff are aware of the current status for all patients on a discharge pathway

Any unresolved issues were escalated to the corporate team. This issue had become more challenging since COVID-19. The trust had recently opened a 19 bedded ward for medically fit patients whilst they waited for community placements and the first 11 were transferred during November 2021.

## Is the service well-led?

**Good**  

Our rating of well-led stayed the same. We rated it as good.

### Leadership

**Leaders had the skills and abilities to run the division. They understood and managed the priorities and issues the division faced although sometimes lacked oversight of safeguarding and flow. They were visible and approachable in the division for patients and staff. They supported staff to develop their skills and take on more senior roles.**

# Medical care (including older people's care)

The General and Specialist Medicine (GSM) divisional triumvirate consisted of a divisional director and divisional chief nurse and an associate director of operations. The triumvirate were responsible for managing the division and recommending strategies to improve services to the board based on outcomes and incidents.

The divisional director had worked for the trust for several years and had a proven track record in acute and general medicine. They were passionate about maintaining their skills and made sure they worked clinically within the division to oversee and support junior colleagues.

The triumvirate was responsible for 11 medical care specialities which included senior adult medical divisions (SAMS), cardiology, gastrology, stroke, palliative care, diabetes and respiratory.

The divisional leads oversaw ward managers and six matrons were responsible for the everyday management of services.

Leaders understood the challenges to quality and sustainability and identified most actions needed to address them. Leaders escalated concerns about staffing and had influenced strategies on overseas recruitment.

Leaders had the relevant knowledge, skills and experience to run services. Staff were complimentary of their local leaders on the ward and found they were always visible and approachable. Staff found senior staff in the triumvirate visible and approachable and felt able to escalate concerns.

Matrons supported staff in career development. Staff gave us examples of how they were encouraged to progress the professional development, through appraisals. Staff with special interests were encouraged to attend courses that would enhance their knowledge base.

However, there were times when managers lacked oversight around safeguarding and flow. Leaders did not provide evidence of level 3 child or adult safeguarding for staff involved in making decisions about care which is not in line with national guidance. Also, during the inspection the triumvirate told us they lacked daily oversight on the length of stay of medically fit stranded patients in the division at any given time. However, the divisional management team was represented at the daily medically fit for discharge meeting and regularly escalated the issue of stranded patients with the trust executive and community partners.

### Vision and Strategy

**The division had a vision for what it wanted to achieve and a strategy to turn it into action, developed with all relevant stakeholders. The vision and strategy were focused on sustainability of services and aligned to local plans within the wider health economy. Leaders and staff understood and knew how to apply them and monitor progress.**

The division had a clear vision and a set of values, with quality and sustainability as the top priorities. The vision and strategy for the medical care division reflected the trust's vision which was "to provide an outstanding experience and best outcome for patients and the team".

The trust had robust and realistic strategic objectives underpinning these visions which prioritised quality and sustainability. The trust's vision was based on the "4P's" which were patients first, personal responsibility, passion for excellence and pride in their team. The clinical practice educators told us they used the vision as a framework to deliver training.

The triumvirate worked closely with commissioners and neighbouring trusts' to deliver services both within the acute setting and the community. For example, they had worked with other organisations to implement and deliver the pilot Alliance 16 project to enhance and monitor the discharge process because this was a known issue across the region.

The division faced various challenges due to demand, fatigue placed on staff; financial constraints and challenging local government decisions. All of which placed strain on staff workload, collaboration and culture. The divisions strategy echoed the trust's and was designed to address some of the challenges. For example, the trust had recognised that an overseas recruitment campaign was vital to improve staffing.

### Culture

**Staff felt respected, supported and valued. They were focused on the needs of patients receiving care. The division promoted equality and diversity in daily work and provided opportunities for career development. The division had an open culture where staff could raise concerns without fear.**

The trust had several introduced initiatives to monitor and improve staff wellbeing over the last year. For example, the trust opened a new wellbeing hub where all staff had access to resources to help improve their wellbeing. Staff were supported by psychologists and on site pastoral services.

Ward managers and matrons were responsible for staff appraisals and well-being conversations. Records from the trust's people's committee workforce report showed appraisal rates of 75%.

The trust had established a BAME network for staff from Black and Asian Minority Ethnic backgrounds (BAME) supporting staff from different cultures with queries and concerns and career development. BAME staff were offered first access to the COVID-19 vaccination because of an increased risk of a poor outcome.

Staff were supported by processes to raise concerns verbally with their line managers, via the incident reporting system or freedom to speak up guardians. Freedom to speak up partners supported the freedom to speak up guardian and their name, contact details and photo was displayed in ward areas. All concerns raised (if not anonymous) were discussed with a manager to make sure there was a fair outcome.

Staff treated patients with compassion and kindness, respected their privacy and dignity, took account of their individual needs, and helped them understand their conditions. We observed staff taking time to care, for example brushing their hair, taking them to the toilet and sitting and speaking with them.

### Governance

**Leaders operated effective governance processes, throughout the division and with partner organisations. Staff at all levels were clear about their roles and accountabilities and had regular opportunities to meet, discuss and learn from the performance of the division.**

The medical care division had recently updated its governance structure and most monitoring was now performed by a central governance team. Although, local teams still monitored local processes. The division had regular meetings with set agendas were recorded and generated action plans. Minutes confirmed these meetings were well attended by consultants, service managers, matrons and clinical practice educators.

There were clear lines of accountability but the divisions governance structures that supported the delivery of sustainable high quality care had recently been reconfigured. Leaders reviewed actions and reported on local governance issues to make sure safety and quality issues were reported in a timely way. However, governance minutes

for October 2021 confirmed that the divisional governance team had been withdrawn and governance was now managed by the trust's central team. Leaders raised concerns that regular meetings may not occur as planning these was a drain on resources. This had the potential for the divisional triumvirate to lose oversight of their services. Other issues discussed in the minutes related to concerns over safeguarding training compliance, clearing a backlog of complaints and staffing on certain wards.

The governance team held meetings to review and update guidelines which were sent out to divisional leads, and the clinical practice educators for review. Once agreed guidelines were ratified and uploaded to the trust website. The trust's policies were made available for public view.

Mortality reviews were completed and shared by the division who presented at specialty governance meetings for discussion and learning. Serious incidents and route cause analysis were shared with relevant specialties for learning at governance meetings.

### Management of risk, issues and performance

**Leaders and teams used systems to manage performance effectively. They identified and escalated relevant risks and issues and identified actions to reduce their impact. They had plans to cope with unexpected events.**

Managers made sure that all risks staff identified were assessed and rated. The divisional leads attended the trust risk scrutiny committee quarterly to review current risks. Risks were sent to the triumvirate for approval to add to the risk register. There are seven identified risks at the time of inspection. The top three risks were lack of staff, inability to create enough outpatient clinic capacity and the safe management of insulin across all areas and staff groups. Matrons in each department were responsible for reviewing and updating aspects of risk that related to their services and when actions were taken to reduce risks these were signed of by the divisional lead.

The division continually monitored safety performance. They had plans to cope with unexpected events which were aligned to the NHS national Operation Pressures Escalation Framework (OPEL) which is a consistent approach to manage services in times of pressure. Leaders met daily to review the challenges of the division and updated their OPEL status. During the COVID-19 peak trust's worked together to maintain safety and would review staffing and logistics to try to keep people safe.

The division used monitoring results well to improve safety. Managers collected safety information and shared it with staff, patients and visitors. The trust used a system called the quality experience workforce and safety monthly triangulation audits (QEWS) to monitor performance and the outcomes were displayed in all areas for staff and patients to see.

The QEWS data showed the division did not always achieve harm free care although there were reductions in poor performance in the last quarter July 2021 to October 2021. For example, performance on preventing or reducing pressure ulcers had not always been in line with national guidance but a drive to increase staff awareness had created a downward trend in poor outcomes.

Medicines and Healthcare products Regulatory Agency (MHRA) alerts (a system for cascading patient safety alerts) known locally as 'CAS' alerts were cascaded from the quality team to managers. CAS alerts were recorded on the trust's internal systems and monitored via the governance team.

Staff performance was monitored and managed effectively. Leaders used the trust's capability policy with support from human resources. Where appropriate and depending on outcome of any investigation, this informed referral to professional regulators.

The division had a consultant appraisal process which included professional supervision and performance. Incidents and complaints and clinical claims involving those consultants were reviewed as part of this process.

### Information Management

**The division collected reliable data and analysed it. Staff could find the data they needed, in easily accessible formats, to understand performance, make decisions and improvements. The information systems were integrated and secure. Data or notifications were consistently submitted to external organisations as required.**

The division collected analysed and stored data in line with the trust's "Information Governance" Policy. Managers relied upon the use and flow of data and information in order to deliver patient care and to meet its targets and monitor services.

The division had an accountability framework for handing information in a confidential and secure manner to the appropriate required professional and quality standards. Clinicians and managers were responsible for making sure they promoted quality information so that it was used appropriately to help inform decisions around performance and make improvements.

The trust's "Caldicott Guardian" was responsible for monitoring compliance, submitting alerts on data breaches and reporting to the trust board.

The trust delivered training aligned to the requirements of the "National Data Guardian" review and monitored the completion of this training. Records confirmed that 85% of staff in the division had completed the E-learning modules. Additional training was required for specialist roles.

The trust worked with local partners to update its digital systems and the planned digital system would enable staff working in neighbouring trusts' to cross reference patient records and use data to improve the services. However, there had been a delay in implementing the system.

The trust implemented information technology drop-in sessions for all staff. However, records confirmed that these were sometimes cancelled due to staff shortages.

Staff had access to mobile computers, and handheld devices to record patients observations and update care records and access guidelines. All staff had secure log in detail so the trust could have an audit trail of when and who accessed patient records. However, staff told us that there were not always enough computers to work on. When we raised this issue with leaders' we were told that a specific procurement project is underway to deliver more computers within the division.

Leaders collected and managed reliable data for commissioners and regulators so that services could be assessed and benchmarked. For example, the trust made sure that data requests from the CQC were arranged in a methodical order and upload securely via a secure file transfer portal. Information regularly submitted to commissioners included performance data, serious incidents reviews, and staffing information.

# Medical care (including older people's care)

### Engagement

**Leaders and staff actively and openly engaged with patients, and staff, including equality groups, to plan and manage the divisions. They collaborated with partner organisations to help improve services for patients.**

Managers engaged well with staff. Managers completed a daily update during the COVID-19 waves with the senior leadership team. A weekly senior nurse meeting was commenced during COVID-19 and continued. Staff engagement took place with COVID wards in the second wave. The trust commissioned a 'COVID' star badge for all staff in recognition of their hard work during the pandemic.

Staff were encouraged to attend a monthly divisional management board meeting, departmental meetings and ad-hoc meetings to keep them abreast of the current issues. The deputy chief nurse held fortnightly ward managers meetings with the senior nursing team. Managers developed and published a monthly newsletter to all nursing staff, with a message from the deputy chief nurse, information on safety updates and a welcome spot for new starters. Posters were updated and information was available on the trust's intranet and via the monthly medical care newsletter.

The trust had various staff forums for example the Unions, BAME and equality and diversity network. Staff were encouraged to engage with these groups to make sure that the management of staff was fair and impartial. Staff from BAME backgrounds told us that they had seen vast improvements to support with career development during the reporting period.

The patient experience team worked with managers to review complaints to identify themes and attended a weekly complaints to monitor responses and to make sure actions were followed up. Patients were offered local resolution meetings and given the option to go to Parliamentary Health Division Ombudsmen (PHSO) if the trust was unable to resolve a complaint.

The division received 82 complaints from June 2021 to November 2021. The main themes were poor communication, concerns around patient care and poor discharges. Mechanisms were put in place to improve these, including volunteers supporting video calls between patients and their families. A working party addressed the property process because management of property needed embedding in all areas.

The trust overall "Friends and Family Test" response rate of 20% was not met with a rate of 3.2% in July 2021 and 3.8% in August 2021. Leaders planned staff engagement to encourage more frequent use of handheld devices.

### Learning, continuous improvement and innovation

**All staff were committed to continually learning and improving. They had a good understanding of quality improvement methods and the skills to use them. Leaders encouraged innovation and participation in research.**

The division was committed to continuous learning, improvement and innovation. The trust had funded the implementation of a team clinical practice educators, to oversee and monitor quality improvement training and development across the division.

There was a programme of training for staff in recognised quality improvement methodology. Staff could access a trust team for support with quality improvement projects.

The division worked with trust leaders to implement a ward accreditation scheme. The accreditation was formed of two parts: A pre-visit evidence gathering for each ward, and unannounced visit to each ward by a panel that consisted of members of the senior leadership team. The framework consisted of 73 areas for assessment these included but were

not limited to note's trolleys, medicine's trolley's, talking with patients' resuscitation equipment checks, and infection control compliance. Following the visit red amber green (RAG) rated feedback was given to the deputy chief nurse, matron and ward manager. Wards were colour rated with platinum being the highest rating achieved by receiving three previous gold ratings. Consultants and clinicians supported the scheme.

Oncology consultants initiated a project to improve cancer outcomes. This was in response to the National Faster Diagnosis Standard for 95% of patients being diagnosed or excluded of cancer, with results being fedback to patients within 28 days; and the National Optimal Lung Cancer Pathway which outlined a timed framework designed for lung cancer investigation to meet this goal. This was because the current two week referral route overloaded the trust's lung cancer service. The project was called the Improving cancer outcomes: GP and provider Collaborative Direct Access Urgent CT Lung Pathway. Consultants worked in collaboration with third party organisations to streamline services so that patients received a rapid diagnosis and treatment. Initial outcomes of the project had shown improvements to the quality and outcomes for patients. This was because the project increased early identification of the correct patient cohort, which significantly improved the time to diagnosis and implementation of management plans.

The Healing Arts Steering Group created the 'Time Garden' project. The project recognised the importance of our environment and the potential for healing, both physical and psychological/spiritual. A space within the hospital was identified and the project was reaching completion. The garden was intended to be used by terminally ill patients in beds and their families and will be open day and night and designed to be a place of peace, tranquillity, and reflection, away from the busy hospital wards.

## Outstanding practice

**We found the following outstanding practice:**

- The Healing Arts steering group created a project called a 'Time Garden' a place for people to regenerate and find peace. The project recognised the importance of our environment and the potential for healing, both physical and psychological/spiritual. A space within the hospital was identified and the project was reaching completion.

## Areas for improvement

Action the trust MUST take is necessary to comply with its legal obligations. Action a trust SHOULD take is because it was not doing something required by a regulation, but it would be disproportionate to find a breach of the regulation overall, to prevent it failing to comply with legal requirements in future, or to improve divisions.

**Action the trust SHOULD take to improve:**

- The service should ensure that it continues to develop a safer discharge process and that all clinical staff are empowered to discharge people safely (Regulation 12).
- The trust should ensure that safeguarding training level 3 training is completed by all staff involved in patient care decision making including doctors and nurses. (Regulation 13).
- The service should ensure patient physiological observations are completed on time (Regulation 12).
- The trust should ensure naso-gastric tubes are managed in line with national guidance, and that food and nutrition charts are accurately completed (Regulation 12).

# Medical care (including older people's care)

- The service should ensure that staff can access current guidelines and reference sources when handling medicines (Regulation 12).
- The service should act so actual staffing numbers match the planned numbers on the ward areas.
- The service should consider increasing pharmacy cover on the wards to support staff with stock issues and the discharge process.

# Our inspection team

The team that carried out the inspection comprised a CQC inspection manager a lead inspector, two other CQC inspectors and two specialist advisors. The inspection team was overseen by Amanda Williams, Head of Hospital Inspection.

This section is primarily information for the provider

# Requirement notices

## Action we have told the provider to take

The table below shows the legal requirements that were not being met. The provider must send CQC a report that says what action they are going to take to meet these requirements.

| Regulated activity | Regulation |
| --- | --- |
| Surgical procedures | Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment |