Kettering General Hospital NHS Foundation Trust

Inspection report

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Ratings

Overall trust quality rating	Requires Improvement
Are services safe?	**Requires Improvement**
Are services effective?	**Requires Improvement**
Are services caring?	**Good**
Are services responsive?	**Requires Improvement**
Are services well-led?	**Requires Improvement**

Our findings

Our reports

We plan our next inspections based on everything we know about services, including whether they appear to be getting better or worse. Each report explains the reason for the inspection.

This report describes our judgement of the quality of care provided by this trust. We based it on a combination of what we found when we inspected and other information available to us. It included information given to us from people who use the service, the public and other organisations.

We rated well-led (leadership) from our inspection of trust management, taking into account what we found about leadership in individual services. We rated other key questions by combining the service ratings and using our professional judgement.

Overall summary

What we found

Overall trust

Kettering General Hospital is provided by Kettering General Hospital NHS Foundation Trust and is a district general hospital in Northamptonshire. Kettering General Hospital serves north Northamptonshire and south Leicestershire and Rutland. It became a foundation trust in 2008 and is led by a board of directors comprising of a non-executive chairman, chief executive, executive directors, and non-executive Directors. The board is accountable to the council of governors that is made up of elected and nominated representatives of the population of north Northamptonshire.

As of July 2021, the trust formed a group collaboration model with a local NHS trust and later extended this to a third NHS trust in October 2023. The aim is to improve access to services with a single vision and shared values and priorities. The 3 hospital trusts remain as separate organisations with their own boards and leadership teams.

Kettering General Hospital is an acute hospital with a 24-hour accident and emergency department. This includes a paediatric emergency department. It has approximately 600 beds which includes medical and surgical beds, maternity, women's and children and critical care beds. The trust has an outpatient's department and a range of diagnostics provided both at Kettering General Hospital and at satellite locations in Kettering, Irthlingborough, Corby, Isebrook and Wellingborough. They also provide surgical day case and ambulatory care. In addition to the full range of district general hospital care, the trust provides some specialist services including cardiac care for the county.

We carried out this unannounced comprehensive inspection of Kettering General Hospital because we received information giving us concerns about the safety and quality of the services and because at our last rated inspection, in December 2022, we rated parts of the service within urgent and emergency care and children and young persons service as inadequate.

We carried out this inspection over 2 consecutive days in December 2023. We inspected 4 core services including:

- Urgent and emergency care.
- Medical care.

Our findings

- Surgery.
- Children and young people's service.

On this inspection we did not cover the well-led key question for the trust overall.

We visited various areas relevant to each of the core services. Our inspection teams consisted of inspectors, pharmacist specialists, specialist advisors for each area including mental health, an operations manager and deputy director.

We spoke with 167 staff members of various roles across different specialities. This included nurses, doctors of all grades, health care support workers, therapy staff, pharmacists, play therapists, operating department practitioners, domestic staff, administrative staff as well as service leaders and managers.

We spoke with 48 patients and 22 relatives, carers and parents. We also reviewed 115 patient records.

Our overall rating of the provider did not change and remains as requires improvement. However, the overall well-led key line of enquiry changed from good to requires improvement, while we found improvement in children and young persons services. In December 2022 the children and young persons service was rated as inadequate overall. While we did carry out a further responsive and focussed inspection of the children and young persons service in April 2023 and took enforcement action, we did not re-rate the service at that time. This meant that the rating from the December 2022 inpsection was carried forward. Children and young persons service is now rated as requires improvement.

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

Use of resources

The use of resources was not inspected on this occassion.

Combined quality and resource

The combined quality and resource was not inspected on this occasion.

Outstanding practice

No outstanding practice was observed during this inspection.

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 services.

We told the trust that it must take action to bring services into line with 7 legal requirements.

MUSTS

Our findings

Kettering General Hospital

Urgent and Emergency Care

- The service must ensure patients are treated with dignity and respect. Regulation 10 (1)(2)(a) Dignity and respect.
- The service must ensure there is appropriate sight and supervision of patients at all times in the emergency department waiting areas. Regulation 12(2)(a)(b) Safe care and treatment.
- The service must ensure patient risks are fully assessed and mitigated in a timely manner. This includes but is not limited to; tissue viability, falls and deterioration. Regulation 12(2)(a)(b) Safe care and treatment.
- The service must ensure effective systems are in place and fully implemented to treat paediatric and adult patients at risk of sepsis in a timely manner and in line with national guidance. Regulation 12 (1)(2)(a)(b) Safe care and treatment.
- The service must ensure national guidance is followed and patients arriving by ambulance receive a face-to-face triage and assessment of their clinical needs. Regulation 12 (1)(2)(a)(b) Safe care and treatment.
- The service must ensure that where a patient requires fluid balance monitoring this is effectively implemented. Regulation 12 (1)(2)(a)(b) Safe care and treatment.
- The service must ensure that staff reconcile medicines in line with trust policy. Regulation 12(2)(g) Safe care and treatment.
- The service must introduce a system to maintain patient confidentiality in public waiting areas. Regulation 12(2)(b) Safe care and treatment.
- The service must continue the work to ensure patients can access treatment in a timely way and in line with national standards. This includes but is not limited to undergo timely assessments, time to triage, first set of observations, medical assessments and senior reviews. Regulation 12 (1)(2)(a)(b) Safe care and treatment.
- The service must ensure staff consistently complete safeguarding documentation in the emergency department and make external safeguarding referrals in a timely manner in line with trust policy. Regulation 13 (1)(2)(3) Safeguarding service users from abuse and improper treatment.
- The service must ensure the paediatric emergency department is safely managed. This includes but is not limited to ensuring waiting areas are safe and risks are assessed and mitigated; ensuring there is appropriate visual supervision of patients at all times. Regulation 15 (1)(2) Premises and equipment.
- The service must continue to address previous breaches of regulations of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Regulation 17(1) Good Governance.
- The service must ensure it introduces a system to improve the security of patient paper notes. Regulation 17(2)(c) Good Governance.
- The service must maintain secure, accurate, complete, and contemporaneous records in respect of each service user, including a record of the care and treatment provided to the service user in relation to the care and treatment provided. Regulation 17(2)(c) Good Governance.
- The service must ensure that there is a clear prescribing audit trail for the supply of over labelled take home medicines. Regulation 17(2)(a) Good governance.
- The service must ensure a staffing tool that correctly calculates the number of patients in the emergency department, and adequately reflects acuity is used. Regulation 18 (1) Staffing.

Our findings

- The service must ensure there are enough nursing staff to ensure safe staffing levels are maintained across the service in line with establishment reviews, trust policy and staffing requirements which meet the Royal College of Paediatrics and Child Health standards. This should include but not limited to consideration of demand, acuity and number of staff required. Regulation 18 (1): Staffing.
- The service must ensure all relevant nursing and medical staff are trained to the highest-level of life support and there is an adequate level of staff trained on each shift with these skills. This includes both the adult and paediatric service. Regulation 18 (1)(2)(c) Staffing.

Medical Care

- The service must ensure the needs of patients with a learning disability or autistic people are regularly assessed and they are provided with person centred care. Regulation 9 (1) (2) (3) (a)(b)(c)(d): Person-centred care.
- The service must ensure that discharge passports are issued for all people with complex mental health and social care needs. Regulation 9 (1) (2) (3) (a)(b)(c)(d): Person-centred care
- The service must ensure all mixed sex breaches are reported and appropriate action taken. Regulation 10 (1)(2)(a)(c): Dignity and respect
- The service must ensure appropriate bathroom facilities are readily available to patients. Regulation 10 (1)(2)(a)(c): Dignity and respect.
- All staff must ensure that medication is correct and appropriate to the patient's situation and needs. Regulation 12 (1)(2)(b)(f): Safe care and treatment.
- The service must ensure any patient record data held electronically is stored on devices which are kept securely within the service. Regulation 17 (2)(c): Good governance.
- The service must ensure there are sufficient numbers of suitably qualified staff across all clinical areas, to make sure the service can meet people's care and treatment needs. Regulation 18 (1): Staffing.

Surgery

- The service must ensure patient observations are completed in a timely manner in line with National Early Warning Score frequency rules to ensure deteriorating patients can be quickly identified and escalated. Regulation 12 (1)(2) Safe Care and Treatment.
- The service must ensure patients showing signs of deterioration or those at risk of sepsis are reviewed by an appropriate grade clinician and treated in a timely manner in line with Sepsis 6 pathways and trust deteriorating patient policies. Regulation 12 (1)(2) Safe Care and Treatment.
- The service must ensure the proper and safe management of medicines. This includes but is not limited to ensuring medication is correct and appropriate to the patient's situation and needs; ensuring staff follow policies and procedures in managing medicines; weights are recorded when prescribing medicines; staff record the number of controlled drugs administered to patients in the controlled drug register in line with trust policy. Regulation 12 (2) (g) Safe care and treatment.
- The service must ensure effective systems and processes are in place to consistently assess, monitor and improve patient safety and the quality of care provided. This includes but is not limited to ensuring effective processes are in place across all specialists within surgery to follow up patient scans and abnormal findings in a timely manner or where quality and/or safety are being compromised. Regulation 17 (1)(2)(a)(b): Good governance.

Our findings

- The service must ensure patients receive timely access to treatment. This includes but is not limited to ensuring waiting times from referral to treatment and arrangements to admit, treat and discharge patients are in line national standards. Regulation 17 Good Governance (1) (2) (a).
- The service must ensure there are sufficient numbers of suitably qualified staff across all clinical areas, to make sure the service can meet people's care and treatment needs. This includes medical, registered nursing and non-registered nursing staff. Regulation 18 (1) Staffing.

Children and Young People

- The service must ensure effective systems are in place and fully implemented to assess and treat patients at risk of sepsis in a timely manner. This includes but is not limited to ensuring antibiotics are administered within 1 hour of suspecting sepsis in line with guidance and to keep patients safe from avoidable harm. Regulation 12 (1)(2)(a)(b) Safe care and treatment.
- The service must ensure children and young people have their observation taken as per risk scoring and clinical condition. Regulation 12 (1)(2)(a)(b) Safe care and treatment.
- The service must ensure people have timely access to services such as first definitive tretament for paediatric services and promptly receive the right treatment in line with national guidance. Regulation 12 (1)(2)(a)(b) Safe care and treatment.
- The service must ensure an effective system in place to ensure consistent recording and referrals following child and adolescent mental health service assessments. Regulation 17 (1)(2)(a)(b) Good governance.
- The service must ensure robust systems and processes are in place to ensure key safety and safeguarding information is handed over when transferring patients between departments. Regulation 17 (1)(2)(a)(b) Good governance.
- The service must ensure there is a robust process in place to effectively review and update policies in line with national guidance. Regulation 17 (1)(2)(a)(b) Good governance.

SHOULDS

Kettering General Hospital

Urgent and Emergency Care

- The service should ensure it introduces a ligature managed and confidential environment for patients experiencing mental health crisis. Regulation 15.
- The service should ensure there is a clear documented and risk assessed procedure in place for transferring a paediatric patient from the paediatric emergency department to the resuscitation area in the event of an emergency where required. Regulation 12.
- The service should ensure all patients are issued with an identity band at the earliest opportunity. Regulation12.
- The service should ensure staff follow guidance and provide worsening advice to patients leaving the emergency department before being seen. Regulation 12.
- The service should ensure they introduce a system for prescribing medicines that does not have an over reliance on staff for its safety. Regulation 12.
- The service should consider how to introduce additional seating for patients waiting for treatment.

Our findings

- The service should consider how it improves the relative's room and signposting to support services.
- The service should continue to explore how it improves speciality response times in the urgent and emergency care department.
- The service should consider introducing a system to improve the supply of wheelchairs in the department.
- The service should continue its recruitment campaign to increase the number of registered children's nurses it employs.

Medical Care

- The service should ensure that appraisal completion for all medical staff meets trust targets. Regulation 18 (2)(a): Staffing.
- The service should ensure that basic life support training completion meets trust targets. Regulation 12 (2) (a): Staffing.
- The service should ensure that 1:1 enhanced care is provided continuously and consistently in line with trust policy and procedure. Regulation 12.
- The service should ensure that clinical waste items should be removed and disposed of promptly. Regulation 12.
- The service should ensure patient privacy curtains are clean, well maintained and replaced in a timely manner. Regulation 12.
- The service should review the discharge process, including staffing levels, facilities, and flow to ensure the safety of patients. Regulation 12.
- The service should ensure that observation rounds are undertaken in a timely manner to minimise delay in identifying deteriorating patients. Regulation 12.
- The service should ensure treatment for sepsis is done so in line with timescales set out within trust policy and procedure and national guidance. Regulation 12.
- The service must ensure staff always follow the correct processes when administering and storing medicines. Regulation 12.
- The service should ensure systems for reconciling patients medicines are embedded to ensure patients are provided with their usual medicines and these are considered when making medication decisions. Regulation 12.
- The service should ensure that staff have adequate dementia and learning disability and autism training to ensure appropriate care is provided at times when specialists are not available. Regulation 12.
- The service should ensure electronic patient data boards on wards protects patient confidentiality. Regulation 17.
- The service should review patient outcomes and ensure they have action plans in place where they do not meet national standards. Regulation 17.
- The service should ensure that records trolleys on wards are always kept closed and locked when not in use. Regulation 17.
- The service should ensure that trust managers are visible on wards. Regulation 17.
- The service should consider engaging more pro-actively with equality groups and other stakeholders in the wider community to improve patients' experience.

Our findings

Surgery

- The service should ensure clinical areas consistently meet expected infection and prevention control measures. Regulation 12.
- The service should ensure processes are in place to re-book cancelled operations within set timeframes. Regulation 17.
- The service should ensure systems and processes are in place to ensure staff are reporting incidents so that learning can be identified, and improvements made. Regulation 17.
- The service should ensure staff complete mandatory training, including but not limited to life support training, safeguarding and learning disability training and to ensure there are effective systems to monitor compliance with trust targets. Regulation 18.
- The service should ensure all staff receive a yearly appraisal. Regulation 18.

Children and Young People

- The service should ensure sterile water is safely stored in all areas. Regulation 12.
- The service should ensure children and young people receive the right care in a timely manner. Regulation 12.
- The service should ensure there is a system in place to monitor actions taken where compliance of cleaning reusable items does not meet the target. Regulation 17.
- The service should ensure managers have effective governance arrangements in place to identify risks to quality and safety and take action to mitigate them. Regulation 17.
- The service should implement a system to ensure children and their families are kept informed when surgical procedures are running late. Regulation 17.
- The service should consider implementing a system to ensure an effective storage of patient records. This includes but is not limited to accessible medical and nursing records. Regulation 17.

Is this organisation well-led?

The well-led part of our inspection was post-poned untill 2024 and will be undertaken using our new well-led methodology.

Key to tables					
Ratings	**Not rated**	**Inadequate**	**Requires improvement**	**Good**	**Outstanding**
Rating change since last inspection	Same	Up one rating	Up two ratings	Down one rating	Down two ratings
Symbol *	→←	↑	↑↑	↓	↓↓

Month Year = Date last rating published

* Where there is no symbol showing how a rating has changed, it means either that:

- we have not inspected this aspect of the service before or
- we have not inspected it this time or
- changes to how we inspect make comparisons with a previous inspection unreliable.

Ratings for the whole trust

Safe	Effective	Caring	Responsive	Well-led	Overall
Requires Improvement →← May 2024	Requires Improvement →← May 2024	Good →← May 2024	Requires Improvement →← May 2024	Requires Improvement ↓ May 2024	Requires Improvement →← May 2024

The rating for well-led is based on our inspection at trust level, taking into account what we found in individual services. Ratings for other key questions are from combining ratings for services and using our professional judgement.

Ratings for a combined trust

	Safe	Effective	Caring	Responsive	Well-led	Overall
Acute locations	Requires Improvement	Requires Improvement	Good	Requires Improvement	Requires Improvement	Requires Improvement
Overall trust	Requires Improvement →← May 2024	Requires Improvement →← May 2024	Good →← May 2024	Requires Improvement →← May 2024	Requires Improvement ↓ May 2024	Requires Improvement →← May 2024

The rating for the well-led key question is based on our inspection at trust level, taking into account what we found in individual services. Ratings for other key questions take into account the ratings for different types of service. Our decisions on overall ratings take into account the relative size of services. We use our professional judgement to reach fair and balanced ratings.

Rating for acute services/acute trust

	Safe	Effective	Caring	Responsive	Well-led	Overall
Kettering General Hospital	Requires Improvement →← May 2024	Requires Improvement →← May 2024	Good →← May 2024	Requires Improvement →← May 2024	Requires Improvement ↓ May 2024	Requires Improvement →← May 2024
Overall trust	Requires Improvement →← May 2024	Requires Improvement →← May 2024	Good →← May 2024	Requires Improvement →← May 2024	Requires Improvement ↓ May 2024	Requires Improvement →← May 2024

Ratings for the trust are from combining ratings for hospitals. Our decisions on overall ratings take into account the relative size of services. We use our professional judgement to reach fair and balanced ratings.

Rating for Kettering General Hospital

	Safe	Effective	Caring	Responsive	Well-led	Overall
Medical care (including older people's care)	Requires Improvement →← May 2024	Requires Improvement →← May 2024	Good →← May 2024	Requires Improvement ↓ May 2024	Requires Improvement →← May 2024	Requires Improvement →← May 2024
Services for children and young people	Requires Improvement ↑ May 2024	Requires Improvement →← May 2024	Good →← May 2024	Requires Improvement →← May 2024	Requires Improvement ↑ May 2024	Requires Improvement ↑ May 2024
Critical care	Good Apr 2017	Good Apr 2017	Good Apr 2017	Good Apr 2017	Good Apr 2017	Good Apr 2017
End of life care	Good Apr 2017	Requires improvement Apr 2017	Good Apr 2017	Good Apr 2017	Good Apr 2017	Good Apr 2017
Surgery	Requires Improvement →← May 2024	Requires Improvement ↓ May 2024	Good →← May 2024	Requires Improvement →← May 2024	Requires Improvement ↓ May 2024	Requires Improvement →← May 2024
Urgent and emergency services	Inadequate →← May 2024	Requires Improvement →← May 2024	Requires Improvement ↓ May 2024	Requires Improvement →← May 2024	Requires Improvement →← May 2024	Requires Improvement →← May 2024
Diagnostic imaging	Good May 2019	Not rated	Good May 2019	Good May 2019	Good May 2019	Good May 2019
Maternity	Requires improvement Mar 2024	Good May 2019	Good May 2019	Good May 2019	Requires improvement Mar 2024	Requires improvement Mar 2024
Outpatients	Good May 2019	Not rated	Good May 2019	Good May 2019	Good May 2019	Good May 2019
Overall	Requires Improvement →← May 2024	Requires Improvement →← May 2024	Good →← May 2024	Requires Improvement →← May 2024	Requires Improvement ↓ May 2024	Requires Improvement →← May 2024

Kettering General Hospital

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Description of this hospital

Kettering General Hospital is provided by Kettering General Hospital NHS Foundation Trust. It is an acute district general hospital in Northamptonshire with a 24-hour accident and emergency department. This includes a paediatric emergency department. It has approximately 600 beds which includes medical and surgical beds, maternity, women's and children and critical care beds. The trust has an outpatient's department and a range of diagnostics provided both at Kettering General Hospital and at satellite locations in Kettering, Irthlingborough, Corby, Isebrook and Wellingborough. It also offers surgical day case and ambulatory care. In addition to the full range of district general hospital care, Kettering General Hospital also provides some specialist services including cardiac care for the county.

The accident and emergency service sees more than 290 patients in the department each day. From September 2022 to August 2023 the trust provided:

- 3657 non-elective admissions per month.
- 330 elective admissions.
- 3, 600 elective day case.
- 30, 590 outpatient appointments were undertaken.

The trust provides the following regulated activities:

- Assessment or medical treatment for persons detained under the Mental Health Act 1983.
- Diagnostic and screening procedures.
- Family planning
- Management of supply of blood and blood derived products
- Maternity and midwifery services
- Surgical procedures
- Termination of pregnancies
- Treatment of disease, disorder or injury

Urgent and emergency services

Requires Improvement  

Is the service safe?

Inadequate  

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

Mandatory training

The service provided mandatory training in most key skills. However, the service did not make sure all staff completed it.

Staff received and mostly kept up to date with their mandatory training. Mandatory training was comprehensive and met the needs of patients and staff. Compliance with training was mostly above the 85% target set by the trust. Training modules included key areas, such as health and safety, fire safety, manual handling, infection prevention and control, equality and diversity, information governance, sepsis, and basic life support. Training was a combination of face to face and online learning.

However, compliance with the highest level of life support training was not achieved for medical or relevant nursing staff. This issue had been raised as a concern during previous inspections. Information supplied by the trust demonstrated training in highest level of life support had been completed by 43% of same day emergency care units (SDEC) nursing staff, 60% of emergency department (ED) senior nurses and 73% of ED nurses against a target of 85%. Training in adult advanced life support had been completed by 60% of medical staff and paediatric advanced life support had been completed by 36% of medical staff. This meant medical and nursing staff had not always received the training they needed to support them to resuscitate patients. The trust had a plan to increase the number of staff who received paediatric advanced life support training.

Managers monitored mandatory training and alerted staff when they needed to update their training. Staff told us they receive protected time to complete training.

Training in sepsis met the trust target of 85% apart from in the minor injuries and minor illness unit (MIaMI) where 50% (1 member of staff) of health care assistants had completed this training. This was a decline in compliance since our inspection of urgent and emergency care in 2022.

The trust had introduced specific training on recognising and responding to patients with learning disabilities and autism in line with national guidance in September 2023. However, 50% of staff had completed this training. The service had a plan to ensure at least 85% of staff had completed this training within 12 months.

Safeguarding

Staff understood how to protect patients from abuse and the service mostly worked well with other agencies to do so. Not all staff had training on how to recognise and report abuse. Although nursing staff were aware of required documentation to record safeguarding concerns and make external safeguarding referrals, we found they did not consistently do this.

Nursing staff received training specific for their role on how to recognise and report abuse. Data demonstrated at the time of our inspection the service exceeded the 85% compliance target for level 2 and 3 safeguarding adult training and level 2 in safeguarding children. Furthermore, 100% of registered nursing staff working in the Paediatric Emergency Department (PED) had completed level 2 and 3 safeguarding children training. Additionally, all support staff had completed level 2 children training as required for their role. This demonstrated improvements made following our inspection in December 2022 of the PED, had been maintained. However, the trust target was not met for level 3 safeguarding training for registered nurses (77%) working in the wider service including the minor injuries and minor illness unit (MIaMI) (81%).

Medical staff did not all complete training specific for their role on how to recognise and report abuse. Data provided to us following our inspection demonstrated at the time of our inspection medical staff were not compliant with the 85% training target for safeguarding adults level 2 (82%) or level 3 (52%) training. Training compliance for level 2 safeguarding children was at 85%, however, only 61% of medical staff had completed level 3. This meant medical staff were not trained to the correct level of safeguarding to support them in identifying abuse and taking action when required. The trust was aware of this risk, and we saw systems were in place to improve safeguarding training compliance. Furthermore, the paediatric emergency medicine (PEM) consultant had been trained to safeguarding children level 4 and was a designated lead within the department.

Staff could give examples of how to protect patients from harassment and discrimination, including those with protected characteristics under the Equality Act. They described how they would identify adults and children at risk of, or suffering, significant harm and worked with other agencies to protect them. They knew how to make a safeguarding referral and who to inform if they had concerns. In the 12 months before our inspection 2,189 referrals had been made to external safeguarding services, having identified abuse or neglect.

We saw evidence that staff completed safeguarding checklists for children, including checking the number of previous admissions and the Child Protection Information Sharing service that enables health and social care workers share information securely to protect vulnerable children and young people already known to social care services. This was an improvement since our last inspection. However, staff did not always follow safe procedures for all children visiting the PED. At this inspection we found although nursing staff were aware of the documentation, they needed to complete to record their safeguarding concerns and make external safeguarding referrals, we found they did not consistently do this. As part of the plan to improve safeguarding processes in the PED, patients' files were regularly checked to ensure documentation was up to date and safeguarding referrals had been made within either a 24 or 48-hour timescale, dependant on risk, and an incident report was submitted when this was not achieved. We looked at 6 incidents reported in November 2023 which related to 355 patients who had not had their documentation fully completed or a safeguarding referral made within a specified timescale. They included 2 safeguarding referrals that had not been made within 48 hours and 2 safeguarding referrals for high-risk patients not being made within 24 hours. The incident reports often cited a high demand for services which reduced staff capacity to complete paperwork or process safeguarding referrals at busy times. As part of the improvement plan PED received daily support from the safeguarding team to assist in completing safeguarding tasks.

In the ED, safeguarding checks had not been recorded in any of the 4 patient records we looked at. This meant there was no evidence to say if these checks had been carried out or not.

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.

All areas, including those at height, were visibly clean and had suitable furnishings which were clean and well-maintained. Furniture such as beds, chairs, and mattresses were in good condition to allow for effective cleaning.

The service performed below average for cleanliness. Patient-led assessments of the care environment (PLACE) scores from 2022 showed 95% compliance with hospital cleanliness measures which was below the national average of 98%. PLACE scores are the outcome of annual patient-led assessments of how the environment supports the provision of clinical care. The assessment includes the cleanliness and general building maintenance of each department.

Cleaning records were up-to-date and demonstrated that all areas were cleaned regularly. Data from internal audits of the environment for ED, PED, and SDEC for September, October and November 2023, showed a high level of compliance. However, the ED compliance with this audit dipped to 83% in November 2023.

Staff followed infection control principles including the use of personal protective equipment (PPE). During our inspection we observed staff wash their hands regularly and in line with the World Health Organisation (WHO) 5 moments for hand hygiene. We also observed staff use hand sanitising gel in between patient contacts. We saw staff reminding a relative to wear PPE while visiting a patient with an infectious illness.

Staff cleaned equipment after patient contact and labelled it to show when it was last cleaned. Most equipment and surfaces across the department had green 'I am clean' stickers. We observed staff cleaning equipment and patient beds in between patients. All commodes and sluices we checked were visibly clean. This was an improvement since our inspection in April 2023.

Environment and equipment

The design, maintenance and use of facilities, premises and equipment did not always keep people safe. Staff were trained to use equipment. Staff managed clinical waste well.

The design of the environment did not always follow national guidance. The layout of the department meant staff did not always have sight of patients waiting in the department. This meant there was a potential risk of a delay in identifying and responding to a deteriorating patient.

Escalation waiting areas used during times of increased demand in the PED were not always supervised by staff. The MIaMI waiting area was used as an overflow for the PED when the service experienced increased demand. A risk assessment was completed of this area in December 2022 which stated that a health care assistant should be present to oversee the safety of children. However, staff told us there were not enough staff to provide this when the area was in use, and we saw the risk assessment did not factor in potential staffing issues. The service tried to limit use of this area and managers told us they had used this as an overflow twice in November and once in December 2023.

There was lack of consistent nursing oversight of the main ED waiting area. The ED waiting room was also used as a 'fit to sit' area for unwell patients who required treatment in the department but had been assessed as clinically well enough to sit up. Some of these patients were receiving intravenous medicines. We observed most of this area was not in the line of sight of reception staff or the nurse undertaking triage. We undertook observations throughout our inspection and saw staff periodically check on patients classified as fit to sit, however, this was not consistently implemented. It was also not clear to staff which patients were waiting for triage and which patients had been assessed as 'fit to sit'. There was a colour coded seat system, however, new patients entering the department were not directed to which colour seats they should use.

Urgent and emergency services

Staff told us the lack of oversight in the main waiting area meant patients or relatives sometimes had to alert them to deteriorating patients. This meant there was a potential risk of a delay in identifying a deteriorating patient in these areas.

Paediatric waiting areas were not always separated by sight and sound from adult waiting areas. The main PED waiting area was separate from the adult ED. However, The MIaMI waiting area when used as overflow, was only separated by a moveable partition. This meant the adult MiaMI area was not securely separated, and children could see and hear through the temporary partition. Staff told us the temporary partition meant patients could easily access the adult area and they were concerned this exposed children and young people waiting to harm. For example, they told us there had been instances of high-risk patients in the MiaMI waiting area and children were able to observe diagnostics being undertaken.

The demand on the service had outgrown the size of the department. We observed the department became increasingly pressured throughout the day and there were not enough seats for all patients, or their family or carers, in the adults' waiting room. This meant there were several people standing up or sitting on the floor.

The service was equipped to safely care for a deteriorating patient. Patients being conveyed to hospital by ambulance who required resuscitation or stabilisation would be directed to a designated paediatric resuscitation bay in the main ED. The PED had a high dependency bay located opposite the nurse's station. Any patient who deteriorated in the PED or who required resuscitation would be cared for in the high dependency bay. The bay had all equipment required to resuscitate and stabilise a deteriorating child. Where ongoing resuscitation or airway management was required including any other emergency procedure, the patient would be transferred to the resuscitation area in the main ED. This was because there was more space to manage more complex situations and to ensure a timely transfer out to a specialist centre if required. Transfers were infrequent as most patients could be safely managed within the PED. Managers told us the transfers were planned and co-ordinated to ensure public walkways were cleared. However, the service did not have a risk assessment in place for this or a clear process so that all staff understood the process to prevent unexpected delays or obstructions on route.

Staff did not always carry out daily safety checks of specialist equipment. Records sent to us following our inspection showed emergency trolleys, which contained emergency medicines and equipment were not consistently checked. Compliance with daily checks of resuscitation trolleys in the 3 months before our inspection varied from 53.3% (September 2023) to 100%, with an average overall compliance of 86%. In 100% of checks there were no out of date items on the trolleys and missing or broken items were only identified in 6% of checks.

Patients being cared for in bays within majors could reach call bells and we observed staff mostly responded quickly when called.

The service did not always have suitable facilities to meet the needs of patients' and their families. Patients presenting with acute mental health concerns did not have access to a dedicated room which met national guidance relating to the provision of a safe environment. For example, the ED did not have a designated room which was free from ligatures or have 2-way doors and suitable furnishings. However, the service had a risk assessment and specific actions to mitigate risks of harm. Patients who were assessed to be a medium to high risk of self-harm were cared for in the majors area. There was an environmental hazards checklist to support staff in removing ligature points and other risks from bays. For example, staff told us ligature points like oxygen tubes were removed from bay. If family or friends were not present, the staff would provide a dedicated member of staff to sit with the patient to provide one to one care. As the bays were

separated by curtains patients could not have confidential conversations about their thoughts and feelings. Staff said some mental health patients in crisis took up a lot of their time by "creating a lot of noise and interfering with the care of other patients" by entering their bays and touching their equipment. The trust had a medium-term plan to create a dedicated room that met national guidance for mental health patients located within minors.

In the adult ED there was an acute liaison mental health team assessment room off the main waiting room. This was not a ligature managed room but could be used for confidential conversations. It had been assessed as a fit and safe environment by the network for psychiatric liaison service mental health assessments to take place. The term ligature managed recognises that people intent on ending their lives can create ligature points from previously unidentified risks, and therefore it might not be possible to have an entirely ligature free room/area.

The PED did not have a designated safe room where patients experiencing thoughts of ending their lives could be assessed or wait for assessment. However, this risk was mitigated by a dedicated member of staff being always present to supervise the patient.

Toilet facilities were limited in the medical SDEC. During our inspection we observed there was 1 toilet for patients and their family. It was located at the end of a corridor used by doctors to assess patients. This meant there was a potential for some poorly patients to have difficulty walking from the waiting area to the toilet.

The service did not always have enough suitable equipment to help them to safely care for patients. Staff told us they ran out of wheelchairs regularly each day. During our inspection, we observed the service run out of wheelchairs twice. We checked consumables in all areas of the department and all the items we checked were in date.

Staff disposed of clinical waste safely. Clinical waste bins were emptied regularly.

Assessing and responding to patient risk

Oversight and management of patients waiting on ambulances was inconsistent and not always in line with national guidance. Staff did not always undertake face to face triage and clinical assessment of patients waiting on ambulances. The self-streaming process meant patients were not always directed to the most suitable pathway to undergo appropriate assessment and treatment. Staff removed or minimised risks and but did not consistently update patient risk assessments. Staff identified and quickly acted upon patients at risk of deterioration. However, treatment for sepsis was not always provided in a timely manner in line with national guidance

Staff completed a triage risk assessment for each patient on arrival, using a recognised tool to categorise each patients' risk score. Higher risk patients were seen by medical staff sooner. The triage nurse streamed patients who arrived on foot to either MiaMI, majors, minors or SDEC. Patients brought in by ambulance were triaged by a senior nurse 'navigator'. However, this was not always a face-to-face triage. Once triaged the patient would be navigated to either the resuscitation area, majors, minors, the ambulance receiving area, or the SDEC unit depending on their level of clinical need.

The provider did not ensure patients self-presenting received a triage within 15 minutes of arriving at the ED in line with national guidance by the Royal College of Emergency Medicine (RCEM). Due to demand on the service, we saw waiting times for triage were up to 40 minutes for patients self-presenting. Staff told us waits sometimes went over an hour. The average time to triage for September, October and November 2023 was 21.3 minutes. The trust had a plan to increase the number of staff trained to deliver triage to help reduce waits for triage.

Urgent and emergency services

The median time from arrival by ambulance to initial assessment was consistently longer (worse) than the England average from August 2021 to July 2023. However, the trust consistently reported a shorter (better) median time from arrival to treatment compared to the England average in the same time frame.

Oversight and management of patients waiting on ambulances due to a lack of capacity in the ED was inconsistent. During our inspection there was not a consistent approach to which members of staff went out onto the ambulances to assess patients, for example, on the first day there was a dedicated team of staff assigned to working with incoming ambulance patients and on the second day there was not. Staff told the approach used was dictated by the consultant in charge so varied from shift to shift. This meant there was not a consistent process for staff to follow and there was a potential that there was not always staff available to manage ambulance patients.

The trust standard operating procedure (SOP) for ambulance handover stated all patients arriving by ambulance would receive a visible triage and diagnostic tests would be performed in the ambulance receiving area unless clinical need determined otherwise. However, the SOP took into consideration the department may reach capacity and during those times patients may need to have diagnostic tests and monitoring on their ambulance until space could be made for them in the department.

Patients who made their own way to the ED or who had been sent there by 111 could self-stream to the service most suitable for their needs, including to the ED, MiaMI or a SDEC using iPads in the entrance to the main ED. However, this process only enabled patients to enter 1 reason for attending. Staff told us this meant patients were often incorrectly streamed. For example, a patient had been streamed to MiaMI because they gave an ankle injury as their reason for attending. However, the patient was intoxicated by alcohol and had suffered a head injury and had required urgent attention in the ED. We saw a patient with chest pains streamed to MiaMI who should have been streamed to ED and quickly passed to the pit stop for time sensitive diagnostic tests.

The department had a system to speed up treatment for patients arriving on foot with chest pain, suspected stroke, or other time critical conditions. This involved patients' being streamed straight to a 'pit stop' for time sensitive diagnostic tests.

Four out of 6 patients in the ambulance receiving area did not have an identity band on. Identity bands help staff identify patients accurately and match them with the care intended for them, such as the right medication or diagnostic tests. We raised this as an issue with the nurse in charge who immediately rectified this.

Senior staff monitored children who left the department before being treated which included contacting the family within 24-hours of their attendance and informing support services. For example, a safeguarding team if there were ongoing concerns about the child's welfare. However, we saw a child, who had a suspected appendicitis, and their parent leaving before being seen because of the long waits for treatment. They were not given any precautionary information about leaving or advised welfare follow-up checks would need to be performed if they left without being seen by a doctor.

All registered nurses working in the PED received paediatric immediate life support (PILS) training. This was to ensure they could manage cardiac arrest in children as well as manage a deteriorating child.

Staff used a nationally recognised tool to identify deteriorating patients and escalated them appropriately. This included the National Early Warning Scores (NEWS2) for adults and Paediatric Early Warning Scores (PEWS) for paediatrics. NEWS2 and PEWS were used to assess the seriousness of a patient's condition. This was a quick and systematic way of identifying patients who were at risk of deteriorating. Clinical observations, such as blood pressure,

temperature, heart, and respiration rate, were recorded and contributed to a total score. Once a certain score was reached, there were specific actions staff should take to escalate, assess, and treat a deteriorating patient. During our inspection we reviewed 12 records and found they had been completed appropriately, escalated where required and follow up actions had been carried out.

Following our inspection, the service provided us with NEWS2 compliance audits from September to November 2023. The audits showed only 30% of observations were completed on time. However, where there were signs of deterioration, 100% of patients had been escalated within an hour to an appropriate clinician.

Staff knew about but did not always deal with specific risk issues. Sepsis screens were completed for patients showing signs of deterioration through their NEWS to determine their sepsis risk. If a risk of sepsis was identified staff used the sepsis 6 bundle. The sepsis 6 bundle is a set of 6 tasks that must be completed within the first hour of a potential sepsis case being identified including giving antibiotics and fluids to reduce the risk of mortality. Following our inspection, we requested but were not provided with the adult sepsis audit results. However, we saw the provider had developed a process to support staff to act promptly in response to suspected sepsis which was overseen by the nurse in charge. When the sepsis 6 bundle had not been carried out in a timely manner staff reported this as an incident. For example, data reviewed prior to our inspection showed delays in receiving treatment for hight-risk sepsis patients was a theme identified from 'Learn from Patient Safety Events' reporting. Several patients faced significant delays in receiving medication upon being identified as high-risk for sepsis. In 3 out of 8 cases, patients endured wait times exceeding 6 hours to receive the necessary treatment. For example, a patient identified as high-risk sepsis at 6.54pm on 6 October 2023, did not have IV antibiotics given until 2am on 7 October 2023. There was no documented reason for a delay in treatment.

Compliance with paediatric sepsis screening standards showed signs of continued improvement since our previous inspections in December 2022 and April 2023. Children were screened for sepsis routinely on presentation to the PED. We reviewed 6 records and found evidence that sepsis screens had been completed correctly and appropriately escalated. Furthermore, monthly sepsis audits undertaken by the service from September to November 2023 showed between 92% and 96% of children received a sepsis screen on presentation to the department. However, we saw an incident report from September 2023 that showed a temporary nurse who had been triaging new patients and had not completed a sepsis screen on any children throughout the shift.

Compliance with paediatric sepsis treatment was not always undertaken in a timely manner in line with guidance. Audits showed of those patients who were identified as high risk for sepsis in September 2023 (12), 5 received intravenous (IV) antibiotics within 1 hour of recognition, a further 6 within 2 hours and the remaining 1 within 3 hours. In October 2023, 10 children were deemed high risk of sepsis. Four received IV antibiotics within 1 hour of recognition, 2 within 2 hours and 1 within 3 hours and the remaining 3 over 3 hours. In November 2023, 4 children were deemed as high risk for sepsis, 3 received IV antibiotics within 1 hour of recognition and 1 within 2 hours. Whilst all children received treatment and there were no reported harms, it meant children did not always receive antibiotics within the hour to reduce the risk of mortality.

Risk assessments for each patient were not consistently completed on admission, and there was no evidence risk assessments were reviewed regularly when they had been completed. Risks to skin viability were not always completed and when they were completed there was no evidence in the patient record, they had been reviewed in a timely manner. We looked at 5 patient records and found 2 patients had been assessed as requiring regular reassessment of their skin viability but neither patient had a documented follow up assessment. A tissue viability assessment audit showed 40% of patients had received an assessment in October 2023, this increased to 60% in November 2023, but was below the service compliance target.

Data provided to us following our inspection showed poor compliance with falls quality standards. For example, audits showed compliance of 60% in August, 40% in September and 100% in October 2023. The number of patients recorded as having a fall in August was 5, 7 patients fell in September and 9 patients had a fall in October 2023.

Venous thromboembolism (VTE) risk assessments were completed in all records we reviewed. However, the trust did not audit VTE assessments, so we do not know if this risk was being assessed in all patients and reassessed for those clinically indicated.

Patients were assessed for their social risk factors, as well as medical conditions as part of the triage process. This allowed for signposting or referrals to other services. For example, homelessness, domestic violence, and mental health services. Staff completed, or arranged, psychosocial assessments and risk assessments for patients thought to be at risk of self-harm or with thoughts of ending their life. The service had 24-hour access to an onsite adult mental health liaison team if staff were concerned about a patient's mental health. The child and adolescent mental health team were based off site and did not offer out of hours support. Staff reported they could normally access adult mental health support quickly, and services for children easily during their operational hours.

The department had access to specialist staff to enhance the care of patients with complex needs. For example, the diabetic nurse specialists, learning disability nurse, the cardiac outreach team, frailty nurses, the end-of-life team, and the substance misuse team.

Neonates, children and young people who required specialist care at other hospitals were transferred in line with trust guidelines. In the 12 months before our inspection, 192 patients under the age of 18 were transferred to other hospitals more suited to their clinical needs, in line with trust policy.

Staff told us they had good access to diagnostic imaging for patients requiring x-ray and computerised tomography (CT) scans. During our inspection we saw staff request CT scans for patients who had fallen and hit their heads. The service had good access to porters who transferred patients to and from diagnostic scans and moved patients from the department to wards.

Staff shared key information to keep patients safe when handing over their care to others.

Shift changes and handovers included all necessary key information to keep patients safe.

Nurse staffing

The service did not have enough nursing staff and support staff to provide the right care and treatment.

Managers calculated the number of nurses needed for each shift in accordance with national guidance, however, actual staffing did not always meet this calculation or staffing levels set out in trust guidance. The service used an adapted national staffing tool to calculate staffing required for the PED, but the trust did not provide us with details of the tool used to calculate staffing in the adult ED. However, the ED operational policy set out the nurse patient ratio as 1 Registered Nurse (RN) to 4 patients in the adult ED and calculated 21 registered nurses were required 24/7 to fulfil this requirement. A staffing review had recently been undertaken and concluded in November 2023 which showed an uplift in RNs was required to maintain safe staffing levels.

The service did not have enough nursing and support staff to keep patients safe. Multiple staff including RNs, medical staff and non-clinical staff raised concerns with us during and after our inspection about the RN staffing levels. Staff told us the number of RNs reduced from 24 for each shift to 18 in September 2023 after a review. Staff considered this

negatively impacted safety and their ability to ensure patients were provided with the care required to meet their needs. Managers told us they had subsequently increased the number of nurses needed by 2 to 20 to take into consideration the increased number of patients likely to access the department during the winter the following month. However, at the time of our inspection this was not yet in line with the uplift identified in the staffing review.

At busy times this meant the ratio of RNs to patients was approximately 1 RN to 7.8 patients (based on 155 patients in the department), and at less busy times 1 to 3.7 (based on 74 patients in the department). This was generally not in line with the 1 RN to 4 patients ratio set out in the ED operational policy and did not meet RCEM recommendations of 1 RN to every high dependency patient, 1 RN to every moderate dependency patient and 1 RN to every 3.5 low dependency patients.

During our inspection, we observed 1 nurse caring for 4 patients in the resuscitation area. Managers told us 2 nurses had been assigned to this area and 1 was on a break and there was not enough staff to provide cover. This did not meet the recomended ratio of 1 nurse to 1 patient in this area and meant should a patient require resuscitation there was insufficient staff to safely manage the emergency and monitor other patients in the area.

Staff told us their breaks were often late or they did not get a break at all. Furthermore, they told us low staffing levels meant patients were not always safe and they were not always able to meet personalised needs. For example, they did not always have their observations taken on time, there were delays in administering medicines, diagnostics tests could be delayed, they were not always able to monitor vulnerable patients or those at risk of falls, patient transfers to other areas of the hospital could be delayed, and they did not always have their nutrition and hydration, or personal hygiene needs met in a timely manner. A nurse gave an example of 1 patient who arrived in the department the previous day who had not been offered a wash due to a lack of time for nursing staff to help them. Prior to our inspection, we reviewed incidents reported in September and October 2023, which showed delays in patients receiving medicine as a common theme, including IV antibiotics for patients at high risk of sepsis. In 3 out of 8 cases we reviewed, patients waited longer than 6 hours to receive the necessary treatment.

Following our inspection, we spoke to 6 patients who had been discharged from the hospital on the days of our inspection. All patients fed back that staff were very kind and caring. However, all patients commented on the staffing levels impacting their experience and care given. For example, they were not always offered food and fluids, there were delays in responding to requests for assistance, delays in being given medicines, and they did not receive regular updates on their care and treatment. During our inspection, members of the inspection team were approached by patients requesting a drink or assistance to help them use the toilet as they could not find staff to ask.

The SOP for ambulance arrivals stated that all patients arriving by ambulance should receive a visual triage from the nurse navigator. During our inspection, the department was too busy for the navigator to triage all patients face to face and we saw the navigator performing other roles. For example, cleaning bays in between patients and printing out forms because there were no other staff available to do this. This increased the delay for ambulance patients waiting to be triaged.

The trust did not have enough Registered Children's Nurses (RCNs) to provide safe care for children in the PED. During our inspection in December 2022, we found the PED did not always meet the Royal College of Paediatrics and Child Health (RCPCH) standard of having 2 RCNs on each shift. During this inspection, we found this had not significantly improved. However, the service continued to have mitigations in place to reduce the risk. For example, there was always a minimum of 1 RCN and 1 adult registered nurse with paediatric competencies to cover a shortfall in RCN levels. Furthermore, the service was unable to meet the RCPCH standard of having at least 1 RCN with European Paediatric

Advanced Life Support (EPALS) skills on each shift. Information supplied by the trust demonstrated they did not always have enough EPALS trained staff to cover this. In November 2023, there were 11 shifts with no EPALS trained staff, in 7 instances there were 2 or more Paediatric Immediate Life Support (PILS) trained staff which mitigated this risk, however, in 4 instances there was only 1 PILS trained nurse available on the shift.

Staff reported incidents where staffing levels with the PED impacted on patient care including delays in patients receiving a triage within 15 minutes. Delays in triage meant that unwell patients arriving in the department might not be seen in time to receive time critical care. During September 2023, 6 incidents were reported where staffing levels impacted patient care. There was 1 incident reported in October and 1 in November. For example, 1 incident reported the PED was staffed overnight by 1 agency RCN, 1 substantive RCN, 1 RN and no healthcare assistants. The report stated there were multiple children with a PEWS above 7 (very unwell) and a child with severe burns. The nurse who was covering triage was required to nurse the burns patient which led to delays in triage. Another incident reported was a day shift where there were up to 26 patients in the PED at 1 time being cared for by 3 RCN (1 RCN to 9 patients) and 1 healthcare assistant. It was recorded there were delays in treatment, observations, and triage during this shift.

The planned number of staff to provide safe care on each shift did not always match the actual numbers of nursing staff in the adult ED. From 2 October to 29 October 2023, there was a shortfall of 12% (2,264 care hours) staffing hours to match the planned number of nursing staff required to provide safe care. From 30 October to 27 November 2023, there was a shortfall of 8.4% (1,352 care hours). From 30 October to 23 November 2023, 17.2% of care hours (520.5 hours) were not staffed and from 27 November to 24 December 2023, 17.5% of care hours (606.67) were not staffed.

MIaMI was staffed with Emergency Nurse Practitioners (ENPs) and GPs. ENPs are specialist nurses who have received additional training to diagnose and treat minor injuries or illnesses in an emergency care setting. Experienced ENPs can often treat patients without needing to involve a doctor. The ENPs were sometimes supported by a health care assistant although the health care assistant was sometimes redeployed to ED. The ENPs were not supported by a RN so they could not consistently manage their time efficiently, for example if a patient required sutures, they would have to complete this task themselves before they could see their next patient.

The service had reducing sickness rates. The sickness rate for qualified nursing staff in urgent and emergency care at the trust decreased from 6.7% in October 2022 to 4.7% in April 2023. Since then, the sickness rate fluctuated between 2.4% and 4.7%.

Managers relied on bank and agency staff use. However, they requested staff familiar with the service. Managers made sure all bank and agency staff had an induction. We spoke to an agency nurse who had received a 1 day trust induction and 1 day ED induction before starting work. As reported above an agency nurse did not perform a sepsis screen on children accessing the service as part of the triage in line with trust policy. This meant the induction may not always be effective to ensure patients need are met and staff are confident in the service processes.

Staff from other areas within the hospital were moved to support the ED and increase the nurse patient ratio. Staff told us this was not always helpful as ward-based staff had a different skill set that was not always transferable to the ED.

Newly qualified and internationally recruited nurses were supernumerary for up to 6 weeks to ensure they developed in confidence and increased their skills prior to being rostered into staffing numbers.

Managers made sure volunteers had a full induction and understood the service. We saw volunteers assisting patients on arrival in the department. Volunteers told us they received a full induction and mandatory training including training specifically for using wheelchairs.

Urgent and emergency services

Medical staffing

The service mostly 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 staffing levels and skill mix.

The service mostly had enough medical staff to keep patients safe. The service had significantly increased the numbers of consultants since our previous inspection in 2020 where there were 8 consultants. During this inspection there were 16 consultants working within the department. This included a PEM consultant who provided clinical leadership within the PED as recommended in RCPCH guidance. Consultants provided cover in the department from 8am to midnight and were on-call thereafter.

Medical staff and nurses we spoke to felt that the department had enough cover from doctors during the day. However, they described a worsening picture of cover overnight and at weekends. There was always a consultant on call but the ED, MIaMI and PED were overseen by 2 registrars out of hours. A registrar is a doctor in the middle of their training. This is the stage of training, after being a junior doctor, and before being a consultant. One registrar oversaw the resuscitation area and majors in the main ED and the other oversaw minors and the PED. Staff told us overseeing the PED could be challenging because they did not have support from the local paediatric team for children requiring high dependency or intensive care.

The medical SDEC was staffed by 5 doctors Monday to Friday with the expectation of treating 46 patients. At the weekend the service was staffed by 2 doctors and would see 23 patients.

The trust had invested in employing Advanced Clinical Practitioners (ACPs). ACPs are health care professionals that have undertaken additional training to allow them to assess, diagnose, and treat patients including prescribing medication and referring on to other services. The ACPs were well managed by the emergency medicine consultant in terms of oversight and skill mix.

Junior, middle grade doctors and ACPs told us consultants were approachable, supportive and could be relied on to offer advice on medical and non-medical patient issues. They told us they received protected teaching sessions, and training and development opportunities.

Managers made sure locums had a full induction to the service before they started work, as well as the same training and developmental opportunities as substantive staff. However, none of the locum or junior doctors we asked said they received an induction on internal professional standards.

Records

Staff did not always keep kept records of patients' care and treatment. Records were not always up-to-date or stored securely.

Staff could not always easily access patient records. Patient notes were combination of electronic and paper records. This meant staff could not always access information about patients easily as they often needed to access both sets of records. Not every member of staff had their own portable device for recording patient notes. We observed staff regularly waiting for portable devices to become free so they could enter notes.

Patient notes were not always comprehensive. We did a deep dive into 5 sets of patient notes and found patient care was not consistently documented. This meant we did not always know if patient care took place or not as it was not documented. In 4 sets of adult notes, we did not see any evidence of intentional rounding. Intentional rounding is a

process of regular patient checks to address issues, such as repositioning patients with skin viability risks, checking pain levels, and that personal needs like going to the toilet had been met. There were booklets for staff to document intentional checks in, but these were not consistently completed. During our inspection we saw on 1 day there had not been any entries in the paper or electronic notes we looked at since the early hours of the morning (approximately 7 hours) for 2 patients. However, the paediatric notes we reviewed were comprehensive and up to date. We did an additional audit of 10 paediatric notes and saw all the necessary documentation was completed correctly. This was an improvement on our last inspection.

Ward notes were electronic which meant when patients were transferred from the ED to a ward, the notes had to be entered manually onto the electronic system. Medical staff told us this process was laborious and their time could have been used more productively seeing patients. It also meant information could be entered incorrectly.

Staff could not show us the electronic referral process as it was not easily accessible to all staff.

Medicine charts could be both paper or electronic and were used interchangeably, this meant staff had to constantly check 2 sets of records to reduce the chance of a prescribing error occurring.

Records were not always securely stored. There were dedicated storage draws for patients notes that could not be locked. Patient paper records were a loose set of forms/papers, not kept in a folder or fastened together. We saw staff looking for files and attempting to retrieve paper notes that had become attached to other patient records. We asked to review a set of patient notes, these could not be immediately located. Part of the paper records were located on top of a set of draws at the nurses' station, several minutes later the matron came in with the rest of the notes that had become part of another patients notes and had been transferred elsewhere with a patient.

Staff ensured computers were locked when they moved away from them.

Medicines

The service did not consistently use systems and processes to safely prescribe, administer, record and store medicines.

Staff did not always follow systems and processes to safely prescribe, administer and record medicines.

The department had a dual prescribing system, medicines could be prescribed on paper charts or, once a decision to admit a patient had been made on the electronic prescribing and medicines administration system (ePMA). Staff told us they checked both paper charts and ePMA. However, this meant there was an over reliance on staff checking 2 systems and there was still a risk that medicines could be duplicated or not prescribed. We looked at the clinical notes of one patient, their doctor requested one of their medicines were withheld due to side effects. This had not been withheld on the ePMA record so there was a risk that this could have been administered by nursing staff. We raised this immediate concern with staff.

The trust recognised the risk of using 2 prescribing systems and had listed it on the risk register. Specifically, this risk concerned the potential for missing, or a delay in prescribing, the second dose of antimicrobials for sepsis by speciality doctors once a decision had been taken to admit the patient.

One of the parents we spoke to told us their child had not been offered pain relief and they were giving their child medicine to relive pain that they had brought with them. The child had been in the department for 15.5 hours. This meant pain relief was not being accurately recorded or monitored by the department.

Staff mostly stored and managed all medicines and prescribing documents in line with the provider's policy. Medicines including controlled drugs (medicines requiring additional controls due to their potential for misuse) were stored securely and safely. Room and fridge temperatures where medicines were stored were monitored and guidance was available for staff for actions to take if excursions occurred. However, the trust did not have a policy to govern the supply of pre-labelled medicines given to patients on discharge from hospital.

Staff did not always follow current national guidance to check patients had the correct medicines. Processes for medicines reconciliation (the process of accurately listing the medicines a patient was taking compared to what had been prescribed) were not always followed. We saw accurate medicines history was not always obtained by staff who were clerking in patients, specifically information about the strength and doses of medicines was not always recorded. Data obtained from the trust showed that only 31.7% of patients in the trust had their medicines reconciled within 24 hours against a target of 90%.

The service had systems to ensure staff knew about safety alerts and incidents, so staff had the information they needed to prescribe medicines safely.

Decision making processes were in place to ensure people's behaviour was not controlled by excessive and inappropriate use of medicines.

Incidents

The service managed patient safety incidents well. Staff recognised and reported incidents and near misses and mostly reported them appropriately. 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.

Staff knew what incidents to report and how to report them. Staff raised concerns and reported incidents and near misses in line with trust/provider policy. During our inspection of the PED in 2022 we were concerned that staff did not always report incidents in line with trust policy. However, during this inspection staff told us they reported incidents. For example, data demonstrated staff reported incidents in relation to delayed medicines and treatment, staffing concerns, including near misses.

Staff reported serious incidents clearly and in line with trust policy. From December 2022 to November 2023, the service declared 4 serious incidents. The service had not reported any never events in any area of the ED.

Managers shared learning with their staff incidents at safety huddles during staff meetings and in newsletters.

Some of the staff we spoke to described a culture of learning from incidents in the department while others described a culture of blame where staff did not acknowledge and talk about their mistakes for fear of ridicule from other staff.

During our inspection, we observed evidence learning had been implemented following a serious incident relating to the death of a patient with a learning disability. For example, training sessions had been rolled out to staff in relation to the safe care and treatment of patient with Prada Willey Syndrome (PWS). Most staff we spoke to understood what PWS was and adjustments that should be made in caring for a patient with this condition. Staff were able to tell us what actions they should take in line with the ED protocol in place for PWS. Improved communication between PWS specific care

homes and the hospital was in place for better oversight of these patients. There was a PWS alert on the electronic system and a prompt to access the PWS alert booklet on the hospital online system. Furthermore, the learning disability nurse reviewed all patients. Further specialist medical training was in the process of being organised for medical staff for on-gong awareness. There was also a new policy in place to support staff in involving carers.

Staff we spoke to understood the duty of candour. They described being open and transparent and gave patients and families a full explanation if or when things went wrong. Staff told us they received feedback from investigation of incidents and met to discuss the feedback and look at how learning could be used to improve patient care.

Is the service effective?

Requires Improvement 

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

Evidence-based care and treatment

The service mostly provided care and treatment based on national guidance and evidence-based practice. Staff knew how to protect the rights of patients subject to the Mental Health Act 1983.

Staff followed up-to-date policies to plan and deliver high quality care based on best practice and national guidance. For example, we saw policies were based on up-to-date clinical guidelines like the management of pain in adults policy which used information from, amongst others, the Royal Pharmaceutical Society. Other policies and guidance used with the Emergency Department (ED) regularly referenced the Royal College of Emergency Medicine (RCEM).

Guidance was not always followed by staff. For example, we observed blood samples were not always labelled at the patient's bedside in line with best practice. We saw 2 occasions where staff took blood from patients and then went to find stickers to label the vials. This was not in line with trust guidance. Checking the identity of each patient and labelling the specimens taken whilst at the bedside reduces the likelihood of the wrong tests being performed on the wrong patient creating delays in treatment.

Internal professional standards were in place but not everyone knew about them and did not always follow them. For example, we observed patients who had been referred to surgical and medical specialities were not always taken responsibility for by the speciality teams at the point they assessed the patient. This concern was also identified at our previous inspection in 2020. Taking responsibility for patient care from the point of assessment is essential to the patient receiving the specialist care and treatment they need to start to recover. Without this specialist intervention patients can start to decondition while waiting for the treatment to start. Deconditioning can start within 24 hours especially in frail elderly patients and is associated with a range of physiological effects including pneumonia, skin breakdown, constipation, incontinence, depression, muscle weakness and an increased risk of falls. Deconditioning can impact on a patient's suitability for surgery and ultimately on their mortality. Guidance about who should take responsibility of a patient at what point is commonly covered by a trust's internal professional standards. None of the locum or junior doctors we asked said they received an induction on internal professional standards. They did not know where to find this document and did not know what it was used for. This meant some medical staff did not have a consistent understanding of the decision-making processes that underpinned safe patient care.

Processes were in place to protect the rights of patients subject to the Mental Health Act (MHA) and followed the Code of Practice. We did not see any patients who were subject to the MHA. However, staff could describe the MHA and

understood how to implement it. This meant if someone had been placed on a section under the MHA, or kept in hospital under the MHA, staff would understand how to protect their rights. Patients who lacked capacity to fully engage in treatment and patients who had thoughts of self-harming and or ending their life were given one to one support when appropriate.

Staff used a 'grab sheet' for death verification when a patient died in the department. It outlined roles in a flow chart that both medical and nursing staff need to follow to ensure the correct processes were followed.

At handover meetings, staff routinely referred to the psychological and emotional needs of patients. We observed a nursing staff handover huddle which identified patients who lacked mental capacity and relatives or carers who advocated on their behalf. The requirements of patients with psychological needs were discussed including how care was to be delivered to keep them safe and reduce their anxiety.

Nutrition and hydration

Staff did not consistently ensure patients had enough food and drink to meet their needs and improve their health.

We saw patients were offered drinks and hot and cold food, including snacks and cooked meals. However, 1 patient who had been in the department for 23 hours told us they had only just been given their first meal at the time we spoke to them and told us all food before that time was snacks.

Staff did not fully and accurately complete patients' fluid and nutrition charts when needed in line with National Institute for Health and Care Excellence guidelines. Evidence provided by the service showed 24% of patients who required a fluid balance chart had one completed in September, 11% of patients had one completed in October and November 2023. Of those who had a chart 75% were fully completed in September, 0% were fully completed in October and 50% were fully completed in November. We looked at records for 2 patients who required a fluid balance chart because they were receiving intravenous (IV) fluids, neither of which had a fluid balance chart in place.

Volunteers offered food and drinks to patients in the waiting and 'fit to sit' area. Patients had access to drinking water and fruit flavoured squash in all waiting areas.

Pain relief

Staff did not always assess and monitor patients regularly to see if they were in pain and gave pain relief in a timely way. They supported those unable to communicate using suitable assessment tools and gave additional pain relief to ease pain.

Staff mostly assessed patients' pain using a recognised tool and gave pain relief in line with individual needs and best practice. They used appropriate tools to help assess the level of pain of children, patients with a learning disability and for patients who were non-verbal. Most but not all patients told us they had been offered pain relief. In the Paediatric Emergency Department (PED) we spoke to the parents of 2 patients who told us their children had not been offered pain relief and they had given their children medicine to relieve pain that they brought in with them. These had not been documented by staff.

Management of pain was monitored by the service using RCEM standards. Data sent to us by the trust showed in October 2023 60% of patients received an assessment of their pain levels within 15 minutes in line with national standards. This was below the 100% RCEM standard. Of the 60% who had received an assessment, 92% were administered analgesia and 94% of patients received a reassessment of pain within an appropriate timeframe.

Urgent and emergency services

The trust participated in the NHS Family and Friends Test (FFT). The FFT is an anonymous survey designed to allow service providers and commissioners to understand whether patients are happy with the service provided, or where improvements are needed. In September 2023 the pain management measure received a score of 4 out of 5 from the 404 respondents who completed the survey. In October and November, the score was 3.5 out of 5 in the PED from 126 respondents, and 4 out of 5 in the ED from 764 respondents.

Patient outcomes

Staff monitored the effectiveness of care and treatment. They used the findings to make improvements and achieved good outcomes for patients.

The service participated in relevant national clinical audits. They completed the RCEM annual audits to ensure they were effectively driving improvements and demonstrating good patient outcomes. The RCEM audit is a quality improvement process that seeks to improve patient care and outcomes through systematic review of care given against 3 treatment criteria each year.

We saw evidence that managers and staff carried out a programme of repeated local audits to check improvement over time. For example, sepsis, falls, safeguarding and deteriorating patient audits. Managers used information from the audits to improve care and treatment by sharing outcomes with staff and introducing training and making other changes to improve performance. However, some things were not checked. For example, delays in transfer of patient to care of speciality teams, or risk of venous thromboembolism (VTE). This meant the trust were not aware of the impact of delays in transfer to speciality teams. Furthermore, managers could not be assured VTE assessments were being carried out for all patients and the risk was being reassessed for those at high risk.

The percentage of patients that reattended the ED department within 7 days of a previous attendance was generally similar to the England average from August 2021 to July 2023. The trust mostly had a higher percentage (worse) than the Midlands average in the year prior to our inspection and in July 2023 had the third highest percentage of patients that reattended within 7 days of all trusts in the Midlands. In July 2023 the trust proportion was 9.4% compared to the England average of 8.8% and Midlands average of 8.3%. From November 2022 to November 2023, 9,613 patients reattended within 7 days, this was an average of 185 patients each week.

Competent staff

The service mostly made sure staff were competent for their roles and appraised staff's work performance.

A small team of clinical educators supported the learning and development needs of nursing staff. They were employed to ensure nurses were competent, felt confident to work in the department and had regular clinical supervision. The guidelines used for the skills and competency framework were based on clinical guidance from the Royal College of Nursing. Staff were able to work towards developing new competencies at a pace that suited them.

To ensure a strong understanding of emergency treatment, training in the use of the tool used to triage new patients was provided to band 6 nurses only when they had worked in the department for at least 6 months. A member of the staff team had recently become a trainer in use of the triage tool and the department had a plan to increase the number of nurses the training was rolled out to in 2023/24. All relevant staff working within the PED had completed Manchester triage training which was a significant improvement following our inspections in December 2022 and April 2023.

Urgent and emergency services

Nursing staff trained to work with adults but who were caring for children had completed competencies to demonstrate they had knowledge and skills to work with children. We saw evidence that staff working with children and young people received Paediatric Immediate Life Support (PILS) or European Paediatric Life Support (EPALS) training and caring for the sick child training. Ten members of the nursing team were due to receive PILS training the day after our inspection.

Advanced nurse practitioners told us the standard operating procedure (SOP) for their service was changing and they were going to be treating minor illness as well as minor injury. They were concerned they had not received training necessary to provide the level of care described in the SOP which had previously being the domain of GPs in minor injuries and minor illness unit.

Managers supported medical staff to develop through regular, constructive clinical supervision of their work. Managers identified any training needs their staff had and gave them the time and opportunity to develop their skills and knowledge. Medical staff told us they had regular protected teaching time each week. Medical staff had an 81.6% appraisal completion rate which meant 9 staff members had not received their appraisal. However, the trust had a framework for doctors to lead their own appraisal as part of the revalidation process. This enabled doctors to consider and plan for their professional development, as well as demonstrate to the trust they remained up to date across their scope of practice.

Managers did not always support nursing staff to develop through yearly, constructive appraisals of their work. For example, allied health professionals and administrative staff had a 100% completion rate for their annual appraisal, and the PED nurses had a 90.48% completion rate. However, registered nurses in the ED had an 82.7% completion rate, this meant 24 ED nurses had not received their annual appraisal.

Managers gave all new staff a full induction tailored to their role before they started work. All staff including locum doctors and agency staff told us they received an induction before they began working in the department. Agency staff received a 2-day orientation induction. While on their induction to develop competencies and confidence newly qualified nurses and overseas nurses were supernumerary for up to 6 weeks.

Managers recruited, trained and supported volunteers to support patients in the service. Their tasks included helping patients book into the service using iPads, making drinks, and serving snacks. Volunteers told us they received regular mandatory training and received a full induction, this included training specifically for using wheelchairs.

Managers made sure staff attended team meetings or had access to full notes when they could not attend. Staff also received a weekly newsletter containing important messages.

Multidisciplinary working

Doctors, nurses and other healthcare professionals worked together as a team to benefit patients. They supported each other to provide good care.

Staff held regular and effective multidisciplinary meetings to discuss patients and improve their care. We saw staff working across health care disciplines as a multidisciplinary team to benefit patients. We saw doctors and nurses working with the mental health team, physiotherapists, and the frailty team.

Urgent and emergency services

Staff mostly worked well across health care disciplines and with other agencies when required to care for patients. Doctors from the medical and surgical teams worked in the ED to assess and care for their patients. Speciality doctors were mostly responsive when asked to review patients in the ED although there were delays for some patients in speciality teams arranging for patients to be transferred to their wards because of congestion in the wider hospital.

Staff referred patients for mental health assessments when they showed signs of mental ill health or depression.

Consent, Mental Capacity Act and Deprivation of Liberty safeguards

Staff supported patients to make informed decisions about their care and treatment. They followed national guidance to gain patients' consent. They knew how to support patients who lacked capacity to make their own decisions or were experiencing mental ill health.

Staff told us they received and kept up to date with training in the Mental Capacity Act (2005) and Deprivation of Liberty Safeguards (DoLS). Staff did not impose DoLS in the department, but they understood and could tell us about the relevant consent and decision-making requirements. They knew who to contact for advice.

Staff completed Do Not Attempt Cardiopulmonary Resuscitation (DNACPR) and treatment escalation plan (TEP) forms with patients and their families in line with national guidance. This process creates a summary of personalised recommendations for a person's clinical care in a future emergency, for example cardiac arrest, in which they do not have capacity to make or express choices. The process is intended to respect both patient preferences and clinical judgement. The agreed clinical recommendations that are recorded include a recommendation on whether cardiopulmonary resuscitation should be attempted if the patient's heart and breathing stop. We looked at DNACPR forms for 4 patients and saw they had been completed fully and accurately. This meant patients and people with the right to act in their best interests had been involved in making future care decisions.

Is the service caring?

Requires Improvement 

Our rating of caring went down. We rated it as requires improvement.

Compassionate care

In general, individual staff members treated patients with compassion and kindness. However, the service was not consistently delivered in a way that always respected patients' privacy and dignity.

Staff were mostly discreet and responsive when caring for patients. Staff took time to interact with patients and those close to them in a respectful and considerate way. We observed curtains being closed when staff were carrying out treatments or meeting patients personal care needs.

Patients said staff treated them well and with kindness. Patients, their parents, and carers mostly provided positive feedback on their experience of care. However, staff did not consistently maintain the privacy and dignity of patients. During our inspection we observed 2 instances when patients and carers privacy and dignity was compromised and not maintained.

In the first instance we saw a nurse repeatedly trying to access a side room in majors despite being told by a patients mother that her daughter was using the toilet. We heard the patient becoming distressed, but the nurse continued to attempt access to the room and raised her voice telling the mother to move out of the way. Other nursing staff intervened to diffuse the situation.

In the second instance we saw a distressed parent who wanted to leave the paediatric emergency department (PED) with her son because she felt she was being judged by the staff. The PED staff did not respond to, or make eye contact with, the parent. The emergency department (ED) nurse in charge (NiC) witnessed this and stepped in to offer reassurance to the parent. Following this the NiC spoke to the staff about how they could have managed the situation better.

The footprint of the department meant the PED and the paediatric resuscitation bay were separated by a busy hospital corridor. This meant a critically unwell child or young person and their parents or carers may have had to make a very public journey in what could be a very distressing circumstance to receive emergency lifesaving care. Furthermore, the high dependency bay in the PED, used in the event of an emergency, was in the middle of the majors area, separated by curtains only. Based on the location and size of the room and department, managers told us this made it difficult to maintain patients dignity and privacy in an emergency as well as support parents privacy.

The layout of the main waiting area meant staff could not always follow policy to keep information about patients confidential. During our inspection we could overhear patients booking in at the reception desk. We did not see any attempts by staff to be discrete to protect patients confidentiality.

The trust participated in the NHS Family and Friends Test (FFT). Feedback from the FFT was variable. Feedback from September to November 2023 was mostly positive. It included the following comment, “Staff dealt with my daughter with compassion and in a non-judgemental way. Also looked after me!”. Other parents wrote how non-judgemental staff had been when caring for their autistic child. However, we saw feedback that said staff had been overheard gossiping about a child who had taken a deliberate overdose. Another patient wrote “Staff were rude and uncaring. Talking over the top of me, judgemental”.

Patients also left feedback to say they did not think confidentiality was consistently maintained. One patient left a comment about overhearing a member of staff asking another patient about their “bowel habits and stool size” in the waiting room. Another patient said, “I was very disappointed to be asked personal questions in front of other patients whilst having my blood pressure checked in the waiting area”. Another patient reflected on a lack of privacy and dignity for some patients in the waiting area where they could see patients having their blood pressure taken and having intravenous therapy. Another comment read “I would have preferred to be able to speak to the doctor in private rather than in the middle of a noisy waiting room”.

Emotional support

Staff provided emotional support to patients, families and carers to minimise their distress. They understood patients' personal, cultural and religious needs.

Staff gave patients and those close to them help, emotional support and advice when they needed it. Staff offered reassurance and were gentle to patients who were distressed.

Staff undertook training on breaking bad news and knew how to demonstrate empathy when having difficult conversations. Staff showed an understanding of the individual end of life care needs for patients and their families. There were dedicated quiet rooms for staff to meet with families for confidential discussions and for breaking bad news.

Urgent and emergency services

Staff understood the emotional and social impact that a person's care, treatment or condition had on their wellbeing and on those close to them. Staff made space for relatives to support patients.

Feedback from the FFT was mostly positive. One family member left the following comment "The doctor and nurse we saw went above and beyond with my elderly mother, they explained everything. Made us as a family feel very comfortable and well cared for".

Understanding and involvement of patients and those close to them

Staff mostly supported and involved patients, families and carers to understand their condition and make decisions about their care and treatment.

Staff made sure patients and those close to them understood their care and treatment. Most of the patients we spoke to told us that they knew what would be happening next, including what the plan was for their continued care or discharge. We spoke to 6 patients who had been in the ED for 4 hours or more. Five patients told us they had been involved in making decisions about their treatment however, 1 patient told us they had not been given any information about their condition or proposed treatment plan by the speciality team responsible for their care.

Staff talked to patients in a way they could understand. Staff told us they had access to communication aids when needed.

Staff supported patients to make advanced decisions about their care. We saw staff completed Do Not Attempt Cardiopulmonary Resuscitation (DNACPR) and treatment escalation plan (TEP) forms with patients and their families.

Patients and their families could give feedback on the service and their treatment and staff supported them to do this. Posters with details of how to raise a concern or make a complaint were on the walls in waiting areas.

Feedback from the FFT was mostly positive. In September 2023 the adult urgent and emergency care (UEC) service received feedback from 374 patients and their family. It showed 77% of the respondents said they were satisfied with the care they received. The PED received 30 FFT responses, of which 90% were satisfied with their care. In October 2023 the adult ED service received 372 responses from patients and their family of which 81% said they were satisfied with the care they received. The PED received 68 responses of which 90% were satisfied with their care. In November 2023 the adult UEC service received feedback from 372 patients and their family of which 74% said they were satisfied with the care they received. The PED received 58 FFT responses of which 80% were satisfied with their care.

Positive feedback for September, October and November 2023 mostly centred on the care patients had received from staff and often mentioned staff by name. Negative feedback for the same period mostly focussed on long waits for treatment, the environment in waiting areas, including uncomfortable seating, a lack of seating, and a lack of air conditioning (September), a lack of stimulation for children in PED, and the cost, and lack of, car parking. The cost and lack of car parking was also a theme with the patients we spoke to.

Parents left comments to say they were pleased with how staff had kept them informed about their child's treatment. For example, 1 parent commented "Lots of attention, communication and explained well. Thank you."

The service had a relative's room which was used for breaking bad news and for grieving relatives. The room was sparsely decorated and furnished. There were no posters or leaflets to signpost families to support services or to the trust chaplain.

Urgent and emergency services

Is the service responsive?

Requires Improvement 

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

Service delivery to meet the needs of local people

The service was not designed to provide care in a way that met the needs of local people and the communities served. It worked with others in the wider system and local organisations to plan care.

Managers tried to plan and organise services, so they met the needs of the local population. However, due to pressures in the wider health and social care system and high levels of demand on the department, along with the wider hospital, the emergency department (ED) was often gridlocked. Senior medical staff told us although staff could keep patients safe the quality of care provided could not be guaranteed because the size of the department and staffing levels did not match the level of demand. This meant facilities and premises were not always appropriate for the services being delivered.

Staff told us there were typically 25 patients in the ED overnight who were the responsibility of a speciality team and who were waiting to be transferred to a different part of the hospital. This was in contradiction to the trust policy which stated that all patients likely to be admitted should be admitted to a ward by their speciality team and the patient should "not wait in ED" even if further investigations were required. It further states patients should be offered a bed on a ward within 30 minutes. However, this was rarely possible due to the wider hospital constraints and pressures with social care in the community meaning there were very limited beds within the hospital.

Specialty doctors spent time in the ED assessing and reviewing their patients as they were often there for long periods due to wider hospital capacity. This involved them using ED resources, for example, computers and desk space, which impacted on the ED staff ability to use these resources. This further impacted delays in bringing new patients into the department quicker.

Patients waiting for transfer were in bays that could not be used by new patients coming into the ED. As the day progressed and the ED became busier this meant that patients coming in by ambulance were delayed from coming into the department and instead had to wait on their ambulance for bed spaces to become available. The trust developed a Standard Operating Procedure (SOP) to guide staff in the process of managing assessment and treatment for these patients. This included patients having diagnostic tests on ambulances and continued monitoring by ambulance service staff while remaining the responsibility of the trust.

'Fit to sit' was used when there were no more beds or chairs for patients in the ED, but patients still needed to be in the department. They were assessed as clinically well enough to sit up. This cohort of patients were sat in the main waiting area on colour coded seats. We sat in this area on 4 occasions for between 7 and 15 minutes, other than staff who walked past the area on their way to somewhere else, we did not see staff observing or interacting with these patients. Two of the fit to sit patients were attached to intravenous (IV) medicine drips. Patients coming into the waiting area were unaware of the colour coded seating system, we saw them using these to wait for triage. This meant staff did not have clear oversight or management of which patients had been assessed as fit to sit in this area. The fit to sit area was not being used in line with the ED operational policy governing the use of this area which states patients requiring IV fluids are managed in a cubicle and fit to sit patients must be under continuous observation by staff.

The paediatric emergency department (PED) did not have a play therapist. Play therapists can provide distraction therapy for potentially distressing procedures and help with the maintenance of a child-centred environment including a safe play area in the waiting area, along with age-appropriate facilities for older children.

The waiting area in the PED was not large enough to hold all of the children and their parents or carers waiting to be seen at busy times. This meant the waiting area had to be expanded into the minor injury and minor illness unit (MIaMI) waiting area during busy times and cordoned off with portable screens. The waiting area in MIaMI was not always large enough for everyone waiting to sit down during busy times and was not staffed so children could not be prevented from entering the adult waiting area or overhearing conversations with adult themes.

The main ED waiting area was not large enough for everyone waiting to be seen during busy times this meant patients and their relatives sometimes had to stand up or sit on the floor.

The service had 3 same day emergency care (SDEC) units (medical, surgical and obstetrics gynaecological) to relieve pressure on the ED. SDECs benefited both patients and the healthcare system by reducing the need for hospital admissions.

Staff could access emergency mental health support 24 hours a day, 7 days a week for adult patients with mental health problems, learning disabilities and dementia. Services for children with mental health problems could not be accessed out of hours. However, staff told us the operating times of the children's mental health services had not created a risk to patients.

There were posters in waiting areas to show that staff use a device that looks like a mobile phone to record patient notes. This was to reassure patients staff were not using their mobile phone while providing treatment.

Meeting people's individual needs

The service was inclusive and took account of patients' individual needs and preferences. Staff made reasonable adjustments to help patients access services. They coordinated care with other services and providers.

The design of the department was not supportive of patients living with mental health problems, learning disabilities and dementia. Patient-led assessments of the care environment (PLACE) scores showed the service was below the national average for measures related to dementia and learning disability care. PLACE scores are the outcome of annual patient-led assessments of how the environment supports the provision of clinical care. The assessment included how well the needs of patients with dementia were met. The hospital scored 71.03% in the 2022 assessment period; this was below the national average of 80.60%. Furthermore, the hospital scored 79.91% in the 2022 PLACE assessment for how well the needs of patients with a disability were met. This was lower than the national average of 82.49%.

However, we saw the service had processes in place to make sure patients living with mental health problems, learning disabilities and dementia received the necessary care to meet all their needs. Patients who were identified as having a learning disability were fast-tracked through the ED to minimise distress caused by the environment and long waits. We saw staff contacting a learning disability nurse to provide communication support for a patient. Staff told us they also speeded up services for patients with autism and dementia and could request the support of specialist nurses to enhance the experience of care for patients from these groups. During our inspection we observed staff liaising with specialist nurses to improve care management of patients living with dementia.

Staff supported patients living with dementia and learning disabilities by using 'This is me' documents and patient passports. These included their likes, dislikes and their preferred choice of communication. Communication aids were in place, but we did not see these being used during our inspection.

Learning disability pathways were in place for patients requiring admission. For example, we saw there were clear pathways in place to designated short stay medical and surgical wards as well as designated wards for patients requiring a longer admission. Furthermore, there were specific pathways in place to support staff in the management of patients with specific issues such as prada willey syndrome which had been implemented following an incident. However, not all staff we spoke to were aware of this.

The service had the names of patients on boards above their beds in most areas of the department, however, these did not always match with the patient who was in the bed. Patients did not always have wristbands on that identified them. During our inspection, 4 out of 6 patients we checked, were not wearing an identity wristband. Identity bands help staff identify patients accurately and match them with the care intended for them, such as the right medication or diagnostic tests. When we raised this as an issue it was rectified.

Managers made sure staff, and patients, loved ones and carers could get help from interpreters or signers when needed.

Access and flow

People did not always have timely access the service when they needed it. The service was not meeting national standards to admit, treat, transfer or discharge patients within 4 hours. There was a declining picture, consistent with increasing numbers of patients coming into the service.

There were long-standing local and national issues with access and flow through the whole health and care pathway which resulted in the service being 'gridlocked'. For example, there was an increase in demand for services impacted by an aging population living for longer with more conditions. There was an insufficient capacity in adult social care continuing to contribute to delays in discharging medically fit people from hospital, and difficulty for some people getting care from a GP practice having a knock-on effect for emergency departments. This meant although managers monitored waiting times, they were not always able to ensure patients could always access emergency services when needed or receive treatment within agreed timeframes and national targets.

From October 2022 to October 2023 the service experienced an 8.6% increase in the number of patients arriving on foot. This was higher than the average national increase. During this period the service also had a higher number of patients (3.6%) who attended more than once, which was higher than the national average. The service also had a higher number of patients (26.5%) who arrived by ambulance than the national average. Despite these challenges the service performed better than most other EDs in the country at seeing 55% of patients within 1 hour of arriving. However, patients who could not be seen within an hour were more likely than the national average to be in the department for 4 hours or more (52.6%). Of the patients who required admission to a ward 39% were still waiting to be transferred after 12 hours. On the first day of our inspection 367 patients presented at the ED over a 24-hour period with an average time in the department of 6 hours and 15 minutes. On our second day 349 patients presented with an average time in the department of 6 hours and 34 minutes.

On the first morning of our inspection there were 74 patients in the ED, 26 of whom had been there 12 hours or longer. By the afternoon there were 155 patients in the department, 13 of whom had been there for 12 hours or longer. At that time there were also 7 ambulances unable to offload their patients because there was no space for them. On the second morning of our inspection there were 68 patients in the ED, 25 of whom had been there for 12 hours or longer.

Urgent and emergency services

The median time from arrival to initial assessment was consistently longer (worse) than the England average from August 2021 to July 2023. Except for a peak of 21 minutes in December 2022. From August 2021 to July 2023, the median time to initial assessment had remained between 13 and 17 minutes. The average time to triage from September to November 2023 was 21.3 minutes. During our inspection waits for triage regularly stood at 40 minutes for patients arriving on foot.

Regular meetings were held throughout day with key staff to look at the situation in the department. We attended 2 internal meetings and 1 virtual meeting with external system partners. The system meeting was attended by a wide range of staff who worked together to identify how hospital and system wide flow could be improved. It was evident from these meeting that at times the hospital and wider system was gridlocked with very little movement to create flow could be achieved. However, the meetings helped managers have oversight of challenges, consider potential solutions, and prioritise and assign tasks to individuals.

Some patients spent longer in the department than planned because they required an inpatient mental health bed. Staff told us there could be long waits for children or adult beds in acute mental health services which meant the patient needed to stay in the ED for longer.

Staff told us patients waiting to be transferred to a speciality ward meant that bays were full in majors and some new patients coming into the hospital who needed treatment in majors were treated in minors instead. The trust did not monitor speciality response times so could not provide us with information about delays in speciality teams assessing patients in the ED or on delays in patients being transferred to speciality wards. However, we saw reports for 13 incidents where there had been a delay in transferring children from the PED to the children's ward. Two incidents were classed as near misses, 2 as causing low harm and the others of causing no harm. Six incidents were reported as capacity issues but 3 (1 near miss, 1 no harm and 1 low harm) were reported as delays in assessment by the speciality team. Despite not monitoring speciality response times the trust provided evidence to demonstrate this was a recognised risk and they were working to improve speciality response times. For example, the introduction of a dual role consultant post that covered urgent care and medicine to improve review times and responsibility of the patient.

At busy times MIaMI was overwhelmed with patients which created treatment delays. Staff told us high numbers of patients attended the ED because they could not get an appointment with their GP or dentist. There were plans to change the SOP for MIaMI to help create flow in ED. However, nursing staff were concerned they had not received training necessary to provide the level of care described in the SOP which included the addition of minor illness to minor injury for them, minor illness previously being the domain of GPs in MIaMI.

The proportion of patients who attended by ambulance and waited over 60 minutes from arrival to handover from April 2021 to September 2023 was consistently lower (better) than the average for regional ambulance service. Throughout 2023 the percentage of ambulance handovers taking over 60 minutes fluctuated between 0.7% and 6.0%. Over the same time period, the mean handover time fluctuated between 21.5 minutes to 28.6 minutes.

We saw patients arrive on ambulances who were unable to receive a triage within 15 minutes of arrival or be immediately admitted into the department due to capacity. The service had a nurse operating as an ambulance navigator who was responsible for taking handover from ambulance crews and triaging the patients based on those with the highest level of risk. The ambulance navigator had an overview of the department and moved patients into the department when there was space available. The ambulance navigator could triage patients straight into other more suitable areas of the hospital such as MIaMI or SDEC to help with patient flow.

There was a SOP for patients arriving by ambulance so staff knew what to do if ambulance patients could not immediately be admitted into the department and the wait exceeded 15, 30 and 60 minutes. Senior hospital leaders were actively engaged in trying to improve the time patients arriving by ambulance were triaged and admitted into the department. However, these improvements were hampered by circumstances outside of their control, for example, there were frequent surges of patients being brought to the hospital by ambulance which meant the department was overwhelmed by a sudden influx of patients. In addition to this the service had to regularly deal with ambulance diverts from 2 local NHS hospitals which resulted in an increase in the number of patients arriving by ambulance. This impacted the amount of time patients had to wait to be found a bed in the department. The service undertook harm reviews of patients who had waited over 15 minutes to be transferred off the ambulance into the department. We saw evidence from these reviews that no patients had come to harm from August to October 2023.

Triggers were in place to rapidly implement the trust surge or super surge plans should the service and hospital experience unprecedented demand or declare a critical incident. The ED had clear processes which staff and managers followed to escalate increases in demand. Surge plans required executive sign off so the responsibility for potentially closing the hospital to new patients and diverting ambulances to neighbouring trusts sat at board level.

The percentage of patients that left the ED before being seen for treatment was consistently lower (better) than the England and regional averages from August 2021 to July 2023. From March to July 2023 the trust percentage was between 3.4% to 4.1%, similar to the same months in 2022 when the percentage was consistently 4%. From September to November 2023 914 of 28,529 (3.21%) of adult patients left before being seen, 166 left before being assessed by a clinician and 748 left after assessment but before meaningful treatment commenced. Over the same time 8 patients under the age of 18 left before treatment commenced.

Processes were in place to support staff to plan for discharges, especially for patients with complex mental health and social care needs. Staff planned patients' discharge carefully, particularly for those with complex mental health and social care needs. The discharge team supported the department and there were 2 admission avoidance nurses on-site who assessed patients discharge needs at the front door. We reviewed 11 records of patients discharged from the department during our inspection, all had been reviewed by the discharge team to assess whether they had any discharge needs. This included patients with complex needs and learning disabilities.

Staff mostly supported patients when they were referred or transferred between services. We saw patients from the department provide handovers to other areas when patients were transferred out of the department or discharged. We also saw examples of staff from other areas being unable to receive information due to lack of available staffing.

Learning from complaints and concerns

It was easy for people to give feedback and raise concerns about care received. The service treated concerns and complaints seriously, investigated them and shared lessons learned with all staff. The service included patients in the investigation of their complaint.

Patients, relatives and carers knew how to complain or raise concerns. The service clearly displayed information about how to raise a concern on posters in patient areas and on the trust's website.

Staff understood the policy on complaints and knew how to handle them. Managers investigated complaints and identified themes. They involved patients and their families in investigations. Managers shared feedback from complaints and investigations with staff and learning was used to improve the service. In the 6 months before our inspection the trust received 41 complaints about urgent and emergency care services. Some complaints covered more

than 1 theme. The main themes were, communication (including the attitude or behaviour of staff), delays in discharge or in receiving care and failure of staff to accurately diagnose a medical condition. The service was committed to settling complaints through early resolution and in the 12 months before our inspection 23 out of 135 complaints about the service were settled this way. This was an improvement since our 2020 inspection.

Is the service well-led?

Requires Improvement 

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

Leadership

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

Leaders had the skills, knowledge, experience to run the service. Leaders understood the challenges to quality and sustainability and could identify the actions needed to address them.

Most staff told us leaders were visible and approachable. However, there was a consensus that there was a lack of visible management in the minor injury and minor illness unit (MIaMI). There had been a change in the senior leadership of the emergency department (ED) and staff told us this had led to improvements in the department. Staff specifically praised the new matron and her hands on approach to supporting staff at all levels with patient care.

Staff felt supported to develop their skills and were given opportunities to take on more senior roles. For example, 1 member of staff told us they had received support to complete their master's degree, and health care assistants had been developed to nursing associate roles. Nursing associate training is the step between working as a healthcare assistant and becoming a registered nurse.

Vision and Strategy

The service had a vision for what it wanted to achieve and a strategy to turn it into action, developed with all relevant stakeholders.

The trust had a vision and strategy in place. Whilst the service did not have a vision and strategy it had a business plan in place which outlined how it would deliver the trust vision and strategy. Senior leaders implemented and managed a business plan which outlined improvements in 2023/24. The business plan included working with other divisions across the trust and external providers, such as the ambulance service and the wider system to improve access and flow.

Culture

Staff mostly felt respected, supported and valued. They were focused on the needs of patients receiving care. Not all staff thought the service had an open culture where staff could raise concerns without fear.

Urgent and emergency services

Staff mostly felt supported, respected, valued and were positive and proud to work in the organisation. They said the teams they worked in were supportive and appreciative. However, staff from all disciplines expressed their unhappiness and concern for patient safety and staff morale following a move that had reduced the number of nurses working in the department. Staff also said when they raised concerns about nurse staffing levels their concerns were listened to but not acted on.

Staff did not always feel part of the wider urgent and emergency care team. They considered the layout of urgent and emergency care meant different parts of the department were led and managed differently. For example, differences in the frequency of team meetings or how learning from incidents was shared. Staff in ED told us they had regular team meetings and received written feedback if they could not attend. Staff in MIaMI reported they had only had 2 team meetings in 3 years.

Leaders and staff understood the importance of staff being able to raise concerns without fear of retribution. The freedom to speak up service was widely advertised across the hospital to encourage staff to share their concerns. Most staff told us they knew about the freedom to speak up service and would access it if they had cause to. However, some staff described a reluctance to speak up about their concerns within the department. They said they had witnessed senior nurses being rude to newly appointed internationally recruited nurses, and that these nurses were allocated to the least desirable roles in the ED rather than routinely being rotated to help develop their skill set and confidence. We were told the newly appointed internationally recruited nurses were reluctant to voice their concerns about their treatment in the department in case this negatively impacted on their ability to reside in the UK. The newly appointed internationally recruited nurses we spoke to did not raise these concerns with us.

Before our inspection we had received information about a culture of bullying and concerns of aggression from staff to patients. Staff told us the change in leadership in the department had brought an end to bullying with the nursing staff team. None of the staff we spoke to had witnessed aggression from staff to patients, conversely, they told us that they were frequently spoken to in an abusive manner by patients subject to long waits in the department. However, we witnessed a member of the medical team being verbally aggressive to a health care assistant about a delay in a patient's discharge.

Governance

Leaders mostly operated effective governance processes, throughout the service. 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. Improvements were not consistently implemented following identification of risk.

There were structures, processes and systems of accountability to support the delivery of the service. The service had a meeting structure in place which meant that senior leaders and managers had regular opportunities to discuss operational issues. Leaders were clear on the links to trust wide groups and committees to escalate risks and issues. A performance report was sent to the board each month which included all key metrics.

Quality meetings were held weekly, and clinical governance meetings were held monthly. We looked at meeting minutes and saw all meeting were documented and key areas including performance, staffing and incidents were discussed.

Senior departmental leaders met frequently throughout each shift. At these meetings they looked ahead for potential problems not just immediate concerns, for example forecasted staffing levels. Key staff attended regular meetings with partner organisations to work together to assess and improve flow across the system. Staff at all levels were clear about their roles and understood what they were accountable for, and to whom.

Urgent and emergency services

There was an effective policy in place to manage the department when it was in escalation. We looked at the policy and saw there were clear actions in place to mitigate risks and manage levels of staffing to meet the needs of patients.

Although there was a system for repeated audits to improve performance, we saw evidence performance remained low in some areas, and audits of processes to reduce risks, such as venous thromboembolism assessments were not completed.

At our last inspection we identified a number of breaches of regulation and some but not all of those breaches had been addressed. For example, we found there continued to be delays for patients accessing treatment, patient's privacy, dignity and confidentiality was not consistently upheld, risk to patients were not always being assessed in a timely fashion, and not all patients were being safeguarded in a timely way. Some but not all of these risks were listed on the risk register. This meant arrangements to mitigate and monitor risks and improve performance were not consistently in place.

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.

There were arrangements for identifying, recording and managing risks, and mitigating actions. There was alignment between recorded risks and what staff said was 'on their worry list'. Potential risks were considered when planning services, for example, seasonal fluctuations in demand.

The risk register identified the risks facing the service, it identified actions required and the people responsible for overseeing actions. We saw the trust were aware of how 1 risk impacted on other risks. For example, the risk of not triaging patients within 15 minutes of presenting at ED could not only risk patients not receiving time critical care but also impacted opportunities to identify safeguarding concerns as staff might rush triage to reduce patients waiting. Consideration was given of how to improve oversight of risk and how it could be reduced through a multitude of actions and interactions.

Managers and staff carried out a programme of repeated audits to check improvement over time. They audited performance and identified where improvements were needed. For example, sepsis identification had been identified as requiring improvement through audits of the National Early Warning Score (NEWS2) and measures, including staff training, had been identified to improve performance.

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 not in line with those used by the rest of the hospital.

Day to day oversight of the service performance, activity, risk and resilience was monitored through an electronic dashboard. The dashboard helped department leaders and the flow coordinator identify opportunities to improve flow and monitor high risk patients, such as deteriorating patients or those at risk of sepsis.

Patient notes were a combination of paper and electronic notes. This included a dual prescribing system. This meant there was an over reliance on staff checking both paper charts and the electronic prescribing and medicines administration system (ePMA). We saw the use of the ePMA and paper system had led to some delays in patients receiving time critical medicines. The trust had plans to improve patients notes to bring the department in line with the rest of the hospital.

Engagement

Leaders and staff actively and openly engaged with patients and staff, to plan and manage services.

People's views and experiences were gathered and acted on to shape and improve the service and culture. This included people in a range of equality groups, people who used services, and those close to them. We saw evidence of patients and their families experience of care being shaped to improve the service.

Staff were also actively engaged, including those with a protected characteristic, so their views were reflected in the planning and delivery of services and in shaping the culture. Staff told us they were regularly asked for feedback about the service, which they could provide anonymously, and the trust held a number of listening events including a specific event for urgent and emergency care staff.

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. We saw transparency and openness with partner organisations about performance at the daily meeting held with system partners to look at demand and capacity within the system.

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 and participation in research.

Leaders and staff aspired to continuous learning, improvement and innovation. This included participation in national benchmarking projects. There were standardised improvement tools and methods, and staff had the skills to use them.

We saw evidence of initiatives introduced to modify the service to improve flow. Staff told us about their willingness to adapt or change the service to improve outcomes for patients.

To speed up treatment for patients with time sensitive health conditions, for example stroke or chest pain staff designed a system for these patients to be seen as quickly as possible.

Medical care (including older people's care)

Requires Improvement 

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 for staff although not all staff had completed it. Medical staff had lower completion rates than nursing and other staff groups.

The mandatory training met the needs of patients and staff. However, data provided to us following our inspection showed nursing and medical staff did not always receive or keep up to date with this training. Records showed only 83% of nursing staff and 68.9% of medical staff had completed Basic Life Support training.

Clinical staff completed training on recognising and responding to patients with dementia. The service was in the process of rolling out Oliver McGowan eLearning training, however at the time of our inspection only 47% of staff had completed it. There was no evidence of any other specific mental health training for staff, although patients with mental health issues were regularly admitted to medical wards.

Managers monitored mandatory training and alerted nursing staff when they needed to update their training. Staff told us they received reminders when their mandatory training was due to be updated. Minutes from staff meetings showed staff were regularly reminded to complete their training.

Safeguarding

Staff understood how to protect patients from abuse and the service worked with other agencies to do so. Some but not all staff had training on how to recognise and report abuse and knew how to apply it.

Nursing staff received training specific for their role on how to recognise and report abuse. Data showed 94% of nursing staff had completed safeguarding adults and children level 1 and 89% had completed level 2 training.

Medical staff were also provided with training specific for their role on how to recognise and report abuse. However, only 74% had completed safeguarding adults' level 2 training, below the trust's 85% compliance target.

Staff knew how to identify adults and children at risk of, or suffering from, significant harm and worked with other agencies to protect them. Most staff we spoke to knew how to make a safeguarding referral and where they could find information on this. Staff told us they would contact the trust safeguarding team for advice and support.

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.

Staff followed infection control principles including the use of personal protective equipment (PPE). We observed staff were bare below the elbow and used PPE, such as aprons and gloves. Furthermore, we observed staff washing their hands and regularly using hand sanitising gel. Data provided to us following our inspection showed that from September to November 2023, most wards were compliant with targets, with no areas falling below the 90% benchmark during this time.

There were information leaflets and posters in the patient areas explaining infection prevention control measures There were adequate supplies of antibacterial hand gel, antibacterial wipes, and PPE in most areas.

Side rooms were available when isolation was required. Staff we spoke to during our inspection understood the process for screening patients for infectious diseases and where there was a risk, the process for isolating patients. Isolation precautions were displayed on side rooms as required and the isolation process staff followed was in line with trust policy.

The service monitored infectious diseases. Data showed that from June to November 2023, the service had no Methicillin Resistant Staphylococcus Aureus (MRSA) cases, with 3 Methicillin-Sensitive Staphylococcus Aureus (MSSA) cases in that time. Escherichia coli (E-coli) cases were sporadic across the medical wards, with 15 cases reported between June and November 2023. Similarly, there were 4 Clostridium difficile cases during this time.

The service generally performed well for cleanliness. All areas we visited appeared to be clean and had suitable furnishings which were well maintained. Treatment rooms, utility rooms, storerooms, and linen rooms we observed during our inspection were well organised and clean. However, 2022 Patient Led Assessments of the Care Environment scores for cleanliness across the trust were 95%, slightly lower than the national average of 98%.

Cleaning records were up-to-date and demonstrated that all areas were cleaned regularly. Cleaning schedules had been completed daily and were up to date, checklists were in place with specific roles allocated to clean specific areas and equipment. Regular cleaning audits (“100 Steps”) were carried out across each ward. Data showed that from June to November 2023 most wards exceeded the 90% target every month. The medical management teams regularly analysed this data as part of the quality assurance process.

We saw staff checking and cleaning patient areas. Staff cleaned equipment after patient contact and labelled equipment to show when it was last cleaned. Staff used ‘I am clean’ stickers on equipment which had been cleaned after use.

Environment and equipment

The design of the premises did not always follow national guidance, but staff were trained to use the equipment to keep people safe. Staff generally managed clinical waste well, although there were issues with removal of clinical waste from some wards.

Most wards visited during the inspection met the national guidance. The endoscopy unit had a good flow of clean and dirty equipment through the department to prevent contamination. Scopes were stored in drying cabinets and monitored and tracked in line with guidance.

Fire exits were clearly signposted and on most wards access was clear of hazards.

Where patients required enhanced observation, their beds were positioned in the line of sight of the nurse’s station. However, the design of some wards did not allow full sight of all patients from the nurses’ station. Therefore any patients at risk of falls or who needed closer monitoring were placed within specific bays on the ward.

Some wards had pictures of the sky and clouds on the ceiling to give visual effect of the outside.

Poplar ward had recently had to close part of the ward due to building safety concerns. This had reduced the bed capacity and access to some rooms. At the time of our inspection, the ward was sharing the sluice and treatment room with the neighbouring ward. There was limited space to store equipment, such as patient records and there was no nurses' station. We observed the ward was cluttered with equipment stored in the corridor. Due to the lack of a nurses' station to store patient files and paperwork, additional cupboards and a drug cupboard were planned to be installed. Managers had completed risk assessments of this ward and had plans in place to improve the environment and access to equipment and medication.

We saw that patients on wards could reach call bells although we observed there were no call bells available for patients in chairs waiting in the discharge lounge. Staff generally responded quickly when called although staff on the short stay ward did not always respond promptly to call bells. Staff on 1 ward told us that the call bell cords on this ward could be disconnected from the wall sockets when patients accidentally sat on the cords, which meant that sometimes they were out of action, although this was not mentioned on other wards.

The service had enough suitable equipment to help them safely care for patients. We saw that all wards had resuscitation trolleys and piped oxygen at bedsides as well as blood sugar and other monitoring equipment. Staff told us there were sufficient patient observation devices to carry out regular patient checks. Equipment checked had an electrical safety testing programme had been completed in line with guidelines.

Staff carried out daily safety checks of specialist equipment. We observed that daily checks of emergency equipment were completed. The daily checks and expiry dates on equipment were recorded for each ward on the trust's electronic system.

Maintenance staff completed regular safety checks of electrical equipment. Out of 10 pieces of equipment we looked at, all had a sticker to show when it was last tested and were in date. All fire extinguishers we checked were within their service dates.

The wards used disposable curtains and were changed every 6 months or more frequently if required. However, on some wards, the curtains were in poor condition and difficult to use. Staff had reported this but told us they were still waiting for replacements.

Staff disposed of clinical waste safely on wards. We saw an adequate number of sharps and clinical waste bins. Sharps bins we checked were assembled correctly, dated, and clean. These were generally removed in a timely manner. However, we were told there had been delays in the removal of clinical waste and sharps bins from 1 ward. This had resulted in the build-up of boxes and bins in the treatment room, impacting on space in that area.

Assessing and responding to patient risk

Staff completed and updated risk assessments for each patient and removed or minimised risks. Staff did not always identify patients at risk of deterioration promptly but did escalate and treat patients in a timely way.

Staff used a nationally recognised tool to identify deteriorating patients and escalated them appropriately. Staff recorded patient vital signs on an electronic system which included National Early Warning Scores (NEWS). If patients

condition deteriorated or they had a high NEWS this would alert staff to review the patient. We checked 15 records and saw that they were completed accurately, although deteriorating patient audits in November 2023 showed that observation rounds frequency compliance was 70.5% across the service. However, the data indicated 98% compliance with prompt escalation and treatment.

Staff completed risk assessments for each patient on admission / arrival, using a recognised tool, and reviewed this regularly, including after any incident. These included assessments for venous thromboembolism (VTE), falls, pressure ulcer risk assessment, manual handling, oral care, nutrition, and bed rail safety. Risk assessments had been completed and reviewed as necessary in the 26 records we reviewed. Patients had appropriate mattresses based on their risk of pressure ulcers and were regularly repositioned which was recorded.

Staff knew about and dealt with any specific risk issues. They knew how to escalate concerns around sepsis, VTE, falls and pressure ulcers. Patients were monitored regularly for pressure ulcers. Ward staff could approach the tissue viability lead nurse for guidance. For patients at risk of falls, we saw mitigation measures in place, including wristbands, non-slip socks and the use of bedrails where appropriate. We also observed the tagging of bays where patients at risk were cohorted.

From January to December 2022, there were 9 serious incidents declared where management of deteriorating patients was identified as a concern. As a result, the trust devised a quality improvement plan, including 'code red' and 'hospital at night' initiatives. During this inspection we found the service had implemented these improvements and staff we spoke to understood how to identify and escalate concerns about deteriorating patients. Data from NHS England Strategic Executive Information System showed that from January to November 2023, the number of serious incidents raised around deteriorating patients were significantly fewer, indicating that these measures had resulted in improved management of these patients.

The service management team confirmed there was a clear protocol for the identification, escalation, and treatment of sepsis. Some nursing colleagues we spoke to could tell us how to check for and escalate concerns about Sepsis. However, other staff were vague about the process. Data showed that from June to December 2023, 95.5% of patients were screened for sepsis at initial deterioration. However, compliance for the administering of antibiotics within 1 hour was 80% and within 3 hours 88.5%. These delays could lead to further deterioration of the patient.

The service had 24-hour access to mental health liaison and specialist mental health support if staff were concerned about a patient's mental health. One staff member told us they had asked for guidance from the mental health team when a patient with a risk of suicide arrived on the ward.

Staff completed, or arranged, psychosocial assessments and risk assessments for patients thought to be at risk of self-harm or suicide. Staff told us that handovers for those patients were thorough and steps taken to minimise risk for that patient and others on the ward. For example, the position of a call bell was altered to ensure the cord could not become a ligature risk for a patient with a known risk of suicide. Staff told us they also worked with the patient's family to provide appropriate care for that person.

Shift changes and handovers included all necessary key information to keep patients safe. At the morning ward handover we attended, we saw changes in health or concerns about patients were highlighted and noted by staff. Information about tests to be carried out, discharge planning and referrals were also discussed. However, handover processes were inconsistent across the service. For example, we saw that staff used both paper records and electronic systems during handover to discuss patients and some handover meetings included the use of pre-printed handover sheets while on other wards staff made their own notes.

Medical care (including older people's care)

When handing over care of patients between wards or down to the discharge lounge, paper records were included with the patient's notes on systems.

When handing over care of patients between wards or down to the discharge lounge, paper records were included with the patient's notes on systems.

Nurse staffing

The service 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.

The service did not always have enough nursing and support staff to keep patients safe. Data showed the service had a high vacancy rate for registered nurses. For example, there was a 16.2% vacancy rate for clinical sisters and 11.5% for band 5 registered nurses. Furthermore, the vacancy rate for healthcare assistants was 15.5%. From January to the end of November 2023, the service reported 59 red flag shifts. Red flag shifts were recorded when there was a shortfall in staffing of more than 8 hours or 35% of registered nurses time available, and where patient care was or could be impacted.

Managers calculated and reviewed the number and grade of nurses, nursing assistants and healthcare assistants needed for each shift in accordance with national guidance. They told us they regularly completed the safer nursing care tool to plan for safe staffing levels. This had recently been completed at the time of our inspection and managers told us all wards had accurate staffing templates in place which they were working towards.

On all the wards we inspected, we saw the planned versus actual staffing numbers displayed in the ward. According to these boards, the actual number of nurses and healthcare assistants matched the planned numbers. However, most wards had a ward manager or sister who worked supernumerary and when required were included in these numbers. A ward sister told us that sisters often covered duties for band 6 nurses on their shifts.

Managers monitored staffing levels twice daily at safety huddles and adjusted staffing levels according to any shortfalls. Patients' acuity and needs would be taken into consideration when allocating staff. Furthermore, staff told us that due to sickness or annual leave, actual staff numbers often did not meet planned. As a result, some wards had staffing levels which were deemed unsafe. This required the ward managers to contact the flow manager to request staff from other areas to address these shortfalls and ensure patient safety.

Data showed that on the cardiac care unit (CCU), only 83% of the planned numbers of registered nurses were on day shift during November 2023. This meant the 17% shortfall in nurses over that period would have required cover by staff from other areas. The medical assessment unit (MAU) had 87% of the planned number of registered nurses on day shift in that period.

Staff on busy wards, such as the short stay ward, cardiac care unit (CCU) and the medical assessment unit (MAU) told us that they were no longer raising staff ward moves as incidents as they occurred on an almost daily basis.

Incidents which were reported, documented delays in administration of medicines, carrying out patient observations and intentional rounding as being caused by below expected staffing levels.

Medical care (including older people's care)

Following our inspection, 2 patients told us they felt staff were extremely stretched and believed this had impacted on their care. For example, there had been delays in being given time critical medicines and sometimes patients experienced long waits when they asked for something.

During our inspection, concerns were raised about staffing levels within the discharge lounge. We saw patients waiting for refreshments, or who were not responded to when asking questions about their discharge. Staff we spoke to confirmed there was a band 6 nurse vacancy at the time. Following our inspection, managers told us they were aware of the shortfalls in staffing within the discharge lounge and intended to undertake a staffing review to ensure staffing levels were safe.

Data showed that the service (including medical and nursing staff) had an average turnover rate of 6.7% from June to November 2023. The staff sickness rate was under 5%, between June and September 2023 but this increased to over 5% during October and November 2023.

The service had high rates of temporary nurse staffing used on the wards. For example, data showed from June to November 2023, an average of 21.4% of the staff roster was filled by bank and agency nursing staff. Managers told us they tried to limit their use of agency staff but if they were required, they requested staff familiar with the service.

Ward managers made sure all bank and agency staff had a full induction and understood the service. An agency staff member confirmed they had completed an induction.

Medical staffing

The service usually 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 reviewed and adjusted staffing levels. At times, doctors worked additional shifts and locums filled gaps in the rota.

The service usually had enough medical staff to keep patients safe. Junior and senior medical staff we spoke to considered the staffing levels were sufficient. They told us the appropriate numbers and grades were available on day, twilight, and night shifts. The service always had a consultant available or on call during evenings and weekends.

Sickness rates for medical staff were low. From June to November 2023, the average sickness rate was 1.9%, exceeding the trust target. However, the service had high vacancy rates for medical staff. Data showed that in November 2023, while speciality registrars and consultants' posts were filled, there was a 56% vacancy rate for career grade doctors.

The medical staff generally matched the planned number on rotas. Following our inspection, we reviewed the on-call medical rota from 1 September to 30 November 2023. We found where there were gaps in the rota these were generally planned and filled with locum doctors or as additional shifts for existing doctors. Over this time there were between 1 to 3 unfilled shifts per month for junior doctors.

Records

Staff generally kept detailed records of patients' care and treatment. We saw records which were clear and up to date. However, data showed that record keeping did not always meet the benchmark. Patient records were available to all staff providing care. Records were held electronically and on paper records, although the paper records were not always kept secure.

Medical care (including older people's care)

The patient notes we reviewed were generally comprehensive, and all staff could access them easily. We checked 38 patient records across the wards we inspected. We found these were legible, signed and dated where required. However, there were multiple processes for recording patient information. For example, there were separate paper records for medical information, nursing information and bedside notes. There was also a patient electronic care pathway which stored notes, plans, results, and actions to be taken.

When patients transferred to a new team, staff told us there were no delays in staff accessing their records. Paper records were transferred with the patients and staff could access the electronic notes.

The service had processes in place to check compliance with record keeping standards. Following our inspection, we reviewed audits from June to November 2023 and found the service did not always meet the 90% compliance target. For example, Harrowden A ward averaged 83% compliance over this time, with Harrowden C ward achieving 67% compliance and Lamport and Twywell ward 75%. Matrons advised us action plans were in place to make improvements.

Records were not always securely stored. Patients' paper records and folders were stored in lockable notes trolleys outside patient bays. They were generally locked when not in use, although we observed some trolleys unlocked and open during our inspection. Data showed that unlocked trolleys had also been observed on a 'quality visit' by the quality compliance manager in October 2023. The quality governance steering group had discussed this and were looking at ways to ensure trolleys were always secure.

Patients' vital signs were recorded on an electronic system. These were mostly recorded using handheld devices available on the wards. However, staff told us they could also use an 'app' on their personal mobile phones to access and record this data. Some staff members expressed concerns about having patient data on their personal devices.

Medicines

The service had systems and processes to prescribe, administer, record and store medicines. However, staff did not always follow the correct processes when administering or storing medicines. Systems to reconcile patient medicines were not always effective.

Staff generally followed systems and processes when safely prescribing and administering, medicines. Patient allergies were always recorded on the electronic prescribing and medicines administration system (ePMA) and medicines were administered as prescribed. Nursing staff understood the importance of critical medicines and prioritised the administration of these appropriately. For example, we reviewed the medicine chart for a patient on a time sensitive medicine for their Parkinsons disease and saw this had consistently been administered correctly.

We saw that specialist advice was available to ensure the medicines were given safely. However, there were no processes in place for recording the site of application for medicated patches. We saw that a medicated patch, which should not be re-applied in the same site for 14 days, had been placed on a patient's arm. However, the nursing staff were unable to confirm that the previous patch had not been placed on the same arm. This would be against manufacturers guidelines and potentially lead to skin irritation at the patch site.

Furthermore, we reviewed a record of a patient who had been prescribed a medicine which should be based on weight. The weight was not recorded on ePMA in line with the medicines management policy, therefore the service could not be assured the dose was correct.

Staff reviewed each patient's medicines regularly but did not always provide advice to patients and carers about their medicines. Medicines were reviewed regularly during daily ward rounds. Each ward had a dedicated pharmacist to

review patients' medicine charts, prescriptions and offer advice to staff and patients on management of medication. However, we spoke to a patient who was being discharged. They told us that they had not been informed about changes to their regular medicines. Staff told us due to capacity challenges pharmacists were not always available to provide advice to patients about their medicines.

Staff generally stored and managed all medicines and prescribing documents safely. Medicines were stored in dedicated secure storage areas with access restricted to authorised staff. Medicine fridges were locked and secure with authorised staff access only. Staff recorded medicine fridge and room temperatures daily and checked they were within a safe range for medicine storage.

Medicines and controlled drugs (medicines requiring more control due to their potential for abuse) were generally stored securely and handled correctly. However, on 1 ward we observed that 2 bottles of oral medicine had an incorrect 'opened' date recorded, whilst 1 opened bottle had no date noted at all. This oversight could have led to the medicine becoming ineffective.

Staff mostly followed current national practice and guidance to check patients had the correct medicines. We reviewed 12 patient records to check medicines history, and these were all complete. However, in the case of 1 patient who was due to be discharged, we saw that the discrepancies identified between the history and the prescribed medicines had not been rectified. We spoke to the patient who had not been informed of the changes in their medicines. This was highlighted to the nurse to rectify. In addition, 2 patients we spoke to told us they did not receive their correct medicines as staff had not written these up on medicines charts correctly. This meant there was a risk a patient's health could deteriorate should they not receive their normal medicines as prescribed. One patient told us they had to escalate several times to get it corrected which led to the patient considering self-discharge.

Data obtained from the trust showed that 31.7% of patients in the trust had their medicines reconciled within 24 hours of admission. The target was 90%. A pharmacist told us that due to dispensary staffing levels outpatint medication takes priority over discharges and in patients care, which can lead to delays in dispensing medication to departing patients and patients on wards.

Staff learned from safety alerts and incidents to improve practice. Incidents were discussed in pharmacy clinical team meetings and learning shared on the medicines management webpage on the trust intranet.

Incidents

The service generally managed patient safety incidents well. Staff recognised and reported some but not all 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.

All staff knew what incidents to report and how to report them. They also knew how to report near misses in line with trust policy. All staff we spoke to knew how to report incidents via the electronic system. Staff could give examples of incidents they had reported, such as patient falls, a patient developing a pressure ulcer and staffing issues.

The service had no never events on any medical wards.

Medical care (including older people's care)

Staff reported serious incidents in line with trust policy. Nursing staff we spoke to also understood the duty of candour and gave examples of when to apply this. These indicated that they were open and transparent and gave patients and families a full explanation if things went wrong. Managers told us they investigated incidents thoroughly and reported findings and shared action plans with patients and their families.

Staff told us they discussed incidents and learning at staff meetings. During handover, any incidents that had occurred during the shift would be discussed, such as a patient fall. They told us that they did not always personally receive updates and feedback on incidents they had reported, but feedback from investigation of other incidents, both internal and external to the service, were mentioned at staff 'huddles' and team meetings.

We observed variable evidence that learning had been implemented following a serious incident relating to a patient death who had a learning disability. For example, training sessions had been rolled out to staff in relation to the safe care and treatment of patient with Prader Willi Syndrome (PWS). Most staff on wards within the learning disability pathway we spoke to understood what PWS was and adjustments that should be made in caring for a patient with this condition. However, we found staff on other wards had limited or no understanding of PWS. Improved communication between PWS specific care homes and the hospital was in place for better oversight of these patients. There was a PWS alert on the electronic system and a prompt to access the PWS alert booklet on the hospital online system. Furthermore, all patients were reviewed by the learning disability nurse. Further specialist medical training was in the process of being organised for medical staff for on-going awareness.

Is the service effective?

Requires Improvement 

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

Evidence-based care and treatment

The service provided care and treatment based on national guidance and evidence-based practice. Staff protected the rights of patients subject to the Mental Health Act 1983.

Staff followed up-to-date policies to plan and deliver high quality care according to best practice and national guidance. The policies we reviewed on safeguarding, medicines control, escalation plans, and the discharge lounge were up to date. Staff followed trust policies to plan and deliver high quality care according to best practice and national guidance. The service followed National Institute for Health and Care Excellence (NICE) guidelines. Staff could access policies on the trust intranet.

Staff protected the rights of patients subject to the Mental Health Act and followed the code of practice. Staff could give examples where the right assessment of a patient's mental health had been done and their care matched their individual needs. One staff member told us that a patient on the short stay ward had been noted as a potential suicide risk. The team carried out a risk assessment of the area to ensure the patient's safety and worked with their family to provide care relevant to their needs.

At handover meetings, staff routinely referred to the psychological and emotional needs of patients, their relatives, and carers. At a ward handover we attended, staff discussed the medical needs of patients and the patients' social and emotional needs.

Medical care (including older people's care)

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. The service adjusted for patients' cultural preferences.

Staff made sure patients had enough to eat and drink, including those with specialist nutrition and hydration needs. Patients we spoke with said they had access to food and drink and a good variety was offered. We saw patients had drinks within easy reaching distance. We observed mealtimes and found trays were placed near to the patient and patients re-positioned to be able to eat their meals. Staff offered support and encouraged patients to eat and drink. Red trays were used to help staff identify where patients needed support with eating and specific meals were provided to reflect patients' cultural preferences. However, 1 family member told us she had to remind staff to support her relative with drinking between meals.

During our inspection we reviewed 15 records and found fluid and nutrition charts were completed where needed. We saw information about food and fluid intake was documented in patient notes. Stool charts were also completed when required.

Staff used a nationally recognised screening tool to monitor patients at risk of malnutrition. The Malnutrition Universal Screening Tool (MUST) was used to assess nutritional needs. We reviewed 15 records and found they had been completed and reviewed where there was a risk.

Specialist support from staff, such as dietitians was available for patients who needed it. Staff could make referrals for assessment and support. We saw a dietitian discuss dietary needs with a patient and staff during our inspection.

Pain relief

Staff checked to see if patients were in pain regularly and gave pain relief in a timely way.

Staff monitored patients' pain using a recognised tool and gave pain relief in line with individual needs and best practice. Most patients we spoke to told us they received pain relief in a timely manner. We saw staff ask patients if they required pain relief and gave it to them promptly if they requested it.

Patient outcomes

Staff monitored the effectiveness of care and treatment. Some patient outcomes were not meeting national standards, although managers used the findings from clinical audits and patient feedback to help make improvements. The service had been accredited under relevant clinical accreditation schemes.

Managers and senior nursing staff carried out a comprehensive programme of monthly audits to check across medical wards. These included environmental checks, cleaning, availability of personal protective equipment (PPE), staff adherence to trust uniform policy, and patient quality checks such as completion of notes and risk assessments.

Audits were conducted on elements of 'harm free care', including nutrition and hydration, pressure ulcers and falls prevention. Data provided indicated that patient outcomes in these areas generally met expectations, although some wards did not meet the 90% compliance target every month.

The service was included in some national clinical audits. For example, the service took part in a national audit in June 2023 to assess compliance with NICE guidelines for assessing and managing delirium. However, results showed that only 1 out of 5 of the criteria was achieved and 1 was "not achieved – critical". The service had noted this on the risk register and created action plans to improve outcomes for these patients.

Medical care (including older people's care)

The service was included in the Patient-led Assessment of the Care Environment (PLACE) assessments in 2022. Although the PLACE scores for 'condition, appearance, and maintenance [of patients] was 96.7%, slighter higher than the national average, scores for 'privacy, dignity and wellbeing' were 78.8%, compared with the national average of 86%. Furthermore, the scores for 'dementia care' were 71% compared with the 80.6% national average.

Data from the 'NHS England Model Hospital' was analysed for re-admission statistics across the service. The 'Model Hospital' tool is a data-driven tool which provides hospital-level benchmarking and identify opportunities for improvement. It showed that from July 2022 to June 2023, the service had a 3.4% higher risk of re-admission for hypoglycaemic patients than the benchmark and a 4.1% higher risk of re-admission for those with chronic obstructive pulmonary disease. However, the rates of urgent re-admission for patients in general medicine were only 1% higher than the benchmark.

The average length of stay in the service by patients after admission was also longer than the Model Hospital benchmark. From July 2022 to June 2023, the percentage of elderly patients staying from 7 to 21 days ('stranded patients') were 15.6% higher than the benchmark and 6.5% higher for those patients still on the ward 21 days or more ('super stranded'). During this time, medical and oncology patients also stayed much longer than the national benchmark; 61.1% of emergency admissions stayed more than 6 days, 38.3% higher than the benchmark and 16.8% of patients stayed over 20 days, 15.4% higher than benchmark.

Managers shared and made sure staff understood information from regular ward-based audits at staff meetings and provided clear guidelines for best practice. They also monitored ongoing issues and reiterated learning. For example, ward managers on Harrowden C ward repeated guidance around cannula care after audits showed there had only been limited improvement in this area.

The endoscopy service was accredited by the Joint Advisory Group on Gastrointestinal Endoscopy (JAG) every 5 years and was due for re-accreditation in 2024.

Competent staff

The service made sure staff were competent for their roles. Managers appraised staff's work performance and held supervision meetings with them to provide support and development. However, completion of staff appraisals did not always meet trust targets.

Staff were experienced, qualified, and had the right skills and knowledge to meet the needs of patients. Most staff had completed basic training and were reminded to complete this if they were overdue.

Managers gave all new staff a full induction tailored to their role before they started work. Staff we spoke to told us they had received an induction and they felt competent in their roles. Staff told us they had worked supernumerary and were supervised during their induction.

Managers supported staff to develop through yearly, constructive appraisals of their work. Staff we spoke to had received an appraisal or knew when their next one would be completed. Data provided showed that nursing staff had regular appraisals with an average compliance of 91% across the medical wards. However, in the cardiology, diabetes and endocrinology areas, the appraisal completions were lower, with a 65% average.

Managers supported nursing staff to develop through regular, constructive clinical supervision of their work. Clinical educators supported the learning and development needs of staff. A student nurse we spoke to was complimentary

about the support she was given by staff to achieve clinical skills and gain confidence. Most staff were up to date with specific competencies. However, 1 newly qualified staff nurse told us they were finding it difficult to be signed off for skills such as administration of intravenous drugs as they were constantly moved from ward to ward and did not always work with their supervisor.

Managers supported medical staff to develop through regular clinical supervision of their work. However, medical staff did not always have regular appraisals. Data showed that across the service only 75% of medical staff had received an appraisal.

Managers made sure staff attended team meetings or had access to full notes when they could not attend. Staff told us minutes were available electronically and we saw hard copies available in staff areas.

Managers identified any training needs their teams had and gave them the time and opportunity to develop their skills and knowledge. Staff we spoke to told us they were able to complete certain courses online and were allowed do this at home. This training time was included in their working hours.

Staff had the opportunity to discuss training needs with their line manager and were supported to build on their skills and knowledge. Staff told us they could discuss their development needs and were offered specific courses such as a leadership course. On 1 ward, a former healthcare assistant had recently taken on the role of activities co-ordinator. She told us that she had been encouraged by managers to do this to make the most of her skills and interests.

Managers made sure staff received any specialist training for their role. Each ward had link nurses for certain roles such as dementia and infection prevention and control. Staff in these roles helped raise awareness in a specific topic, carry out audits and be a role model.

Managers recruited, trained, and supported volunteers to support patients in the service. Volunteers were provided with an induction and ongoing support. We saw several volunteers on wards we visited, providing drinks and snacks, and talking to patients.

Competent staff

Doctors, nurses, and other healthcare professionals worked together as a team to benefit patients. They supported each other to provide good care.

Staff held regular and effective multidisciplinary meetings to discuss patients and improve their care. Several staff commented on the effectiveness of the multidisciplinary team, and we saw evidence of multidisciplinary input in all the patient records we reviewed.

Staff worked across health care disciplines and with other agencies when required to care for patients. We saw pharmacy staff, physiotherapists and occupational therapists on the wards discussing patient care. Specialist teams, such as the dementia, tissue viability and infection control teams could be contacted and would visit the wards to offer support and advice. In addition, some wards had activity co-ordinators who would set up activities for patients to keep them stimulated and prevent boredom.

Staff referred patients for mental health assessments when they showed signs of mental ill health or depression. One staff member told us that the mental health team had provided guidance in caring for a patient suffering from mental illness in addition to their physical concerns.

Medical care (including older people's care)

Patients had their care pathway reviewed by relevant consultants. Daily ward rounds took place where each patient was discussed. This included their medical and social care needs.

Seven-day services

Most services were available seven days a week to support timely patient care, although some services operated only on a Monday to Friday basis.

Consultant led ward rounds were conducted daily on most wards. However, we observed that consultants were not present in all ward rounds we observed. Furthermore, a patient we spoke to who had been on the ward for 3 days believed they had not yet been reviewed by a consultant. This led to the patient being concerned about their ongoing treatment.

Staff could call for support from doctors and other disciplines, including mental health services and diagnostic services, 24 hours a day, 7 days a week. However, across the specilaist dementia, learning disability and autism conditions specialist support was limited. The endoscopy service was not fully staffed 24 hours a day, but there was an on-call system. Processes were set up so that discharge plans were in place for any patients being discharged at the weekend by the end of the working week.

According to trust policy, the discharge lounge operated a 7 day a week service. It was open from 8am to 8pm Monday to Friday, with a shorter opening time at weekends and Bank holidays. The discharge lounge was included in the trust's escalation policy, which means it would be opened overnight when the trust was at OPEL3-4 (Operational Pressures Escalation Levels) for capacity. Staff told us this meant that the lounge often became an overnight escalation area. We spoke to 1 patient who had been waiting overnight for discharge.

Health promotion

Staff gave patients practical support and advice to lead healthier lives.

We saw examples of wards displaying information which promoted healthy lifestyles and support, such as hand washing, falls prevention and healthy eating. Information leaflets were available on some wards for specific conditions.

Staff told us they assessed each patient's health when admitted and provided support for any individual needs to live a healthier lifestyle. We saw some staff encouraged patients to use their hearing aids and spectacles and worked to keep them as mobile and active as possible during their stay on wards. We also observed staff responding to patients' requests for bed washes and help with getting dressed so that the patients could move around the ward and engage in social activities.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

Staff supported patients to make informed decisions about their care and treatment. They followed national guidance to gain patients' consent. They knew how to support patients who lacked capacity to make their own decisions or were experiencing mental ill health. They used measures that limited patients' liberty appropriately.

Staff understood how and when to assess whether a patient had the capacity to make decisions about their care. For example, staff told us they gained verbal consent for routine care and treatment and understood when written consent would be necessary. Staff gained written consent on the day in the endoscopy department and cardiac catheterisation laboratory.

Medical care (including older people's care)

Staff told us they had received and kept up to date with training in the Mental Capacity Act 2005 and Deprivation of Liberty Safeguards. They could describe how and when to apply Mental Capacity Act 2005 and Deprivation of Liberty Safeguards policies and how to escalate concerns.

Staff gained consent from patients for their care and treatment in line with legislation and guidance. When patients could not give consent, a matron told us that staff made decisions in their best interest, taking into account the patient's and their loved ones wishes and preferences.

Staff clearly recorded consent in the patients' records. Staff told us that patients who had been in hospital for a longer period would have repeated Mental Capacity Act 2005 checks. Staff would also ask patients and their carers if they wished to confirm or change their longer-term choices.

Staff understood the relevant consent and decision-making requirements of legislation and guidance, including the Mental Health Act, Mental Capacity Act 2005 and the Children Acts 1989 and 2004 and they knew who to contact for advice. Ward staff told us they would seek advice from ward managers and the safeguarding lead about specific cases, if necessary.

Managers monitored the use of Deprivation of Liberty Safeguards and made sure staff knew how to complete them. We saw that staff implemented Deprivation of Liberty Safeguards in line with approved documentation.

Is the service caring?

Good 

Our rating of caring stayed the same. We rated it as good.

Compassionate care

Staff treated patients with compassion and kindness, respected their individual privacy and dignity and took account of their individual needs.

Staff were discreet and responsive when caring for patients. Staff took time to interact with patients and those close to them in a respectful and considerate way. We saw that while having treatment or bed-based care, staff always drew the curtains around patients and ensured they maintained their dignity.

Patients said staff treated them well and with kindness. We observed staff speaking politely and with respect to patients and visitors. One patient told us, 'they can't do enough for you, they are so kind'. Another said, "they always asked if I was OK". During our inspection we saw a patient received cards and balloons on his birthday and staff sung happy birthday to him. However, other patients told us they noticed that staff seemed 'rushed off their feet' and 2 patients mentioned that they felt staff wanted to move them on.

Staff followed policy to keep patient care and treatment confidential. We witnessed staff knocking on doors before entering a room and staff introduced themselves. We observed that whilst a deceased patient being moved from a ward, curtains around the other beds were closed to preserve that patient's dignity and minimise distress to other patients.

During handovers and safety huddles, staff referred to patients by their bay/bed number. However, on some wards, patient's names were displayed on an electronic patient data board on the wall. Although these were usually near the nurses' station, they were still on view for other patients and visitors to see.

Staff understood and respected the individual needs of each patient and showed understanding and a non-judgmental attitude when caring for or discussing patients with mental health needs. Staff understood and respected the personal, cultural, social, and religious needs of patients and how they may relate to care needs. A patient's wife told us that staff respected her husband's wishes if he declined to do something. A staff member told us that the nursing team made a point of speaking to any patients who were waiting for a bed space to make them feel welcome on the ward.

Emotional support

Staff provided emotional support to patients, families, and carers to minimise their distress. They understood patients' personal, cultural, and religious needs.

Staff gave patients and those close to them help, emotional support and advice when they needed it. One patient told us, 'staff have spent time with me and have listened to me'.

Staff supported patients who became distressed in an open environment and helped them maintain their privacy. Staff on wards told us that overnight they would closely monitor those patients who were likely to get confused or distressed and would give assistance promptly.

Staff undertook training on breaking bad news and demonstrated empathy when having difficult conversations. We saw a relative who had lost a loved one being supported by staff ; the staff were caring, compassionate and spent time with them in a private room.

Staff understood the emotional and social impact that a person's care, treatment, or condition had on their wellbeing and on those close to them. We saw staff talking to patients about their home life. They also recognised and welcomed patients' families and carers when they visited the wards.

Understanding and involvement of patients and those close to them

Staff supported patients, families, and carers to understand their condition and make decisions about their care and treatment.

Staff made sure patients and those close to them understood their care and treatment. One patient who was waiting for a bed space was moved closer to an electric plug socket to allow them to watch videos whilst waiting. We saw staff talking with the patient and keeping them updated on when a bed space would be available.

Staff talked with patients, families, and carers in a way they could understand, using communication aids where necessary. A patient told us that staff took time to explain everything, and they could ask questions. Patients and their families could give feedback on the service and their treatment and staff supported them to do this.

The service had recently implemented a carers policy which we saw displayed on wards we visited, called "John's Campaign". The policy provided staff with guidance to enable patients' families and carers to be more involved in their care and be able to offer support to the patient outside of normal visiting hours.

Medical care (including older people's care)

Carers of patients with a learning disability we spoke to generally felt involved in the care of their family member. We observed that carers and family members were present outside of normal visiting hours to provide support to their family member. We also saw that paid carers also visited when required, to enable continuity of care in hospital.

Staff supported patients to make informed and advanced decisions about their care. A ward matron confirmed that staff had conversations with patients and their families about their preferences when their circumstances changed, for example around discharge or end of life care.

Many patients gave positive feedback about the service. One patient told us 'Staff are supportive, I'm going to miss them'. Another patient said she received very good care and spoke highly of the cheerfulness of 1 staff member.

Is the service responsive?

Requires Improvement 

Our rating of responsive went down. We rated it as requires improvement.

Service planning and delivery to meet the needs of the local people.

The service did not always plan and provide care in a way that met the needs of local people and the communities served. However, it worked with other teams across the trust to plan care.

Staff knew about and understood the standards for mixed sex accommodation and knew when to report a potential breach. During inspection we saw there was a mixture of single and mixed sex wards. In general, mixed wards had single sex bays. The endoscopy unit had single sex lists to prevent any mixed sex breaches. However, on the cardiac catheterisation laboratory where there were sometimes medical patients staying overnight, staff told us not all mixed sex breaches were reported as incidents.

Most facilities and premises were appropriate for the services being delivered. However, on the cardiac catheterisation laboratory there were no bathroom facilities for patients when it was used as an overnight escalation area.

Staff could access emergency mental health support 24 hours a day 7 days a week for patients with mental health problems. Staff we spoke to told us these teams were responsive to requests for support for patients, although their resources were shared across the trust.

The trust had a learning disability lead nurse who worked Monday to Friday who supported the service. The lead nurse reviewed most patients flagged as having a learning disability and provided support to staff. However, this level of support was not provided outside normal working hours. To mitigate this, the service implemented a learning disability pathway with the medical assessment unit and Harrowden C ward designated to care for patients with a learning disability. On these wards staff were more knowledgeable and skilled to support these patients.

The service could access a trust wide enhanced care system to help care for patients in need of additional support or specialist intervention. If a patient required close monitoring or 1:1 support, this could be requested. Flags could be put into patients' records to alert staff with specific impairments or needs, such as difficulties with hearing or sight or if a patient required support with communication.

Medical care (including older people's care)

Meeting people's individual needs

The service aimed to be inclusive but did not always take account of patients' individual needs and preferences. However, staff tried to make reasonable adjustments to help patients access services. They also worked to coordinate care with other trust services and other external providers where possible.

In general, most substantive staff were able to describe individual patients' additional needs. However, as these were not always fully assessed or documented, we could not be assured the patients' needs were being met. Furthermore, we could not be assured temporary staff or those covering from other wards would understand the patients' additional needs to ensure person centred care was being delivered.

Most staff were responsive to patients' needs and provided timely care. However, we observed some enhanced care workers who provided 1:1 patient care, did not always pro-actively engage with their patients.

Staff did not always make sure patients living with mental health problems, learning disabilities and dementia received the necessary care to meet all their needs. However, we saw assessments were completed for all patients and referrals completed on the electronic system for any additional support such as the dementia nurse, tissue viability or the learning disabilities team. Staff could track the referrals and review outcomes on the electronic system.

Staff did not always make sure the needs of patients with a learning disability or autistic people were assessed to ensure they were provided with person centred care. During our inspection we found the service had an effective system to flag a patient with a learning disability on the electronic patient record. We reviewed the records and care provided to 9 patients identified as having a learning disability. All 9 patients had been flagged, even those without a formal diagnosis. However, there was limited evidence that the patients' individual needs and learning disability had been considered through the medical assessment and nursing assessment process. For example, we found that there was no evidence in any of the 9 records that the patients learning disability had been considered as part of the medical assessment and on-going clinical decision making. In some records there was an acknowledgement of the learning disability but nothing to indicate the impact and risks had been considered.

There was also no evidence of a learning disability care bundle having been completed in any of the 9 records we reviewed. In the nursing assessment document, there was a prompt for staff to complete the care planning checklist and the additional support risk assessment, but we did not see evidence of either being completed.

Hospital passports were present in 4 out of 9 records of patients with a learning disability we reviewed. Hospital passports assist hospital staff to provide better care to a patient with a learning disability by outlining relevant information which is important to the person including their likes and dislikes. These were usually completed by family or carers. We found hospital passports in some patient records; however, we did not see evidence that they were consistently used in caring for the patient whilst in hospital. For example, in 1 record we reviewed, the passport advised the patient needed to wear glasses due to poor sight and needed to have a mobility frame close by. We observed the patient did not have any vision glasses or a mobility frame close by which meant the patient's person-centred needs were not met and their independence was not supported.

We found staff sometimes lacked situational awareness of the environment in meeting the needs of patients with a learning disability or autistic people. For example, on Harrowden C ward, we observed patients becoming distressed by an observation machine left on and making a continuous loud noise for a long period of time.

Although wards were not specifically designed to meet the needs of patients living with dementia, an outdoor garden had been created which aimed to meet the needs of these patients. This was used by patients and their visitors during summer.

Staff supported patients living with dementia by using 'this is me' documents and hospital passports. Staff were able to demonstrate a good knowledge of the needs of patients living with dementia and the support needed for the patient's family. There was access to a dementia nurse who staff told us was very responsive to requests for support or advice. The dementia nurse also provided support to a patient and their families. There would always be a staff member present in a bay with dementia patients.

Staff understood and applied the policy on meeting the information and communication needs of patients with a disability or sensory loss. For example, we saw a staff member help a patient to put in their hearing aids when visitors arrived. Another ward had access to a light machine which projected pictures onto surfaces to provide activities for patients.

We did not see any information leaflets available in other languages spoken by patients. However, managers made sure staff, and patients, loved ones and carers could get help from interpreters or signers when needed. We saw a doctor speak to a patient in a language other than English.

Patients were given a choice of food and drink to meet their cultural preferences. Some patients told us that they liked the variety of food available. Patients' families and carers were also encouraged to bring snacks and treats their loved ones enjoyed.

Staff did not always have access to communication aids to help patients become partners in their care and treatment. During our inspection we observed variable practice in supporting patients with communications difficulties or those who were non-verbal. We saw staff using communication aids to communicate with 1 non-verbal patient, however, not all staff knew whether they had any communications aids on the ward. We found improved understanding and practice on wards which were part of the learning disability pathway, such as on the medical assessment unit and Harrowden C ward. However, temporary staff and staff on other wards did not have as good an understanding of non-verbal communication or know where to access communication aids.

Access and flow

People could access the service when they needed it and received the right care promptly. However, arrangements to admit and treat patients across the trust did not meet national standards. Patients awaiting discharge sometimes experienced lengthy delays.

Managers did not always make sure patients could access services when needed and receive treatment within agreed timeframes and national targets. Patients experienced delays to admission to wards and some patients were nursed in corridors (boarded) whilst waiting for bed space.

Patients were not always cared for in the most appropriate environments for their clinical needs. Some patients with specific medical conditions, such as cardiac issues, were not always cared for on the cardiac wards. During our inspection we saw there were 4 medical patients on the coronary care ward. Staff told us that patients with cardiac conditions were sometimes nursed on general medical wards due to lack of bed space on the coronary care ward. Both nursing and medical staff raised concerns of the number of general medical patients being nursed in the cardiac specialist areas, as this reduced the access and flow in these departments and increased cancellations for planned procedures.

Medical care (including older people's care)

Managers made sure they had arrangements for medical staff to review any medical patients on non-medical wards. Medical staff would visit to review patients daily and staff told us they could contact medical staff for advice.

The service aimed to move patients only when there was a clear medical reason or in their best interest. Managers tried to keep patient moves between wards/services to a minimum although we saw examples of patients who had moved 2 or 3 times during their stay. However, staff supported patients when they were referred or transferred between services.

Staff tried not to move patients between wards at night. However, we saw 1 patient was moved to the escalation ward during the night to help with bed capacity. The trust was unable to provide us with exact numbers of how often this occurred.

Managers and staff started planning each patient's discharge as early as possible, but we saw cases of late discharges due to delays in receiving medication and/or discharge letters or because of delays with patient transport. Furthermore, a junior doctor told us that accessing the relevant information to produce discharge letters was 'cumbersome', particularly when prescribing medication, as it required multiple checks across different systems.

Processes were in place to plan discharges for patients with complex mental health and social care needs. For example, the service created a discharge assessment tool known as the 'discharge SBAR' to assess patients who had been identified as having discharge needs. The discharge team consistently achieved the 4-day target for assessing the patient once they had received the referral. All those patients assessed were presented to a daily discharge multi-disciplinary team (MDT). At this meeting key partners were involved in deciding the most appropriate discharge pathways and planning the patient's discharge.

However, we found inconsistent practice in documenting and communicating discharge needs with partner organisations involved in the patient's care. The service had implemented a trust wide discharge passport. This was a document that included a nursing discharge summary including body maps and key medical and medicine information. Managers told us where staff completed these, discharges were improved. During our inspection we reviewed 7 records where a discharge passport was required. We found 3 records that had been completed and 4 had been requested but not completed at the point of discharge. This meant inconsistent information could be given to GPs and other services such as care homes and was dependent of whether staff completed the required documentation or not.

We reviewed the discharge process for 5 patients discharged around the time of our inspection and found 3 out of 5 patients discharged to a care or nursing home were of a good standard and included the correct information and equipment to safely care for the patient post discharge. However, in 2 cases there were concerns about the information provided around wound and catheterisation management. On review of discharge summaries, these issues were not effectively communicated.

Managers monitored the delayed discharges using handovers and audits. They would have daily briefings with ward colleagues to monitor wards which had the highest number of patients ready for discharge. Managers acknowledged that discharge passports were not always in place, which sometimes caused delays.

Learning from complaints and concerns

It was not always easy for people to find out how to give feedback and raise concerns about care received. The service treated concerns and complaints seriously and investigated them but not always in a timely way. The service did not always share lessons learned with the appropriate staff.

Medical care (including older people's care)

The service did not always display information in patient areas about how to raise a concern. However, patients, relatives and carers told us they would normally raise immediate concerns with ward sisters or medical staff. We spoke with 3 patients who told us they had already raised concerns, most of which were dealt with promptly at a ward level.

Staff knew how to acknowledge complaints and patients usually received feedback from managers after the investigation into their complaint.

Managers investigated complaints and identified themes, although not always within the trust complaints policy timescales. Data provided to us following our inspection showed that 2 complaints remained under investigation beyond the agreed response time of 60 days. We reviewed complaints in the 6-month period prior to our inspection. Key themes included inappropriate discharges and poor care and treatment by nursing staff. Some cases were escalated to service managers for investigation and a few complaints were upheld. Ward staff we spoke to told us that complaints were discussed at handovers and team meetings.

Staff could give examples of how they used patient feedback to improve daily practice. For example, a complaint was received in relation to lost property. During our inspection we found that in response the ward implemented a patient property checklist to be completed for all transfers. This ensured patients' property was documented on arrival to wards.

Is the service well-led?

Requires Improvement 

Our rating of well-led stayed the same. 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. However, the ongoing staffing and bed capacity issues across the service impacted their ability to run the service well. The service leadership team were approachable and supported staff, but senior trust leaders were not as visible.

Leaders had the skills and abilities to run the service. An experienced leadership team had oversight of the medicine division. This team consisted of a Head of Nursing (HoN), a Chief of Division (CoD) and a Divisional Director (DD). The divisional leaders were supported by a team of matrons to oversee nursing care and clinical leads to oversee clinical care.

During our inspection ward managers demonstrated organisational skills and understanding of the needs of the service, patients, and staff. However, the staffing and bed capacity issues across the division impacted the effectiveness of their ability to run the service well. The trust had adapted the Bristol model of patient boarding to mitigate bed capacity issues. Ward managers were required to move staff across wards to ensure staffing levels on wards were adequate, despite this having an impact on morale. Each ward had a matron who would support and visit the ward. Some wards told us the matron visited daily, other said the matron visited once or twice a week but could always be contacted. One newly appointed ward sister was being supported to develop their leadership skills and people management knowledge.

Staff told us that the service leadership team were pro-active and engaged with staff and patients, however the trust leadership team were not as visible.

The service had key lead roles to support quality and safety. For example, the learning disability lead nurse provided advice and support to staff in the management of patients with a learning disability within the service. They visited more complex patients and carers to ensure their needs were being met. This nurse was well known and visible within the service. Staff we spoke to were complimentary about the support provided by this nurse. However, there was recognition that at times there was a heavy reliance on 1 person to support the entire hospital. To mitigate this risk, the service had created a learning disability pathway to provide support in specific wards including the medical assessment unit and Harrowden C ward.

The service also had access to trust wide mental health support team. This team could provide advice and support for patients with mental health issues 24 hours a day, 7 days a week.

In addition, the service had a dedicated dementia lead nurse who regularly visited wards to provide guidance and support. There was also a safeguarding lead who was also available across the service to provide guidance and support when needed. Many staff we spoke to worked regularly with the lead and knew how to contact them.

The service had recently appointed a new discharge matron who was responsible for safe and appropriate discharges. They acknowledged that there were ongoing issues in the discharge lounge and around discharge passports and pathways and were working with relevant teams to make improvements.

Vision and Strategy

The medicine division had a vision and a strategy to turn this into action. It also had a business plan which included new initiatives to address risk. The medicine service had action plans to address the requirement notices issued by CQC on previous inspections, although some of these remained of concern on this inspection.

The medicine division had a vision which was underpinned by long term strategic priorities and plans. The division also had an integrated business plan for 2023/24, which included projects and initiatives to mitigate risks and implement business ideas.

The strategy also covered closer working with other divisions across the trust and with external providers such as the ambulance service and the neighbouring trust. They were further developing partnerships across the local Integrated Care Board (ICB).

The service highlighted good practice and recent improvements, such as the falls improvement programme, the implementation of twice daily safety huddles and the roll out of divisional dashboards to improve oversight of data across the service.

The service also had action plans to achieve the ‘must’ and ‘should’ requirements identified during our previous inspection but had not yet achieved compliance across all areas. For example, they acknowledged staffing levels and basic life support training compliance were 2 areas to focus on improvements. They had put plans in place to mitigate these, however staffing numbers and BLS training completion rates remained a concern in this inspection.

Medical care (including older people's care)

Culture

Not all staff felt respected, supported, and valued. The service provided opportunities for career development, but some staff felt that the service did not always have an open culture. Most patients felt confident they could raise concerns or complaints with ward staff.

Not all staff felt supported, respected, and valued. During our inspection feedback from staff about this varied. Some staff told us they could speak openly with their line managers about personal issues or work-related concerns. Furthermore, some staff said they were given opportunities to progress in their careers.

However, some staff we spoke to did not always feel respected and valued at work. We received feedback that staff felt bullied by senior leaders and many staff told us that their concerns or grievances were not always being listened to, understood, or taken seriously. These issues had led to low morale amongst some colleagues on some wards we visited.

Several nursing staff we spoke to were upset with constantly being moved from 1 ward to another. Although they appreciated the need to support other wards, some managers felt this was the norm rather than exception. One nurse we spoke to had worked on 3 different wards during their shift. As a result, they felt undervalued and they could not get the supervision needed to gain key skills, such as intravenous drug administration.

Ward managers spoke of a having a 'tightly knit' team within their wards and felt they could approach service leaders, but they did not always feel connected with the trust's senior management team.

Patients we spoke to said they would feel able to discuss any concerns or complaints they might have with ward staff.

Governance

Leaders operated effective governance processes, throughout the service. Staff had regular opportunities to meet, discuss and learn from the performance of the service.

The service had a clear structure of reporting lines from the ward up to board level and conducted regular audits across the service. The divisional management team could explain the lines of information flow, both up from the ward/service and down from the management team.

The service held separate governance meetings for the specialities within the division, including adult medicine and cardiology. The service also had a divisional integrated governance board meeting, where reports from the specialities were considered. Financial issues, performance, and wider business issues such as new initiatives and workforce concerns, were also discussed at this meeting.

The service held monthly mortality and morbidity meetings jointly with the urgent and emergency care service. They investigated specific cases where aspects of care which fell below expectations were discussed and actions planned. These were documented within the minutes and noted for sharing with ward teams. Cases highlighting good practice were also shared. Serious incidents were investigated, and action plans made within the serious incident review and learning group.

The service held regular staff meetings at ward level and provided feedback from service management about incidents, complaints, and feedback from audits. Minutes were available for staff who were unable to attend.

Although service managers regularly visited wards, some staff felt they did not have regular opportunities to meet with the senior leadership team. A staff member mentioned that colleagues would be unlikely to know if any trust managers visited the wards as they were not well known in the service.

Management of risk issues and performance

Leaders and teams used systems to measure performance. They identified relevant risks and issues and planned actions to reduce their impact, although this was not always achieved. They had plans to cope with unexpected events and recently managed a major incident on the trust estate.

Assurance systems were in place to monitor performance of safety and quality. For example, there was a programme of routine quality and safety audits undertaken at ward level in relation to falls, pressure care management and infection prevention control (IPC), although we did not see ward-based audits on managing deteriorating patients and sepsis. The audits outcomes were monitored as part of ward dashboards by matrons who reported up to the head of nursing. This meant there were processes in place for oversight of safety and quality.

Arrangements for identifying, recording, and managing risks, issues and mitigating actions were in place. The service held risk registers for all wards. Data provided to us after the inspection showed that the main risks across the wards in December 2023 were falls prevention, patients at risk of developing hospital acquired VTE and the care of patients with reduced mental capacity. The risks associated with the boarding of patients was also noted on the service risk register. Ward managers and matrons carried out daily and weekly audits. Senior staff would carry out audits on other wards. Results would be shared and benchmarked within the service.

During 2023, reinforced autoclaved aerated concrete (RAAC) was discovered in a building on the site. RAAC is a form of lightweight concrete used in construction and is susceptible to structural failure when exposed to moisture. The division management team flagged this as an urgent risk as this resulted in the need to move patients from the wards affected. Leaders promptly put in place mitigations to manage the impact of these moves. The team also planned longer term resolutions to the issue.

The management were aware of key areas for improvement, identified in previous inspection in 2019, including staff record keeping and training compliance, and had set out plans to address these. However, monthly audits of record-keeping on some wards and statistics for training completion by nursing and medical staff showed that these were still falling short of benchmarks.

Action plans has also been put in place after previous inspections highlighted staffing levels, recruitment and retention and bed capacity as major risks to the service. However, staff told us during inspection they felt these remained the main risks to the service.

Information Management

The service collected reliable data and analysed it. Division management staff could find the data they needed in easily accessible formats to understand performance and make improvements. The information systems were integrated but not always secure. Data or notifications were consistently submitted to external organisations as required.

Staff could access patient notes in paper format and on an electronic system. Notes we reviewed were generally of a good standard, legible and comprehensive. Staff could report incidents using an electronic system which the service could access for monitoring incidents.

Staff also used mobile devices on the wards or computers to access patient information. Some staff used their own mobile phones to access the electronic systems, although they had concerns about the security of this system.

Some staff felt the combined use of paper and electronic systems could delay care and treatment including the production of discharge letters. There was also inconsistency across the wards in relation to where and how paper patient records were stored. Some wards kept paper nursing and medical records together, others were stored separately. This could mean that patient care could be delayed while staff who had been moved from other wards to provide cover located the appropriate records.

All staff had access with secure logins, to the trust intranet to gain information relating to policies, procedures, national guidance, and e-learning. Staff were able to demonstrate the use of the system and retrieve information. Staff knew to log out of computers when they were left unattended.

Service managers advised that they had not previously been made aware of the potential patient confidentiality issue around the electronic patient data boards on wards. They confirmed the service has some mobile screens which could be moved out of the way but that on some wards, there is too little space for these. Apparently, 'locking' the screen at other locations had caused problems with obtaining prompt access. They advised staff should know to select the 'minimal information' screen when not being actively used. However, patient names were still visible on this screen.

Engagement

Leaders and staff aimed to actively and openly engage with patients and staff. They collaborated with other trust services and partner organisation to improve services for patients. However, we did not see evidence of active collaboration with equality groups or in the wider community.

Managers told us there were various methods for patients to share their experiences, good and bad. They had examples of friends and family responses with some departments setting up "you said, we did" boards in waiting areas. They also said on occasions they would ask patients and their families to discuss their issues in face-to-face meetings.

In addition to the trust wide staff survey, managers told us they visited wards to ask about staff's concerns directly. They also received feedback from the freedom to speak up team and aimed to respond quickly to issues raised. For example, after the discovery of the RAAC concrete above a ward, managers held a listening event with a follow up meeting to keep staff informed about the mitigations in place and longer-term plans for resolution.

Divisional management staff told us they were looking at ways to improve referral pathways, for example working with primary care providers to set up virtual wards. They had also started to develop services jointly with another local trust. However, there was no evidence of any involvement with equality groups or examples of more community wide work.

Learning, continuous improvement and innovation

Staff were generally committed to continually learning and improving services. Managers understood quality improvement methods and had set up improvement programmes. Leaders encouraged innovation and participation in research.

Managers monitored the regular ward and team meetings including daily safety huddles. The governance team held weekly meetings in which the previous week's incidents were analysed. Learning and guidance from meetings were relayed to matrons and ward managers to share at team meetings.

Medical care (including older people's care)

We saw improvements in some areas we had previously identified as concerns, for example with falls prevention and risk assessments of ligatures. In addition, the service management team had put in place measures to mitigate issues raised at previous inspections, such providing protected time for staff for learning and completing training. However, some areas such as discharge passports, and staffing levels and competencies were still areas of concern from this inspection.

The service had various quality improvement programmes in place, including learning disability and frailty pathways and a service wide discharge team, which focused on improving the discharge pathway.

The service leadership encouraged innovation. For example, 1 staff member was praised for their work on creating an information board about the learning disability pathway, which helped staff become familiar with the process.

Teams within the service had been involved in medical research projects with the NHS Health Research Authority, including controlled drug trials for cardiology patients.

Surgery

Requires Improvement ➔➔

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, not all staff had completed it.

The mandatory training the service provided was comprehensive and met the needs of patients and staff. Training modules included key areas such as health and safety, fire safety, manual handling, infection prevention and control, equality and diversity, information governance, sepsis, basic life support and deteriorating patient management. Training was a combination of face to face and online learning.

Nursing staff received but did not always keep up to date with their mandatory training. Following our inspection, the service provided us with a breakdown of mandatory training compliance data at the time of our inspection. Registered Nurses (RN) were compliant with the 85% mandatory training target across most modules. However, only 58% of RNs were up to date with mandatory deteriorating patient management training, with 15% of RNs working within theatre recovery having completed it. Whilst on average across the service the compliance with sepsis training was 89%, Geddington ward, Barnwell B ward and general theatre RNs were below the 85% target.

Medical staff were provided with mandatory training. Medical staff were compliant with the trsuts training target of 85% in 6 out of 14 modules. However only 48% of staff had completed safeguarding adults level 3 and 56% had comleted safeguarding children level 3.

Compliance to the highest level of life support training was generally achieved, apart from Immediate Life Support (ILS) training. Data provided to us following our inspection showed 77% of staff who were required to complete ILS had completed it which was below the trust 85% compliance target. The data provided to us also showed all staff meeting the requirement for advanced support training, had completed it. Furthermore, the 85% target for basic life support was achieved by RNs for both adults and paediatrics.

Clinical staff were provided with training on recognising and responding to patients with learning disabilities, autism and dementia. However, not all staff had completed it. The trust had introduced specific training on recognising and responding to patients with learning disabilities and autism in line with the law, in September 2023. However, only 44% of staff across the service had completed this training. Compliance for medical staff was only 24%. The service had a plan to ensure at least 85% of staff had completed this training within 12 months. Data did show that 95% of staff across the service had completed dementia awareness training.

Managers monitored mandatory training and alerted staff when they needed to update their training. Staff told us they were reminded to complete training when it was overdue and were given time within their working day to complete it.

Surgery

Safeguarding

Staff understood how to protect patients from abuse and the service worked well with other agencies to do so. Most staff had completed the required training on how to recognise and report abuse and they knew how to apply it.

Nursing staff received training specific for their role on how to recognise and report abuse. Data provided to us following our inspection showed the 85% compliance target was exceeded for safeguarding adults and children level 2 and safeguarding adult level 3 training for RNs.

Medical staff were provided with training specific for their role on how to recognise and report abuse.

Staff could give examples of how to protect patients from harassment and discrimination, including those with protected characteristics under the Equality Act (2010). Staff gave us examples of when they had raised safeguarding concerns and how they had actioned them. We observed staff seek guidance and advice about a vulnerable patient where their family wanted to take them home against medical advice.

Staff knew how to identify adults and children at risk of, or suffering, significant harm and worked with other agencies to protect them. Staff knew how to make a safeguarding referral and who to inform if they had concerns. Staff were able to explain the safeguarding referral process to us and identify the relevant safeguarding leads. The areas we visited during our inspection had safeguarding information displayed on walls for staff and patients to refer to.

Cleanliness, infection control and hygiene

The service generally controlled infection risk well. However, audits of surgical wards did not always meet expected standards for infection, prevention and control measures. The service used systems to identify and prevent surgical site infections. 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 visibly clean and tidy. They had suitable furnishings which were visibly clean and well-maintained. Staff cleaned equipment after patient use and labels were used to show when equipment had last been cleaned. We saw cleaning schedules were in place, up to date and signed daily.

Infection prevention and control (IPC) audits did not always meet expected standards. Monthly audits were completed to assess staff compliance with IPC standards, cleaning of reuseable equipment and devices, and hand hygiene. Audits from September to November 2023 showed all areas performed well for hand hygiene. However, most areas performed poorly for the audit specifically called Infection, Prevention and Control (IPC). Deene B ward scored the lowest in November 2023, with a score of 50% compliance with IPC standards. Audits were discussed at ward meetings, and we saw actions to improve were discussed and documented.

Staff followed IPC principles including the use of personal protective equipment (PPE). Handwashing facilities were located throughout all areas that we visited. There were signs at the entrances to patient areas, including theatres, reminding patients and staff of hand hygiene. We observed a range of staff including nurses, doctors and theatre department staff follow best practice for PPE and being ‘bare below the elbows’ when delivering care. Furthermore, we observed theatre staff had suitable theatre wear.

Side rooms were available on wards for patients who required isolation. Staff told us how they would manage the risks associated with transmittable infections.

Surgery

The service worked effectively to prevent, identify, and treat surgical site infections (SSI). The service SSI rates were above the England average for hip replacement surgery; however, the numbers were very low. For example, from April 2022 to March 2023 the rate was 1.1% (including readmissions) and the England average was 0.5%. This was based on 2 cases over this time. For knee replacements and repair of neck of femur, the trust had no SSIs which was better than the overall England average for these procedures.

Data provided to us following our inspection showed from June and November 2023, the service had no cases of hospital acquired Methicillin-resistant Staphylococcus aureus (MRSA) or Methicillin-Sensitive Staphylococcus Aureus (MSSA). Rates for clostridium difficile were low and there had been 8 hospital acquired cases of Escherichia coli (E-coli) reported in the service.

Elective patients were assessed for risk of infection during their pre-operative assessment. For example, records we reviewed demonstrated MRSA tests were routinely completed.

Surgical equipment was decontaminated in line with the Department of Health, Health Technical Memorandum (HTM) 01-01 on the management and decontamination of surgical instruments. Surgical packs and instruments were checked before each operation and discarded if any faults were found in the packaging.

The service was compliant with HTM 04-01: Safe water in healthcare premises. A process was in place to flush taps to reduce the risk of legionella bacteria in water supplies throughout the service. During our inspection, we observed theatre staff flushing taps.

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 when called. We saw that each patient bed area had a call bell which was located within reach of the patient. Patients we spoke to told us call bells were responded to quickly.

The design of the environment followed national guidance. Ward areas were generally clean, tidy and free from clutter. The service had 6 theatres, 2 of which were reserved for emergency surgery cases. There was a changing room for surgical staff which was clean and tidy. We found theatres to be tidy and well organised with equipment kept in good order and stored neatly. Operating theatres were complaint with HTM 03-01: Specialist ventilation for healthcare premises guidance. Of the 6 theatres in action, 3 had a laminar flow system which is used to create a clean air zone around the operation area, removing bacteria from the air.

Staff carried out daily safety checks of specialist equipment. We saw that all equipment, such as blood pressure monitoring equipment was tested regularly to ensure their safety and effectiveness. We checked the resuscitation trollies on 2 wards and found that checks had been completed and all items for use in an emergency were in date.

The service mostly had enough suitable equipment to help them to safely care for patients. All theatres and wards had equipment needed for resuscitation. However, some staff we spoke to during our inspection gave evidence of occasions where there had not been enough equipment such as thermometers or observation equipment.

Surgery

We saw that staff disposed of clinical waste safely and followed safety guidelines. Sharps bins were readily available across all areas and were safely stored and replaced when full. We saw guidance was available for the segregation, storage and the transportation and disposal of clinical waste. The signage explained which colour bag to use for specific clinical waste.

During our inspection we saw that fire doors were clear and easy to access. Fire evacuation procedures were up to date. All areas could only be accessed using a trust issued key card or by requesting admittance by a member of staff.

Assessing and responding to patient risk

Deteriorating patients or those at high risk of sepsis were not always assessed by a senior doctor in a timely manner. Observations were not always completed on time. However, most staff identified and escalated deteriorating patients. Staff completed and updated risk assessments for each patient and removed or minimised risks.

Staff used a nationally recognised tool to identify deteriorating patients. Staff used the National Early Warning Score (NEWS2) when performing observations. Observations were recorded on an electronic system which automatically alerted staff when a patient was scoring 5 or more, or 3 in 1 parameter. We reviewed 21 patient records across 5 wards. We found observations were completed in a timely manner on admission to the ward. However, they were not always completed within set frequencies according to their NEWS2. Staff we spoke were able to explain the escalation process clearly and examples of when they would escalate. Staff told us high workload and staffing pressures impacted their ability to complete observations in a timely manner.

We found where NEWS2 were elevated, staff generally escalated these within a timely manner. There were set actions staff had to take where NEWS2 were elevated, and we saw in general these were completed. However, during our inspection we identified 2 patients where the NEWS had been escalated by nursing staff for a senior doctor review overnight and they had not been reviewed within a timely manner. For example, a record we reviewed showed nursing staff contacted the on-call registrar during the night to review a patient with a NEWS of 8 and the on-call doctor could not attend the ward. The patient was not reviewed for more than 10 hours after they were escalated. In another record there was a 3 hour and 30-minute delay in the on-call doctor reviewing a patient who was showing signs of deterioration.

Staff told us they were concerned that patients were not always assessed by senior medical staff where they were showing signs of deterioration. Some staff told us they did not feel confident to escalate a concern above the senior doctors or their immediate manager if they were not available. We provided the trust with specific details of incidents at the time of our inspection and the trust were taking action to review the procedures and discuss concerns with staff. Staff incidents involving deteriorating patients were discussed at team meetings. Managers told us they could contact the critical care outreach team should they want a second opinion or additional support.

Staff completed risk assessments for each patient on admission, using a recognised tool, and reviewed this regularly, including after any incident. In the records we viewed all patients had assessments for pressure care management, falls assessment, fluid balance monitoring, mobility management, allergies identified, risk management and discharge planning where appropriate. Furthermore, we saw pre-operative assessments were completed for patients where required.

The surgery division reported into the trust wide deteriorating patient quality improvement programme, and we saw quality improvements linked to sepsis identification and management had improved in general.

If a risk of sepsis was identified staff used the sepsis 6 bundle. The sepsis 6 bundle is a set of 6 tasks that must be completed within the first hour of a potential sepsis case being identified including giving antibiotics and fluids to reduce the risk of mortality. Data provided following our inspection showed from July to September 2023, 96% of sepsis screens had been completed in a timely manner and 100% of those where there was a risk of sepsis has been escalated to a senior clinician. Furthermore, data showed all patients checked had been seen by a senior clinician within an hour, however, only 87% of these had received the required intravenous (IV) antibiotic treatment within the hour and only 63% had been started on IV fluids within the hour. IV antibiotics had however, been administered within 3 hours in 90% of those cases where there had been a delay.

The service had an action plan for increasing compliance with sepsis pathways which included extended medical/ surgical teaching, teaching on immediate life support and acute illness management training and daily audits to address issues in real time.

The National Institute for Health and Care Excellence (NICE) guidance (NG89) for March 2018 states all surgical and trauma patients should be assessed to identify the risk of venous thromboembolism (VTE) and bleeding, as soon as possible after admission to hospital, or by the time of the first consultant review. We found VTE assessments were completed for all patients admitted. We saw VTE and prophylaxis checks were completed prior to surgery. We saw patients had thrombo-embolic deterrent (TED) stockings where appropriate and pneumatic compression stockings during and post-surgery, depending on the procedure. Compliance audits from September to December 2023 showed compliance with VTE re-assessments generally met the service compliance standards, and audits showed improvements overtime.

To reduce and potentially eliminate errors occurring in the operating theatre, the trust used the World Health Organisation (WHO) surgical safety checklist, in line with National Patient Safety Agency guidelines. We observed good practice in relation to carrying out essential safety checks prior to patients undergoing their surgical procedure. All staff we observed engaged with the checklist. The service undertook monthly audits to check compliance with each stage of the WHO checklist. Audits undertaken in December 2023 showed a good level of compliance across the service. For example, we observed 100% compliance across all standards in head and neck surgery, general surgery, and main theatres.

Shift changes and handovers included all necessary key information to keep patients safe. We observed a shift handover between nursing staff. An assessment tool was used to identify patients at risk of deterioration which detail the patient situation, background, assessment and any recommendations. Information, such as diabetic status was highlighted, as well as which patients needed 1-to-1 support from a staff member.

Processes were in place to ensure emergency theatre capacity was available when needed. A Standard Operating Policy was in place which provided staff with guidance about considerations and actions to prioritise emergency operations. This was implemented following an incident where there was a delay in undertaking emergency surgery where a contributory factor was a lack of understanding of theatre capacity processes. During our inspection, we found the safe use of theatres was monitored and managed through daily theatre safety huddles, where risks were identified, managed and escalated.

Staff discussed the escalation process for deteriorating patients at team meetings. Meeting minutes we reviewed showed staff were regularly reminded about how to identify and deal with deteriorating patients and how to escalate.

Surgery

Nurse staffing

The service 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, and gave bank and agency staff a full induction.

The service did not always have enough nursing and support staff to keep patients safe. The service had high vacancy rates. Data provided to us following our inspection showed from June to November 2023 the average vacancy rate for Staff Nurses was 10% over this time. Vacancy rates for all levels of Registered Nurses combined (excluding Matrons) was lower at 8%. Furthermore, the vacancy rate for Healthcare Support Workers/Healthcare Assistants over the same time was 11%. The vacancy rate for modern matrons was high at 25%.

The service had high rates of bank and agency nurses used on wards. Data showed that from 15 May to 26 November 2023 there was a high use of bank and agency staff. For example, the highest being on average 28% on Deene B ward, 27% on Barnwell B ward, and 28% on Barnwell C ward. In theatres on average 31% of the rota was filled with temporary staffing over the same time. Bank and agency staff we spoke to said they had a full induction and understood the service. Where possible managers used bank and agency staff who were familiar with the service.

Staff we spoke to said they felt the staffing levels were not sufficient and this added extra pressure to ensuring safe patient care. For example, staff told us they were not always able to staff tagged bays where there were several patients who needed enhanced observations due to risk of falls or confusion. We visited ward areas at night. On 1 ward there were 3 bays which were tagged and 3 members of staff undertaking observation of multiple patients. Whilst we were assured these patients were being observed, the ward did not have any additional staff which impacted their ability to undertake other duties. RNs told us they were not always able to complete timely observations and there were sometimes delays in medicines being administered due to the volume of tasks needed and a requirement to manage high dependency patients. Furthermore, the 2022/23 trust staff survey showed only 11% of staff agreed there were enough staff to do their job properly which was below the trust average of 25% for this measure.

The service had increasing sickness rates. From June to November 2023, the average staff sickness rate for the whole of the surgery division was 4.4%, the highest being in October 2023 of 5.3%. This was not specific to RNs as it was a divisional sickness rate. The turnover rates were lower than the trust 11% target. From June to November 2023, the average staff turnover rate for the whole of the surgery division was 6%.

Managers accurately calculated and reviewed the number and grade of nurses and healthcare assistants needed for each shift in accordance with national guidance. However, staff were often moved to different wards where the staffing levels were assessed as unsafe. Managers we spoke to told us they would incident report low staffing and that sometimes staff were moved from other areas to support them but that this is not always possible. Where patients required enhanced care, staff told us they did not always have additional staff to manage this and if they did have extra staff they were often moved. Staff did not always escalate or report this as an incident.

Processes were in place to review staffing risks across the service. Safe staffing meetings were held at 8am, 3.30pm and throughout the day to review acuity and staffing levels during the day and night. A staffing cell meeting was held with managers at 9.30am and another staffing meeting at 1pm to make sure risks were monitored and escalated. A similar process happened at the weekend but not as frequent. Theatres teams held daily ‘kick start’ meetings at 8am with managers to discuss theatre lists and staffing numbers. Meetings were documented to record decisions made to share with other services who may need to be on standby to support such as the intensive care team.

Surgery

Medical staffing

The service did not always have 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. However, managers regularly reviewed and adjusted staffing levels and skill mix and gave locum staff a full induction.

The service did not always have enough medical staff to keep patients safe. The service had a high vacancy rate for medical staff. Data provided to us following our inspection showed that from June to November 2023, the service had a vacancy rate of 35% for senior clinical medical officers and 23% for speciality doctors. However there was an over budget actual of career level trust grade doctors of +41%, which off set this deficit.

All acute surgical services had a consultant on call during evening and weekends. Managers reviewed the on-call consultant cover to meet the needs of the service. There were 2 separate rotas for general surgery and urology. A consultant was on call off site but available to attend site when required and be contacted for advice and support for both specialities. However surgical registrar cover did not always meet the needs of patients. There was a registrar onsite for general surgery to manage emergencies and 1 for urology. Managers told us registrar provision had been increased prior to our inspection to support the management of deteriorating patients and winter pressures. However, staff including nurses and junior doctors told us the registrar support was limited due to lack of availability of registrars. This was due to the volume of patients requiring support and the varied task they had to undertake during their shift. Whilst there had been an increase in registrar cover, during our inspection, we saw there had been delays in a registrar attending wards to review patients and staff told us this was an on-going issue.

The general surgery and urology services have junior doctors on-call and onsite including one foundation year doctor and a senior house officer to cover both areas and assess new patients attending the emergency department.

Improvements in speciality clinical staffing and consultant job planning had been made to improve safety and team working. For example, clinical staffing within the breast service had been identified as a concern in terms of capacity, interpersonal relationships, and leadership. The service had taken action to review the multi-disciplinary team by recruiting to a new clinical lead to implement leadership and improved governance processes. Each consultant underwent a job plan review which had been completed and set out responsibilities, clinical skills, lead roles and project/audit work. The service had also recruited to a registrar position who was in post as of May 2023. Work had also commenced to improve interpersonal relationships within the team, and we saw there were further planned events to continue these improvements.

The turnover rates were lower than the trust 11% target. From June to November 2023 the average staff turnover rate for the whole of the surgery division was 6%.

The service had increasing sickness rates which were higher than the trust 5% target. From June to November 2023 the average sickness rate for the whole of the surgery division was 4.4%, the highest being in October 2023 of 5.3%. This was not specific to medical staff as it was a divisional sickness rate. Staff we spoke to told us that staff sickness could make completing daily work challenging as cover for other areas would be needed.

The medical staffing generally matched the planned number. Staff told us most shifts were covered. Managers could access locums when they needed additional medical staff and the service had increasing rates of bank and locum staff for theatres. Data showed that from 15 May to 26 November 2023, there was an increasing use of bank and locum staff for theatres, this was on average 17% for the period with the highest period being 4 September to 1 October 2023 which was 24.7%. Managers made sure locums had a full induction to the service before they started work.

Surgery

Records

Staff generally 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 generally comprehensive, and all staff could access them easily. We reviewed 21 patient records across the wards we inspected. We found these were legible, signed and dated where required. Patient paper records were stored securely in lockable cabinets. The service also used an electronic care pathway which stored notes, plans, results and actions to be taken.

Patient information such as vital signs were also stored electronically, and staff could access these using mobile devices.

The service leads completed audits in all departments of the patient records notes and informed staff of any action to be taken as part of the audit outcomes. Patient records audits reviewed following our inspection showed that the service did not always meet the trust compliance target of 90% with scores between 50% to 84%. However, some wards did score above the compliance rate of 90%.

Medicines

The service did not always use systems and processes to safely prescribe, adminster, record and store medidines.

Staff mostly followed systems and processes to prescribe and administer medicines safely. Patient allergies were always recorded on the electronic prescribing and medicines administration system (ePMA) and medicines were administered as prescribed. However, out of 4 patients' ePMA charts seen on surgical wards, 3 patients did not have their weight recorded on ePMA as per trust policy.

Staff reviewed patient medicines regularly but did not always provide specific advice to patients and carers about their medicines. Medicines were reviewed regularly during daily ward rounds. Staff told us due to capacity issues pharmacists were not always available to provide advice to patients about their medicines.

Staff did not always follow current national practice/guidance to check patients had the correct medicines. Staff told us that they did not have capacity to carry out medicine's reconciliation (the process of accurately listing a person's medication and comparing to what has been prescribed in hospital). Data showed that 31.7% of patients in the trust had their medicines reconciled within 24 hours. The target was 90%. This meant there was a risk of patients not receiving their medicines correctly. We saw 1 patient was prescribed a medicine for their parkinson's disease incorrectly. We raised this with staff who rectified it immediately.

Staff mostly stored and managed all medicines and prescribing documents in line with the provider's policy. Medicines including controlled drugs (CD) were stored securely and safely. CDs are medicines requiring additional controls due to their potential for misuse. However, in some theatres, staff did not record the number of CDs administered to patients in the CD register in line with trust policy. When raised with staff, they were unaware this needed to be recorded. Fridge temperatures where medicines were stored in theatres were also not consistently monitored.

The service had systems to ensure staff knew about safety alerts and incidents, so patients received their medicines safely. Medicines incidents were discussed in clinical team meetings, with themes and trends cascaded via the trust intranet.

The service ensured people's behaviour was not controlled by excessive and inappropriate use of medicines.

Surgery

Incidents

Staff did not always report all incidents which meant there may be missed opportunities to learn. However, staff recognised which incidents needed to be reported and demonstrated a good knowledge of the process. The service generally managed patient safety incidents well. 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.

Staff knew what incidents to report and how to report them. Staff were able to describe the incident reporting processes gave examples of incidents they had reporting such as, patient falls, pressure ulcers, staffing levels or stock supplies.

Staff raised concerns but did not report all incidents and near misses in line with trust policy. During our inspection, staff told us they did not always have time to report all incidents. For example, where deteriorating patient policies and procedures had not been followed staff did not always report these or escalate them where they had concerns. Furthermore, service leaders were not aware there were sometimes difficulties in senior doctors being able to review patients in line with trust policy who had shown signs of deterioration. Managers were concerned these issues had not been escalated to them and intended to review this following our inspection. Furthermore, staff told us they did not always report staffing concerns as incidents as they did not consider the incident would be acted on.

Data showed that staff had reported 717 incidents across the surgical service from June to 30 November 2023. Incidents were categorised by severity, the majority being no harm or low harm. Of the incidents reported 118 were pressure ulcers and all were categorised as low or no harm. Staff reported 77 incidents of delay in treatment or diagnosis and/or failure to follow policy and/or protocol or guidelines.

Data we reviewed prior to our inspection from June 2022 to May 2023, showed the trust reported 943 incidents relating to surgical specialties. Of these 943 incidents, 266 resulted in patient harm. Delay or failure to monitor categorised incidents accounted for 26, infection control 22, slips, trips and falls 17 and documentation 11. It was notable that breast surgery accounted for a disproportionately large (9.3%) number of incidents. This compared to 2.2% from March 2021 to February 2022. We discussed this with service leaders during our inspection who told us they had sought an external review and there was a quality improvement plan in place as a result of incidents. For example, they had made significant improvements to the multi-disciplinary team (MDT) working model, processes for monitoring and reviewing scans and improved MDT working relationships and quality improvements.

Staff reported serious incidents (SI) clearly and in line with trust policy. Processes were in place to review incidents with moderate harm and above. SIs were referred to a trust wide serious incident review group where SIs were considered and declared if they met the SI criteria. From December 2022 to November 2023, the trust reported 12 SIs concerning surgical specialties. Five were in relation to delayed diagnosis and treatment and 4 were in relation to suboptimal care of the deteriorating patient/failure to escalate. One was a delay in treatment/aspiration and there were 2 allegations of abuse. Having reviewed these incidents, we saw they underwent a detailed investigation and learning had been identified and implemented. For example, there had been learning implemented on Deene A surgical assessment unit and Deene B ward where there had been learning in relation to management of the deteriorating patient. In general staff could describe how they monitored patients for signs of deterioration and how they escalated them. Furthermore, records we reviewed in general showed evidence of nursing staff monitoring and escalating deteriorating patients, demonstrating learning had been implemented. There had been no further incidents declared as an SI where deteriorating patient management had been a concern since March 2023.

Surgery

The service had no never events on any wards. Never events are serious, largely preventable safety incidents that should not occur if the available preventative measures are implemented. They include things like wrong site surgery. From December 2022 to November 2023, the trust reported 0 never events.

Staff met to discuss the feedback and look at improvements to patient care. Outcomes from incidents and investigations were discussed at team meetings. Meeting minutes we reviewed showed discussions took place following incidents and what needed to happen to improve and prevent a recurrence. There was evidence that changes had been made because of feedback for example improvements to documentation or processes. Theatre staff also told us of improvements made following a near miss incident where a swab had been left in a patient following an operation. This was recognised before the patient left theatre and the incident was reported. Staff told us a detailed review had been undertaken and quality improvements implemented to improve the swab reconciliation process and counting process improved in line with national guidance. We observed swab boards had been introduced in theatres to provide further visual prompts and assurance swabs had been counted before and after.

The trust practice development team had supported staff where incidents had resulted in a new procedure, or a training need had been recognised.

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. Staff were familiar with the duty of candour and the concept of being open and transparent when things went wrong. Senior staff were able to describe the process for undertaking, and when to formally undertake the duty of candour. We reviewed the last 3 serious incident reports completed which clearly documented how they intended to apply duty of candour and confirmed they had done so.

Is the service effective?

Requires Improvement 

Our rating of effective went down. We rated it as requires improvement.

Evidence-based care and treatment

The service provided care and treatment based on national guidance and evidence-based practice. Managers checked to make sure staff followed guidance. Staff protected the rights of patients subject to the Mental Health Act 1983.

Staff followed up-to-date policies to plan and deliver high quality care according to best practice and national guidance. For example, the management of adult physiological observations and deteriorating in-patient policy was based on national guidance. This policy provided staff with appropriately nationally recommended monitoring templates and provided guidance for staff to follow to ensure post-operative observations were made. We reviewed 3 trust policies and found them to be in date and version controlled. Staff told us they were notified of changes in National Institute for Health and Care Excellence (NICE) guidance by email or on a closed group WhatsApp communication. New NICE guidance was placed in a folder for staff to view and sign to show they have read the updated information.

The service participated in clinical audits which enabled them to evidence care was being provided in line with national recommendations and best practice. For example, the service participated in the national bowel cancer audit and the inflammatory bowel disease standards audit.

Clinical pathways were in place which were based on best practice and national guidance. These were mostly followed by staff and the trust were reviewing the compliance to the deteriorating patient pathway.

Multidisciplinary clinical practice and quality assurance groups met on a regular basis to discuss and review clinical policies and guidelines. This meant there were regular reviews to ensure policies and procedures were based on the most up to date guidance. Meetings held included surgery divisional board meeting, general surgery mortality and morbidity meetings, ward meetings and handover meetings and daily morning kick start meetings. Meetings we attended were well organised and effective. Meeting minutes we viewed following our inspection detailed the topics and issues to be discussed at meetings, actions and learning from incidents/quality audits.

Staff protected the rights of patients subject to the Mental Health Act and followed the Code of Practice. At handover meetings, staff routinely referred to the psychological and emotional needs of patients, their relatives, and carers.

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. Staff followed national guidelines to make sure patients fasting before surgery were not without food for long periods.

Staff made sure patients had enough to eat and drink including those with specialist nutrition and hydration needs. We saw that nutrition audits had been completed and results were displayed on boards with a score of 100%.

Staff fully and accurately completed patients' fluid and nutrition charts where needed. We saw that each day 1 of the health care assistants on each ward was allocated to patient's nutrition needs which included checking fluid balances, offering drinks to patients and mouth care. The service had protected mealtimes and food charts were completed for each patient. On some wards we saw there were specific roles to support patients requiring support at mealtimes. For example, on Geddington ward we saw there was a 'nutritional floor walker' who we saw supporting patients at mealtimes and meeting patients' nutrition and hydration needs.

Staff used a nationally recognised screening tool to monitor patients at risk of malnutrition. The Malnutrition Universal Screening Tool (MUST) was used to assess a patients risk of malnutrition. In all records we reviewed, staff had completed a MUST assessment and had re-assessed the patient if required.

Specialist support from staff, such as dietitians and speech and language therapists were available for patients who needed it. The trust has a nutritional nurse specialist who can be contacted for advice and information.

Patients waiting to have surgery were not left nil by mouth for long periods. Staff we spoke to could describe the fasting process and timeframes.

Pain relief

Staff assessed and monitored patients regularly to see if they were in pain and gave pain relief in a timely way.

Staff assessed patients' pain using a recognised tool and gave pain relief in line with individual needs and best practice. Patients we spoke to who had requested pain relief said it was given in a timely manner. We saw staff ask patients if they required pain relief and gave it to them promptly if they requested it. Patient records we viewed evidenced that patients were asked about their pain at repeated intervals.

Staff prescribed, administered and recorded pain relief accurately. Patient records we reviewed showed that staff assessed patients' pain in a timely manner and took appropriate action. The service completed monthly pain audits and data showed variable results on some wards but an improving picture for some areas and other areas, for example Ashton Ward and the Surgical Day Case Unit scored 100% each month.

Patient outcomes

Staff monitored the effectiveness of care and treatment. They used the findings to make improvements. The service did not always achieve good outcomes for patients.

The service participated in some relevant national clinical audits. Outcomes for patients were not always positive, consistent and did not always meet expectations, such as national standards. However, the trust had detailed actions plans for improvement in place with ongoing monitoring. For example, the service had participated in the National Emergency Laparotomy Audit (NELA). Following previous audits, the service had implemented actions to improve. The latest audits were not yet available for 2022/23 audits for us to review. However, the service action plan demonstrated they had implemented actions following the previous audit.

The trust took part in the National Hip Fracture Database 2023. Results showed the service was in the lowest (worst) quartile for 5 metrics in the 2023 audit (based on 2022 data). The proportion of cases where surgery was supervised by a consultant surgeon and anaesthetist had also reduced considerably since 2022. The proportion of patients documented not to have developed a pressure ulcer increased (improved) considerably compared to 2022, but nevertheless remained in the lowest (worst) quartile. None of the trust's eligible patients (or close to none; the figures below are rounded) received 120-day follow-up (last metric). There were also 7 metrics where the trust was in the highest (best quartile). For the remaining 10 metrics the trust was in the second or third quartile (interquartile range). The service had a detailed action plan in place to improve across metrics not achieved and a progress tracker to monitor completion and outcomes.

The service participated in the National Ophthalmology Database audit 2023 audit (covering April 2021 to March 2022 data) and the results were within the expected range.

Data reviewed from February 2021 to January 2022 showed the service had a lower-than-expected risk of readmission for elective care and non-elective care than the England average. However, patients in elective general surgery and plastic surgery had a higher-than-expected readmission rates for elective admissions when compared to the England average. Following our inspection, the service provided readmission rates from September to November 2023 which showed the readmission rate was low. The rates recorded for September 2023 was 2.7%, October 5.6% and November 3.4%.

Managers and staff carried out a comprehensive programme of repeated audits to check improvement over time. This included a deteriorating patient monthly audit, World Health Organisation (WHO) checklist audits.

Managers used information from the audits to improve care and treatment. The service completed an audit on acute kidney injury (AKI) and fluid management specifically to audit the knowledge and awareness of junior doctors on AKI in surgical patients and fluid management. The audit consisted of a questionnaire completed by junior doctors in October 2023. The audit results found that the confidence in prescribing fluids routinely and in AKI for surgical patients was average to low among junior doctors but most of them had knowledge regarding causes and risk factors of AKI and choice of fluids. However, improvement was needed to improve the knowledge of the criteria used in identifying AKI,

management in AKI and of routine maintenance fluid calculations. The service planned for improving the knowledge of the junior doctors with teaching sessions and educational posters. The service also audited the effectiveness of surgical handovers, the quality of surgical notes and the completion of patients consent forms prior to surgical procedures and produced an action plan for the recording of surgical risks.

Common themes or issues arising from national and local audits, mortality, patient claims, complaints, incidents, risks and infection prevention were reviewed by the service leads, discussed at service meetings and action plans put in place.

Competent staff

The service made sure staff were competent for their roles. Most managers appraised staff's work performance and held supervision meetings with them to provide support and development.

Staff were experienced, qualified and had the right skills and knowledge to meet the needs of patients. Staff we spoke to said they had received a comprehensive training package and had access to ongoing training and development. The service also had a team of clinical educators which staff had access to.

Managers gave all new staff a full induction tailored to their role before they started work. The staff induction booklet we saw covered areas such as a staff list for the surgery core service and emergency numbers, ward round times, on-call contact number and the escalation process. The induction pack also included details on the importance managing workload and discussing any need to work overtime with the consultant in charge and the importance or taking breaks.

Most managers supported staff to develop through yearly, constructive appraisals of their work. Across the surgery division 85% of staff had received a yearly appraisal. However, in some areas of the service only 50% of staff had received their yearly appraisal.

Managers made sure staff attended team meetings or had access to full notes when they could not attend. Minutes from team meeting we saw following our inspection showed that these meetings were well attended and recorded for review if staff were unable to attend.

Student staff we spoke to told us they felt supported in their new roles and that a clinical supervisor attended the service weekly from the university to support them in their learning.

Multidisciplinary working

Doctors, nurses and other healthcare professionals did not always work together as a team to benefit patients. They did not always support each other to provide good care.

Multi-disciplinary team (MDT) working was not always effective across services in ensuring patients received the right care and treatment at the right time. Prior to and following our inspection we reviewed serious incidents that had occurred where surgical input was required in reviewing suspected cancer. In 2 recent cases we found there was a common theme of lack of oversight and follow up of patients who had been referred for diagnostics, such as Computerised Tomography (CT) scans or Magnetic Resonance Imaging (MRI) scans. In both cases, scans with abnormal findings had not been flagged by radiology or followed up by the requesting consultant until the patient attended for a planned appointment or re-presented through the emergency department. This meant lack of oversight and systems to monitor patients through this MDT process were not always effective and led to exposure to harm.

Surgery

Breast services had improved their MDT process as a result of similar concerns raised in 2022 in relation to effective MDT working and oversight of patients undergoing diagnostics and reviewing scans/images. The breast service had undergone an MDT review and recruited a clinical lead to improve leadership and governance. At the time of our inspection, managers provided assurance of improvements made to breast services and we saw there was a quality improvement in place.

Processes were not always in place to ensure patients requiring surgical management were safely managed where the service was under pressure and unable to admit patients to a surgical ward. For example, there was a serious incident involving a patient requiring a nasogastric (NG) tube which was placed by the surgical on-call team. However, there was no surgical bed to manage the patient. The report demonstrated lack of surgical oversight of this patient, confusion over who would take responsibility for the NG tube management and limited MDT working with the emergency department to ensure the patient was safely managed outside of the normal care pathway. This demonstrated a lack of MDT working across services to ensure the patient was safely managed.

Locally at ward and theatre level, staff held regular and effective multidisciplinary meetings to discuss patients and improve their care. Staff at these meetings included doctors, nurses, healthcare assistants, physiotherapists, pharmacists, dietitians, specialist nurses (including pain, learning disability, tissue viability). All staff spoke positively about the support they received from the wider MDT at ward level.

The service held safe staffing meetings throughout the day which were attended by some of the multi disciplinary team to ensure safe staffing levels for the wards for both the day and night-time shifts, and to review staffing for the following day.

Staff referred patients for mental health assessments when they showed signs of mental ill health, depression. Staff we spoke to were able to identify the leads for mental health services and the process for making a referral for assessments.

Seven-day services

Key services were available 7 days a week to support timely patient care.

Consultants led daily ward rounds on all wards, including weekends. Patients were reviewed by consultants depending on the care pathway. Occupational therapy services were also available 7 days a week and pharmacy support were available 7 days a week.

Staff could call for support from doctors and other disciplines, including mental health services and diagnostic tests, 24 hours a day, 7 days a week.

Health promotion

Staff gave patients practical support and advice to lead healthier lives.

The service had relevant information promoting healthy lifestyles and support on wards. We saw health promotion posters and leaflets on wards and in patient reception areas.

Staff assessed each patient's health when admitted and provided support for any individual needs to live a healthier lifestyle. The service had access to a smoking cessation nurse, dietitians and substance misuse services.

Surgery

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

Staff supported patients to make informed decisions about their care and treatment. They followed national guidance to gain patients' consent. They knew how to support patients who lacked capacity to make their own decisions or were experiencing mental ill health. They used agreed personalised measures that limit patients' liberty. The service was unable to provide assurance staff had been provided with Mental Capacity Act and Deprivation of Liberty Safeguards training.

The service was unable to provide assurance they had provided staff with mandatory Mental Capacity Act (MCA) and Deprivation of Liberty Safeguards (DoLS) training. However, following our inspection the service provided assurance they had provided staff with mandatory Mental Capacity Act (MCA) and Deprivation of Liberty Safeguards (DoLS) training, and that training compliance levels were monitored by divisional heads and all areas achieved the trust target level of 90%. In general staff understood how and when to assess whether a patient had the capacity to make decisions about their care. Staff also said they would review a patient's capacity during treatment and if there were any changes in their condition or diagnosis. Staff were able to demonstrate understanding of the relevant consent and decision-making requirements of legislation and guidance, including the Mental Capacity Act (MCA), the Children Acts 1989 and 2004 and they knew who to contact for advice.

Staff we spoke with understood the relevant consent and decision-making requirements of legislation and guidance, including the Mental Capacity Act (MCA), the Children Acts 1989 and 2004 and they knew who to contact for advice." Those staff also told us they kept up to date with their consent, MCA and DoLS training. Staff were able to explain the Mental Capacity Act, it's uses and when they should seek consent from a patient.

Staff gained consent from patients for their care and treatment in line with legislation and guidance. Staff clearly recorded consent in the patients' records. Files we viewed had evidence that consent had been discussed and procedures explained to patients and the appropriate documentation had been signed.

When patients could not give consent, staff made decisions in their best interest, considering patients' wishes, culture and traditions. The learning disability nurse provided an example of how the surgical team made a best interest decision to undertake a surgical procedure for a patient with a learning disability and implemented a support plan to help the patient have the surgery they required. This showed the service were committed to acting in the patients best interests in terms of their health but tailoring a plan to meet their wishes and emotional/psychological needs.

Is the service caring?

Good 

Our rating of caring stayed the same. We rated it as good.

Compassionate care

Staff treated patients with compassion and kindness, respected their privacy and dignity, and took account of their individual needs.

Staff were discreet and responsive when caring for patients. Staff took time to interact with patients and those close to them in a respectful and considerate way. We observed staff taking time to talk to patients and explain treatments or processes. Staff ensured that curtains were drawn when giving personal care to maintain patients' dignity.

Surgery

Patients said staff treated them well and with kindness. Patients we spoke to during our inspection said that staff were caring and responded to requests for help especially considering how busy they were. Feedback we saw from patients following our inspection complimented staff and 1 patient said staff were 'amazing'.

Staff followed policy to keep patient care and treatment confidential. We observed staff having conversations with patients about their care but taking time to ensure personal information could not be overheard.

Staff understood and respected the individual needs of each patient and showed understanding and a non-judgmental attitude when caring for or discussing patients with mental health needs. Staff were able to give us examples of times where they had respected individual needs of patients and the actions they had taken.

Emotional support

Staff provided emotional support to patients, families and carers to minimise their distress. They understood patients' personal, cultural and religious needs.

Staff gave patients and those close to them help, emotional support and advice when they needed it. Patients we spoke with told us that staff took time to talk to them and listen to their concerns.

Staff supported patients who became distressed in an open environment and helped them maintain their privacy and dignity. We observed staff in ward areas during the evening shift monitoring those patients who were likely to get confused or distressed and would give assistance promptly. The interactions we saw staff having with patients who were distressed was kind and staff acted quickly to reassure them.

Staff understood the emotional and social impact that a person's care, treatment or condition had on their wellbeing and on those close to them. We saw staff talking to patients and their families, taking an interest in their social and relationship circumstances, and offering support.

Understanding and involvement of patients and those close to them

Staff supported and involved patients, families and carers to understand their condition and make decisions about their care and treatment.

Staff made sure patients and those close to them understood their care and treatment. Staff we spoke to were able to demonstrate a good understanding of the consent process and the importance of explaining surgery and its possible risks clearly to patients and their families.

Staff talked with patients, families and carers in a way they could understand, using communication aids where necessary.

Staff supported patients to make informed decisions about their care. Patients were given all essential information to enable them to make informed decisions and where necessary give informed consent.

Patients gave positive feedback about the service. Patients and their families could give feedback on the service and their treatment and staff supported them to do this. The main source of feedback was through the Friends and Family Test. Information received after the inspection showed that 88% of the patients who responded from 1 June to 30

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November 2023, had rated their experience of the service as very good or good. Common themes in the comments on the survey were how helpful, friendly, caring and attentive the staff were. Patients had been able to give feedback on what could have made their stay better. Some examples included, that the staff were very busy and the communication with families and between departments could be improved.

The service also carried out a 'Hospital at Night' survey in November 2023, which was conducted by the trust's Patient Experience Team and they visited several areas including the surgical wards. The site team reported that most wards were calm and patient feedback was generally positive. Staff were also asked for feedback by the site team and suggestions were made such as less patient transfers of an evening. This feedback was then reported to the senior leadership team for review.

The governance team undertook quality visits across the service, these were supported by specialists from infection prevention and control, safeguarding, pharmacy, and others. During these visits feedback was sought from patients. The visits were carried out in July, August, and September 2023 and 16 patients were asked for feedback on their care. Of the 16 patients, 14 had said they were very happy with their care; 1 patient had been unhappy with care and had not been offered the support needed and 1 had not been kept up to date with the treatment planned.

Is the service responsive?

Requires Improvement 

Our rating of responsive remained the same. We rated it as requires improvement.

Service delivery to meet the needs of local people.

The service generally planned and provided care in a way that met the needs of local people and the communities served. It also worked with others in the wider system and local organisations to plan care.

Managers planned and organised services, so they met the needs of the local population. The service had developed strong links with another local NHS hospital to help meet the needs of local people.

Staff knew about and understood the standards for mixed sex accommodation and knew when to report a potential breach.

The service had systems to help care for patients in need of additional support or specialist intervention. Staff could access support for patients needing emergency mental health support, learning disabilities and dementia. Staff told us that the service lead for learning disabilities and dementia was easy to contact and offer advice and support.

Changes to the service had been made to try and maximise the flow for surgical patients and to work on reducing the patients waiting for operations. There were 3 slots daily on weekdays for referrals from GPs for urgent assessment rather than an emergency admission. The patients were reviewed by the on call surgical registrar or consultant.

Meeting people's individual needs

The service was inclusive and took account of patients' individual needs and preferences. Staff made reasonable adjustments to help patients access services. They coordinated care with other services and providers.

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Staff made sure patients living with mental health problems, learning disabilities and dementia, received the necessary care to meet all their needs. Staff told us that the ear nose and throat clinic have a separate clinic 1 day a week for patients with learning disabilities and dementia who required dental surgery. In patient records we saw referrals had been made for patients to the dementia and delirium teams where required.

Staff told us of an occasion where a patient with a learning disability had been anxious about attending for surgery. A care plan was implemented inclusive of the patient, their family, and staff. Staff met with the patient prior to the procedure and introduced themselves and answered any questions the patient or family had. On the day of the procedure the same surgical team were present, and they adjusted the process to enable to patient to have the best opportunity possible to tolerate the procedure.

Staff supported patients living with dementia and learning disabilities by using 'About me' documents and patient passports. We saw these passports in patient files. Staff understood and applied the policy on meeting the information and communication needs of patients with a disability or sensory loss. Staff told us about a trust training initiative where staff had been put in a simulation situation so they could experience how a dementia patient would feel. The simulation had been set up in a bus which had been designed to give staff insight into how sensory loss and changes of environment can affect a person living with dementia. We were also shown an activity box that could be used with dementia patients to help with communication.

The service had information leaflets available in languages spoken by the patients and local community. Telephone translation services were available for staff to access.

Patients were given a choice of food and drink to meet their cultural and religious preferences.

Access and flow

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

Although managers monitored waiting times they could not always meet agreed timeframes and national targets. Waiting times from referral to treatment (RTT) had increased because of the COVID-19 pandemic, this was a national problem that had arisen because of the need for social distancing restrictions. In addition to this industrial action meant some patients operations had been cancelled. This impacted on patients not always being able to access services when they needed them.

At the time of our inspection 6,606 patients were on the service waiting list for over 18 weeks. In the trauma and orthopaedics speciality there were 81 patients awaiting spinal surgery over 42 weeks, and 271 patients awaiting their first appointment. Sometimes patients could not attend their appointments due to illness or other commitments and this impacted on the ability of the hospital to meet its targets.

Although overall the number of patients on the waiting list had increased over 18 months, from 13,886 in March 2022 to 16,076 in August 2023. The percentage of patients waiting 18 weeks or less had decreased from 69.4% in March 2022 to the lowest rate of 60.8% in August 2023. The percentage of patients admitted for treatment within 18 weeks or less has decreased from 48.5% in August 2022 to 46% in August 2023.

However, the number of patients waiting more than 52 weeks had increased considerably from 21 in March 2022, to 423 in August 2023. As of August 2023, there was 1 patient who had been waiting for 78+ weeks. This patient was in the urology speciality.

Managers told us the service took action to improve waiting times. For example, they had implemented extra surgical appointment at weekends. They had systems in place to prioritise and re-prioritise patients where there had been changes since waiting. Patients who had been waiting in a treatment pathway longer than 52 weeks and potentially at risk of experiencing a degree of harm underwent a clinical harm review by a consultant. This enabled the service to constantly review those waiting, reassess risks and re-prioritise where appropriate.

The national standard for patients to be seen within 2 weeks from referral (93%) for suspected cancer was not always met but in some cases the service performed better than the England average. In August 2023, the service was around the middle (3rd quintile) of all providers nationally for patients seen by a specialist within 2 weeks of an urgent GP referral and was below the national target with 81.7%. Overall the trust met the national target in 4 cancer types but did not meet the target in 8 types. In comparison to England data, the service saw a higher percentage of patients for 8 suspected cancer types.

The national standard for patients to be treated within 31 days was 96%, based on admitted patient data. In August 2023, the service treated 94.8% of patients within 31 days of a decision to treat, which was below the national target. The trust was in the 2nd quintile of trusts nationally. The service did not meet the national standard for 2 cancer types including lower gastrointestinal and 'other'. However, breast, skin and urology cancer types did meet the national standard of 96%. By comparison, England overall did not meet the 96% target for any cancer types for this measure.

The service ranked well against other trusts for patients waiting longer that 62 days on the waiting list for urgent suspected cancer interventions.

The national target to treat patent within 62 days of a decision to treat is 85%. In August 2023, the trust treated 36.8% of all patients within 62 days of a decision to treat, which was below the national target. The service was in the bottom 20% of trusts nationally. The service met the 85% target in 1 cancer type (skin) but did not meet the national standard for 5 cancer types. England overall did not meet the national standard of 85% for any cancer types for this measure. In comparison to England data, the service treated a higher percentage of admitted patients for 2 suspected cancer types.

The national standard for patients to be seen by a specialist within 2 weeks of a GP referral for exhibited breast symptoms was 93%. In August 2023 the service saw 83.3% of patients within 2 weeks of a GP referral for exhibited breast symptoms, which is below the national standard. The service was around the middle (3rd quintile) of trusts nationally. There was a plan in place for improving breast services which had been implemented in August 2023. The plan included actions such as a review of the timetables for specialist clinics, an expansion of mastalgia clinics, and a review of the waiting lists and escalation procedures.

Data provided to us by the service following our inspection showed from December 2022 to November 2023, 2,616 operations had been cancelled by the service. This was both for elective and non-elective operations. The service tracked cancellations and made plans for rebooking patients.

From January to December 2023, data from NHS England showed the number of patients not receiving treatment within 28 days of an elective operation cancellation showed a worsening picture over this time. For example, from January to

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March 18.3% (15 out of 82 not re-booked) of patients whose surgery had been cancelled had not received treatment within 28 days. This was better than the 25.4% England average. However, performance had worsened through this time and from October to December 2023 44% (41 out of 109 not re-booked) of patients had not received treatment after 28 days of their cancelled operation which was much higher than the 24% England average.

Managers were aware of the need to re-book cancelled appointments and processes for escalation and harm reviews where required. However, they recognised the need to improve performance and standardise the process. A standard operating procedure had been produced to outline to staff what action they should take when operations were cancelled due to non-clinical reasons. However, this was in draft and had not been fully implemented at the time of our inspection.

Managers and staff worked to make sure patients did not stay longer than they needed to. Staff involved in the discharge process for patients told us they worked with multi-disciplinary teams within the trust including the discharge team, dementia leads, physiotherapists and medical staff to ensure patients had the correct support in place for a successful discharge and to meet the patients need. They worked with other organisations external to the trust such as adult social care, cancer support charities, and patient transport. They reported that these pathways generally worked well, however recognised there were occasions where a discharge would be delayed due to transport timings or medications to take home not being ready. Managers told us they were working to improve these outcomes. Furthermore, the service reviewed any failed or unsafe discharges to identify what went wrong and learn from this.

Managers made sure they had arrangements for surgical staff to review any surgical patients on non-surgical wards. The service had on average 21 surgical patients on non-surgical wards each week for the period from 1 July to 12 December 2023. Data showed most of these patients were under the trauma and orthopaedic speciality. The service had a procedure in place for ensuring continued reviews of patients on non-surgical wards.

Managers and staff started planning each patient's discharge as early as possible. Staff planned patients' discharge carefully, particularly for those with complex mental health and social care needs. Files we viewed during our inspection contained a 'discharge passport' for each patient. The service also had a discharge coordinator. There was a discharge coordinator in post who help with the discharge process and also with the multi-disciplinary approach needed for complex discharges, for example engaging a care home, relatives and other support services.

Managers monitored the number of patients whose discharge was delayed, knew which wards had the most delays, and took action to reduce them. The service had a dedicated discharge team, which focused on improving the discharge pathway across the trust and supported surgical discharges.

Learning from complaints and concerns

It was easy for people to give feedback and raise concerns about care received. The service treated concerns and complaints seriously, investigated them and shared lessons learned with all staff. The service included patients in the investigation of their complaint.

Patients, relatives and carers knew how to complain or raise concerns. The service clearly displayed information about how to raise a concern in patient areas. During our inspection we saw complaints information displayed in public areas with details of how patients, their families or other members of the public could make complaints. The trust website also displayed the complaints process.

Staff understood the policy on complaints and knew how to handle them. The service had a complaints procedure and process which was in date.

Surgery

Managers investigated complaints and identified themes. The service had improved its responsivity and management of complaints received. The service had a complaint lead who tracked complaints and monitored response times. Where appropriate, complaints were resolved by the local team and handed over for oversight by the trust wide complaints team if they were a formal complaint. During the 6-month period prior to our inspection the surgery division received 88 complaints. The most common complaint themes were complications during/following treatment (11 complaints), delay in receiving treatment (9 complaints), and inappropriate discharge (7 complaints). We saw evidence of actions taken to resolve or address complaints.

Staff knew how to acknowledge complaints and patients received feedback from managers after the investigation into their complaint. The majority of the 88 complaints received had been acknowledged within 3 days. Furthermore, in general complaints were investigated within timescales outlined within the trust complaints policy. The service had been working on improving complaint responsivity and investigation timescales, as well as quality of investigation and outcome to complainants. We saw on the complaints action log that patients had been given an explanation or that the service was investigating the complaint and would be responding to the patient's complaint once the investigation had been completed.

Managers shared feedback from complaints with staff and learning was used to improve the service. Minutes of team meetings detailed discussions about complaints and outcomes.

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 mostly understood and managed the priorities and issues the service faced. Some but not all staff told us 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 was led by a Chief of Division, a Head of Nursing and Divisional Director. The divisional team was quite newly formed at the time of our inspection. They worked closely together in the same office and had good oversight of the service, challenges, and priorities. They were passionate about the service and improving it for patients and staff. Staff we spoke to said they felt the local leadership team were visible and approachable. However, some staff felt they were not as connected to the senior leadership team, particularly those who worked at night.

Most junior doctors told us they felt well supported by their registrars and consultants. However, some junior doctors and nursing staff felt more support was needed for escalation of deteriorating patients of an evening, and some nursing staff also felt more support was needed for the evening staff.

Vision and Strategy

The service had an integrated business plan that was aligned to the trust wide vision and strategy which was focused on sustainability of services and aligned to local plans within the wider health economy. However, managers were taking a reactive approach to improving the service whilst reviewing the service priorities as a newly formed leadership team.

Surgery

The service had an integrated business plan in place for 2023/24 which outlined how the service intended to deliver the trust wide strategy and vision. There was a 3-to-5-year improvement plan, so the service was addressing more immediate, medium and longer term improvements to the service. The business plan included key areas such as reductions in waiting times, reviewing of the urgent and routine pathways, improvements to patient experiences including response times to concerns and complaints, sustainability, safe staffing, and supporting training and development. The plans included how they intended to align with other local hospitals to improve the service in key areas across the Northamptonshire area, such as breast services. However, some of these plans were in the early stages of being planned and implemented.

The leadership team was relatively newly formed at the time of our inspection and recognised they were taking a more reactive approach to improve the service. Whilst they were working towards their business plan, they told us some areas of focus were not included in this and the team recognised the need to improve their overall governance including documentation of priorities and oversight of service improvements. Leaders had been working on these more immediate priorities such as improving vacancy rates and addressing service specific issues. However, they told us the initial approach was more reactive in dealing with issues as they arose, and they recognised the need to incorporate these priorities into the business planning process to ensure there were clear plans, targets and outcomes in place.

Some leaders had not been involved in the current business plan so they were also reviewing progress against their business plan, speaking to staff, and identifying further key priorities.

Some staff said they felt that there were good plans in place for the future but immediate challenges such as staffing and deteriorating patient escalation process should be addressed.

Culture

Staff did not always feel respected, supported and valued. 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 generally had an open culture where patients, their families and staff could raise concerns without fear.

There was variable feedback from staff about how respected, supported and valued they felt at work. Some staff we spoke to considered managers were very supportive and that they were listened to. Some staff told us they were comfortable escalating concerns they had, and feedback was received positively. However, others felt their feedback was not appreciated or listened to by managers. Particularly at night, staff felt feedback about staffing levels and acuity on wards was not taken seriously leading to some staff experiencing stress at work and being worried they were not able to provide a good level of care to their patients. Some staff felt they could not raise concerns about patients above their immediate line manager. For example, staff did not always feel confident to escalate a deteriorating patient to an on-call consultant if they did not get a response from an on-call registrar level doctor. We fed this back to managers at the time of our inspection who acknowledged this was an area they intended to address to improve communication and confidence in escalating.

Staffing levels and acuity was the main concern expressed by staff which they did not feel had been sufficiently addressed by managers. However, despite this most staff told us they liked their job.

Staff described the trusts wellbeing initiatives for staff where they could attend a wellbeing café or call a wellbeing service which was available 24 hours a day. Staff told us that they felt the environment they worked in was inclusive and that there were equal opportunities for progression.

Staff we spoke to said they felt they could contact the Freedom To Speak Up Guardian (FTSUG) for support or advice. We saw posters in staff areas with the details of the FTSUG and staff told us the guardian was also invited to some team meetings.

The service also had a guardian of safe working, this role was designed to support junior doctors in their role to oversee safe working practice, such as the working hours of doctors and patient safety.

Governance

Governance processes were in place 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.

Systems were in place to assess, monitor and improve care within the surgery division. There was a monthly directorate governance meeting from which each triumvirate within the directorate produced an action log which they monitored and updated progress. They also reviewed performance, staffing and audit outcomes. They investigated serious incidents and shared learning.

Ward meetings were held weekly, we looked at meeting minutes for the last 3 meetings and saw all meeting were minuted and key areas including performance, staffing and incidents were discussed in these meetings.

Senior department leaders met frequently throughout each shift. At these meetings they looked ahead for potential problems not just immediate concerns, for example forecasted staffing levels. Key staff attended regular meetings with partner organisations to work together to improve flow across the system.

Mortality and morbidity meetings took place monthly involving senior medical staff and senior nurses. We saw the minutes from these meetings, and they discussed audit outcomes, specific cases were presented, and learning outcomes discussed.

Staff at all levels were clear about their roles and understood what they were accountable for, and to whom.

Management of risk, issues and performance

Systems to manage performance were not always effective in identifying patient safety risks. They mostly identified and escalated relevant risks and issues and identified actions to reduce their impact.

Systems were in place to monitor performance and safety; however, these were not always effective. The service completed a weekly, monthly, and yearly programme of nursing led audits which were completed at both ward, theatre and service level. Audits included documentation of key nursing and safety standards including infection prevention and control and environmental checks. The audits outcomes were monitored as part of ward dashboards by matrons who reported up to the head of nursing. This along with a review of incidents, patient outcomes and complaints were discussed at monthly surgery governance meetings. This meant there were processes in place for oversight of safety and quality.

However, we identified concerns with the process for escalation of deteriorating patients and sepsis management. We escalated these concerns to managers. For example, we saw evidence of delays in medical review where there were

signs of deterioration and multiple staff expressed concerns of difficulties getting the appropriate grade of medical staff to review patients out of hours. Managers were not aware this was an issue at the time of our inspection. Whilst work had been done to improve oversight of nurse led identification and escalation of deteriorating patient management, we were not assured there was as effective oversight of medical management of these cases once escalated.

Furthermore, we found staff did not always report incidents relating to delays in medical staff in reviewing patients or staffing pressures, therefore managers did not always have information to address concerns.

Staff we spoke to were able to tell us about the challenges the service had and also the wider trust. Managers were aware of the risks on the risk register for the service and action plans that were in place. Some staff said they felt that there were good plans in place for management of risks but that there was a culture of 'firefighting' and reacting to situations rather than planning and that concerns about staffing levels were not listened to.

The service had a risk register. Risks included longstanding vacancy gaps and possible impact on the safe delivery of the service, capacity issues within the outpatient's department and surgery for spinal services as there was only 1 locum consultant. The service had put actions in place to mitigate risks until there was a long-term solution to risks. Each ward also had a risk register reflecting the challenges at a local level. Examples such as staff moves to cover other areas needing support leaving the wards short staffed, lifts breaking down, the impact of this being that there was only 1 lift available for moving patients on beds or in wheelchairs from lower Ashton ward to upper Ashton ward, boarding of patients (patients awaiting discharge from other specialities) and the need to replace spinal microscopes for surgery. These risks also had actions and mitigations in place.

Information Management

Information management systems to track patients were not always effective. 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.

Information management systems to track patients and maintain oversight of patients were not always effective. Serious incidents where there was a delay in following up on scan results or lack of surveillance processes demonstrated managers and clinical leaders were not provided with effective systems to support them to follow up patients and have good oversight to track patients. We found there was not always effective systems in place to alert consultants of abnormal findings or to track where images were ready for review. Systems were not always effective in providing managers with oversight of this until a serious incident investigation highlighted this as a contributory factor or root cause. This meant systems to identify delays at the time were not always effective to prevent harm. Furthermore, where improvements had been made within a specific speciality to improve the patient tracking process, this had not always been effectively shared across all specialities and multidisciplinary teams as the themes were often repeated, suggesting the system is not effective and consistently implemented.

Staff we spoke to explained that patient notes were accessed through a combination of paper and electronic notes and information was not always immediately available. The trust had plans to improve the access to patients notes.

Access to all areas was controlled by a door pass security system. Staff had access to trust electronic systems through a secure login. We saw staff using the systems to retrieve information. Staff knew to log out of computers when they were left unattended. Staff could report incidents using an electronic system which the service could access for monitoring incidents.

Surgery

Engagement

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

Patients could give feedback on the service via the friends and family feedback questionnaires. We also saw that patient experiences were shared at board meetings, and plans for improvements or examples of good practice were shared with staff.

The service took part in a yearly NHS staff survey. The most recent survey in 2022/23 results were provided to us following our inspection. It showed 75 staff across the division completed it. In some areas the service performed well. For example, 92% of staff felt they were trusted to do their job and 73% felt the job they did made a difference to patients and service users. However, performance was below the trust average performance in several measures. For example, only 10% of staff felt there was enough staff to do their job properly which was below the 24% trust wide response rate. Additionally, only 11% of staff felt they had unrealistic time pressures which again was below the trust average of 24%. Survey results were discussed at staff meetings and feedback given. Feedback about staff concerns was also given at the trust board meeting by the freedom to speak up team and issues raised we discussed, and actions and feedback planned.

The service collaborated with another local hospital to discuss how they could work together to improve access to treatment for patients in specific areas. For example, the service was in the process of planning a collaborative approach with a local hospital to improve breast services.

Learning, continuous improvement and innovation

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 and participation in research.

The service had regular divisional, ward and team meetings. Incident reports were monitored and plans for improvements put in place from outcome of investigations.

The service had various quality improvement programmes in place. For example, in 2022 the service requested an external clinical review of breast services due to concerns with culture, multidisciplinary working and an increase in serious incidents. The review took place, and an action plan was implemented and completed. During our inspection managers provided assurance of improvements and had also implemented a further improvement plan in August 2023 to build on work already undertaken. We saw breast cancer pathways were discussed at a twice monthly multidisciplinary team meeting. Patient outcomes or delays in treatment were reviewed and action plans agreed to make improvements. The service had team workshops for breast radiographers and plastic surgeons for training. They regularly reviewed the referral pathway and waiting lists.

The trust practice development team organised training and practice improvement sessions for staff to either introduce new clinical processes or support staff development.

The service had received a National Joint Registry Quality Data Provider Award certificate. This is award was given for the high-quality standard in the way it collects information about joint replacement surgery to support patient safety.

Services for children and young people

Requires Improvement 

Is the service safe?

Requires Improvement 

Our rating of safe improved. We rated it as requires improvement.

Mandatory training

The service 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. Mandatory training was provided both by eLearning and face to face. Information provided identified overall 96.7% of staff on Skylark ward and the neonatal unit were up to date with mandatory training. Medical and nursing staff were compliant with the trust 85% target in all 16 modules, ranging from 89.4% to 100% compliance. This had improved since our last rated inspection in December 2022, when this was raised as a concern.

The mandatory training was comprehensive and met the needs of children, young people and staff. Staff were required to complete mandatory training in a range of topics including safeguarding adults and children, sepsis, deteriorating patient management, information governance, basic life support, equality and diversity, fire safety, health and safety, moving and handling, medicines management and infection prevention and control.

Compliance to the highest level of life support training was achieved for medical and nursing staff. Data provided to us following the inspection showed 13 medical and nursing staff had completed the European Paediatric Advanced Life Support (EPALS) and 22 staff had completed the Paediatric Immediate Life Support (PILS) respectively. Compliance for both training modules was at 97%. Managers told us this enabled at least 1 EPALS trained person on each shift.

Compliance for newborn life support was at 100%. This had improved since our last rated inspection in December 2022 when this was raised as a concern. Furthermore, 100% of nursing staff on Skylark ward had completed sepsis training and 89% in the neonatal unit.

Clinical staff completed training on recognising and responding to children and young people with mental health needs, learning disabilities and autism. As of the end of November 2023, 71% of registered nurses and 68% of non-registered staff had completed mandatory learning disability training. The service was on track to achieving the 85% compliance target set for September 2024. More than 90% of staff had received training in dementia awareness.

Managers monitored mandatory training and alerted staff when they needed to update their training. Staff confirmed they received email alerts and could access the electronic system to check so they knew when to renew their training. Local managers had oversight of their staff completion of mandatory training.

Safeguarding

Staff had training on how to recognise and report abuse. They worked well with other agencies to do so. However, they did not always protect children, young people and their families from abuse.

Services for children and young people

Effective systems were not in place to enable staff to consistently identify, record and escalate mental health assessments. Child and adolescent mental health service (CAMHS) recording, and assessment was inconsistent. For example, 2 children who were admitted following a medication overdose and history of self-harm there was no evidence of consent to treatment on both records we reviewed. Both patients had been referred to CAMHS but there was no clear evidence of documentation of 7-days follow up arrangement including no evidence of the outcome of Multi-Agency Safeguarding Hub referral. We saw no evidence of mental health assessment, no evidence of families involved in the plan and information about how the family could maintain patient safety at home was lacking. Whilst we understand that the Child and Adolescent Mental Health service (CAMH's) is provided by staff employed in another organisation, the responsibility to ensure children, young people and their families are protected from abuse is everyone's responsibility. As such the trust should ensure systems, they have put in place to manage safeguarding referrals and concerns were effective.

Staff received training specific for their role on how to recognise and report abuse. Staff received levels 2 and 3 adult and children safeguarding training which met national safeguarding training guidance. Data provided following our inspection showed between 93% and 100% of staff on Skylark ward and the neonatal unit had completed this training.

Staff knew how to identify adults and children at risk of, or suffering, significant harm and worked with other agencies to protect them. Staff were able to provide examples of how they identified children at risk.

Staff knew how to identify children and young people at risk of female genital mutilation. Each patient on Skylark ward had a safeguarding checklist completed. This was started at the point of admission and quality checks were completed. The checklist included confirmation that nationally approved child protection information sharing systems had been checked and relevant assessments had been completed to determine whether there was a safeguarding risk.

Systems were in place to add an alert to electronic patient records should there be a safeguarding concern or specific actions to take. For example, to identify frequent attenders or record individualised safeguarding risks. Where a risk had been identified, staff on Skylark Ward were required to complete a multi-disciplinary safeguarding assessment to document concerns, actions taken, and referrals made to safeguard the patient and their family. However, we reviewed 3 records on the neonatal unit and saw no clear plans in place for managing relatives where safeguarding concerns had been raised. There were gaps in the handover between maternity and neonatal services. For example we found inofrmation relating to a neonate with a child protection plan in place had not been shared duirng the maternity to neonatal services handover process. This meant there was a potential risk an adult could have access to a baby where there were child protection plans in place to prevent this.

Staff could give examples of how to protect children, young people and their families from harassment and discrimination, including those with protected characteristics under the Equality Act. Staff knew how to protect children, for example if a staff witnessed inappropriate behaviour from a person towards a child, they would raise this immediately in line with the trust policy.

Staff knew how to make a safeguarding referral and who to inform if they had concerns. Staff understood how to report abuse and could describe internal escalation and local referral processes. Staff told us if they had a concern, they would make a referral to the local authority in line with trusts processes. Staff members were able to ask for advice from managers and colleagues if they had a concern with a child's welfare.

Services for children and young people

Staff followed safe procedures for children visiting the ward. We observed that staff on all wards monitored when parents and families were visiting. Staff could see on an intercom screen when a visitor had pressed the bell to enter the wards. Staff checked and verified which patient they were visiting. Staff were familiar with parents and families who were visiting. The staff used swipe cards to enter wards. The security was managed safely on all wards.

Children and young people services were represented at the bi-monthly trust safeguarding steering group. This included the paediatric named safeguarding consultant and a nursing lead. The Head of Nursing or matron produced a monthly activity report to feed into this meeting. For example, they reported on training compliance, patients admitted on a self-harm pathway, mental health referrals, time to mental health review, patients requiring enhanced supervision, safeguarding referrals made and other safeguarding incidents.

Cleanliness, infection control and hygiene

The service-controlled infection risk well. Staff used equipment and control measures to protect children, young people, their families, themselves and others from infection. They kept equipment and the premises visibly clean.

Ward areas were visibly clean and had suitable furnishings which were clean and well-maintained. This included patient rooms, clinical areas, toilets and communal areas, such as relative rooms and kitchens. This was an improvement from our inspection in December 2022 where this was raised as a concern.

The service generally performed well for cleanliness. The service undertook monthly 100 step audits which checked compliance against hygiene and cleanliness standards. We reviewed 4 audits completed from September to November 2023 and found an average 93.5% compliance. Furthermore, cleanliness audits completed in November 2023 on the neonatal unit showed 99% compliance with standards.

Cleaning records were up-to-date and demonstrated that all areas were cleaned regularly. We reviewed the play specialists cleaning rota for toys and equipment. Weekly cleaning of toys was consistently documented. Staff cleaned sensory bubble tubes monthly and recorded they had done this.

Staff cleaned equipment after patient contact and labelled equipment to show when it was last cleaned. We observed "I am clean" stickers were used to let staff know when clinical equipment, such as cots and blood pressure monitors, had been cleaned last.

The environment on Skylark ward appeared clean during our inspection. We spoke with domestic staff who used colour coded devices for cleaning. For example, they now used green mops and cloths in the kitchen, yellow for potentially contaminated areas, red to clean the bathrooms and blue for general cleaning.

Data provided showed the average score for the cleaning of reusable equipment was at 70.8% in November 2023, on both Skylark ward and the neonatal unit. There was no evidence of actions being taken to improve this.

Staff followed infection control principles including the use of personal protective equipment (PPE). We saw staff across all areas we visited were bare below the elbow and wearing PPE during patient care and intervention. Staff wore PPE when entering high risk areas where there may be a patient with a transmissible infection. Hand washing facilities and hand sanitising gel was available across all areas we visited.

Patients with infections or at risk of harm from infections were clearly identified and cared for in side-rooms. Cubicle doors where patients were being source isolated due to having a communicable disease, were kept closed during our inspection. This was an improvement from our December 2022 inspection where this was raised as a concern.

Staff we spoke with understood the process for screening patients for infectious diseases and where there was a risk, the process for isolating patients. Skylark ward had a 4 bedded bay with a bathroom and 18 ensuite cubicles which meant there were enough rooms to isolate patients if required. Staff used red hands on the door for patients with suspected communicable diseases, such as scarlet fever and respiratory diseases.

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.

The design of the environment generally followed national guidance. Though the neonatal unit was challenged due to the layout of the unit, the trust recognised this as an area of concern and added it to the service risk register, and the service took action to mitigate these environmental risks. Patients were not always visible to nursing staff which meant there was a risk staff may not be able to quickly identify a deteriorating patient. There was a risk to patient safety and quality of care due to the layout and lack of visibility of all babies, furthermore, there was only 1 call bell in each of the bays. However, mitigations were in place to reduce these risks, with patients cohorted together in as few rooms as possible. A minimum of 1 or more nurses were assigned to each room, depending on the level of care being provided, and when a nurse left a room, this was handed over to another staff member. A central monitoring system was available at the nurses' station on the neonatal unit and a business case had been agreed at board level to change the layout to improve visibility and access to equipment, this was due to be completed by 2025.

The service had been temporarily regraded to a special care baby unit and no longer provided level 2 care. The intensive care room was used for babies receiving transitional care at the time of our inspection. The room had restricted view to the nurses' station as it was located in a separate area. However, staff mitigated risk by always having at least 1 staff present in the room when in use.

Staff carried out daily safety checks of specialist equipment. Staff checked equipment before use. Staff were aware of the process to report and escalate concerns when equipment was not in full working condition. Skylark ward had a paediatric emergency trolley, 2 adult trolleys and a difficult airway trolley. Two emergency trolleys were available for use in the neonatal unit to enable staff to respond to an emergency in the unit and support the delivery suite. There was an alert system in place to manage expiry dates for items on the emergency trolleys, which had been developed by a team which was called 'The Air Team'. This was a purchased system which was implemented by the Acute Illness Response team across the trust. All expiry dates were monitored through an electronic monitoring system and staff also carried out daily and weekly checks of the contents of the emergency trolleys. Staff monitored resuscitation trolley daily checks compliance, and this was at 100% at the time of our inspection.

Most blood gas machines on Skylark ward were linked to the patient records, reducing risk of patient record error. This had improved since our last rated inspection in December 2022. The blood gas machine on Skylark ward provided staff with receipts with the results on. We saw the receipts were copied into paper medical records. However, the unique identifier recorded did not always reflect the patient hospital or NHS number.

Services for children and young people

The service had suitable facilities to meet the needs of children and young people's families. Skylark ward had a play area and sensory room to help distract children and meet their sensory needs. The waiting areas had toys and equipment and there was a family room on the neonatal unit with facilities for families to prepare food and drinks. The neonatal unit and Skylark ward had facilities for parents to stay overnight. A parent kitchen with facility to make food, drinks and store food was available on the ward.

The service had enough suitable equipment to help them to safely care for children and young people. Furthermore, the neonatal unit had purchased a cooling machine which was expected to be in place by January 2024. The service was in the process of producing a standard operating procedure and there were plans for staff to be trained in January 2024.

Environmental risk assessments were in place. For example, the service had a suitable and up to date fire risk assessment. During the inspection, all fire exits were clear of blockages and accessible if a fire were to occur. Ligature risk assessments had been completed and updated.

Children, young people and their families could reach call bells and staff responded quickly when called.

Staff disposed of clinical waste safely. Sharp bins were available in all clinical areas and staff used them safely on all wards and units. There was appropriate waste segregation which was clearly labelled.

Assessing and responding to patient risk

Staff completed and updated risk assessments for each child and young person and removed or minimised risks. Staff identified but did not always quickly act on children and young people at risk of deterioration.

Staff used a nationally recognised tool to identify children or young people at risk of deterioration and escalated them appropriately. Staff used the Paediatric Early Warning Score (PEWS) system to assist them with the early recognition of sick patients and management of any deterioration. PEWS were escalated in a timely manner. Vital signs, such as heart rate, respiratory rate, oxygen saturation, temperature, and behaviour were used to assess each child's clinical status. This was immediately recorded on an electronic system which generated a score alerting staff to any potential deterioration. A new-born early observation warning system was used on the neonatal unit which was specific to neonates.

Patients had their observations completed in a timely manner all the records we reviewed during our inspection. However, data provided by the trust showed the service did not meet the 90% compliance target for observations to be completed within 15 minutes of arrival on the ward. For October 2023, this was 88% and November 2023 86%. Compliance with PEWS frequency was variable with all observations completed within set frequencies in October 2023, and only 77% in November 2023. Furthermore, audits demonstrated variable compliance with full observations which showed 100% in October 2023, and 88% in November 2023. This had improved since our December 2022 inspection.

Sepsis identification had improved since our December 2022 inspection, with clear evidence of timely escalation to the medical team. Although we found significant improvement in the management of sepsis in most of the records we reviewed, we still identified a delay in administering medicines where sepsis had been triggered. For example, in 1 out of 9 notes we reviewed, sepsis 6 was triggered at 7pm but antibiotics were not administered until 10pm. The national guidance requires patients to receive treatment for suspected sepsis within an hour. This meant there was a risk of sudden patient deterioration. Another sepsis trigger was de-escalated by a doctor after a clinical review but there was no consideration of a differential working diagnosis despite other risk factors which may have increased the risk of sepsis.

Services for children and young people

From 2021/22 to 2022/23, there was a 36% decrease in admissions (ages 0 to 15), where the primary diagnosis for admission was sepsis related.

Staff carried out neonatal golden hour audits. The golden hour of neonatal life is defined as the first hour of post natal life in both pre-term and term neonates. Following our inspection, data provided by the trust showed compliance of 89.6% from 1 September to November 2023.

Staff knew about and dealt with any specific risk issues. Compliance with sepsis screening and treatment was routinely audited. The service had implemented a programme of weekly audits of sepsis compliance to enable them to quickly pick up any issues. We observed a public display board with the latest sepsis audit compliance level for week commencing the 27 November 2023. This showed 95% compliance against sepsis standards for screening and follow up actions. Data provided to us showed from 1 September to November 2023 the average compliance was 79.6%. To improve consistency and clinical documentation, the trust sepsis team were rolling our targeted education sessions for the medical team, agency nurses and redeployed nurses.

There were 2 dedicated cubicles on Skylark ward for children requiring higher level observation. This consisted of a 2 bedded bay providing level 1 care, the service was not currently commissioned for level 2 activity. Three registered nurses had commenced the level 1 and 2 high dependency care course to increase the number of staff competent to manage patients requiring high dependency care.

Children who required intensive care were transferred to a tertiary centre. Paediatric patients were collected by another NHS acute hospital retrieval team, and neonates transferred by the neonatal network retrieval team. Where a patient could not be immediately transferred, processes were in place to treat and stabilise the patient on site. The paediatric team was supported by the trust intensive care and anaesthetics team to provide intubation, ventilation, central lines and monitoring, if required.

Staff completed risk assessments for each child and young person on admission using a recognised tool, and reviewed this regularly, including after any incident. Staff carried out pressure ulcer risk assessments. The pressure ulcer risk assessment scale required daily reassessment or every time the condition changed. Notes we reviewed showed no gaps in reassessments.

We saw completion of fluid balance monitoring had improved compared to our April 2023 inspection. Fluid input and output was effectively totalled and monitored in the 10 charts we reviewed. We saw evidence of escalation and a prescription of diuretic medication (water tablets) by a clinician where a positive fluid balance was identified. This meant that clinical decisions were based on accurate information.

The service had 24-hour access to mental health liaison and specialist mental health support (if staff were concerned about a child or young person's mental health). Staff had access to rapid assessment with Child and Adolescent Mental Health Services (CAMHS) when needed, either in person or by telephone. Skylark ward had an established joint working initiative with CAMHS. We saw examples of positive and regular communication with CAMHS to support the safe management of patients. The trust monitored the number of children and young people admitted on the self-harm pathway who were referred to CAMHS. From October 2022 to October 2023, a reported total of 111 were admitted on this pathway.

Staff completed, or arranged, psychosocial assessments and risk assessments for children or young people thought to be at risk of self-harm or suicide. The trust had a policy for the 'observation of paediatric patients with mental health

problems, self-harm and/or acute behavioural disturbances'. The policy was written in conjunction with a CAMHS local to the hospital. Patients at risk of self-harm or suicide were provided with continuous supervision and usually located in cubicles within close proximity and line of sight to the nurses' station to provide extra monitoring. Patients were assessed to ensure they had the correct level of supervision and to check the environment was safe.

Staff shared key information to keep children, young people and their families safe when handing over their care to others. The team communicated with leads within the community and communicated collaboratively and effectively within multi-disciplinary teams. Following discharge, the service handed children's care over to the community mental health team to maintain their safe care where appropriate.

Shift changes and handovers included all necessary key information to keep patients safe. For example, we observed a handover on the neonatal unit where staff discussed babies high level clinical needs, discharges, and attendance for antibiotics.

The service had a paediatric assessment unit (PAU) which was open 5 days a week and cared for patients from the paediatric emergency department, the community and patients admitted for elective day surgery. PAU operating hours were from 9am to 9.30pm daily, with referrals being taken until 9pm. The service stopped taking patients from the emergency department at 4pm daily. Skylark ward provided staffing for the PAU and managers always ensured a EPALS trained nurse was allocated to work on PAU. A consultant was also allocated to work on PAU.

Central monitoring was not available in all areas on the neonatal unit. This meant nurses did not have eyes on all babies. However, staff mitigated risk through regular observation.

Nurse staffing

The service had enough nursing staff with the right skills, training to keep children, young people and their families 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.

The service had enough nursing and support staff to keep children and young people safe. The paediatric assessment unit (PAU) was staffed by staff from Skylark ward. It was covered by 2 registered nurses (RNs) and a healthcare assistant. Skylark ward was heavily reliant on agency staff to provide cover for gaps caused by high vacancy rates and due to sickness and absences. The service had an action plan in place to address staffing issues this included, a robust recruitment plan. Staff told us that staffing levels had improved, and consistency was getting better. Managers told us staffing had improved as they had been able to cover gaps in the rota by agency staff and the number of beds had been reduced.

The number of nurses and healthcare assistants matched the planned numbers. We reviewed the rota at the time of our inspection and found that there were no gaps in staffing. Skylark ward displayed a safety performance board. We looked at other months and the ward maintained safe staffing across the PAU and Skylark ward. Leaders were continuously reviewing staffing levels to ensure safety.

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. Managers constantly reviewed staffing levels and had a recruitment strategy in place. This included for planned recruitment events, offering incentivised rates to enable regular agency workers to join the trust nurse bank and changing 3 band 5 vacancies to band 6 for Skylark ward.

Furthermore, a retention strategy was in place within the neonatal unit. This included but was not limited to developing a training pathway for neonates for those undertaking "Qualified in Speciality" (QIS) training to become a band 6 on completion of training and competencies and a neonatal nurse foundation course for all RNs prior to undertaking QIS.

The ward manager could adjust staffing levels daily according to the needs of children and young people. Managers assessed staffing levels across all areas of children services and deployed staff from other wards if required. All staff we spoke to on Skylark ward during our inspection told us they were short staffed and used a lot of agency staff but staffing levels were safe.

Processes were in place to review staffing levels daily. Registered nurse and non-registered nurse staffing levels were planned and reviewed against the actual numbers. A safe staffing tool was used to analyse the staffing levels based on the acuity of patients on the ward. This indicated where more staff were required to ensure safe staffing.

The British Association of Perinatal Medicine (BAPM) recommended staffing levels of 'Qualified in Specialty' (QIS) trained nurses and required 70% of RNs to be QIS trained for level 2 neonatal units. At the time of our inspection, the service had recently been temporarily regraded from a level 2 neonatal unit to a level 1 special care baby unit. This meant the service was not required to meet these standards. However, should the service return to a level 2 the BAPM staffing standards would be required. Data provided by the trust showed 59.8% of neonatal nurses had completed their post registration qualification. Whilst this was an improvement, it did not achieve the 70% standard. This concern had been raised during our inspection in December 2022. This was acknowledged as a risk on the risk register. In mitigation, managers planned rotas to ensure a minimum of 2 QIS trained staff on both day and night to provide continual QIS cover and to support non-QIS staff on duty. Data provided by the trust showed that QIS nurse staffing to acuity had been maintained.

The service had an increasing vacancy rate across children and young people services. The vacancy rate for all nursing staff across Skylark and the neonatal ward increased from 14.3% in September, 15% in October and 15.1% in November 2023. However, the vacancy rate on Skylark ward was reducing since our previous inspection with a 16.2% vacancy rate for RNs. There was an 11.5% whole time equivalent gap on the neonatal unit.

The service had reduced turnover rates in November 2023 across all staff levels and grades from the previous 3 months to 4.2% on Skylark ward and 2.9% on the neonatal ward. The trust did not provide their turnover target with the data submitted.

The service had increasing sickness rates, with sickness rates for RNs at 5.8% in September, 6.1% in October and 5.1% in November 2023, respectively. Services for children and young people, had anxiety, stress and other psychiatric illnesses as the top reason for sickness, and there had been a sharp increase since June 2023. We reviewed the rota on Skylark ward and found 4 staff members were on long term sickness.

Managers felt empowered to cover gaps in the rota by using agency staff who had attended the wards regularly. The service had high rates of bank and agency nurses. Agency and bank nurse usage at the time of our inspection was at 30 to 60%. Both agency nurses we spoke with at the time of our inspection had received a local induction and information on how to escalate concerns.

Where bank and agency staff were used, they were block booked to maintain consistency and provide high quality and safe care. The service used known agencies for consistency across all wards. However, most agency staff were general nurses who lacked paediatric skills and staff said this sometimes-put pressure on paediatric nurses working with them.

Services for children and young people

Medical staffing

The service had enough medical staff with the right qualifications, skills, training and experience to keep children, young people and their families 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 service had enough medical staff to keep children and young people safe. The trust reported there were no gaps in medical staffing. There were enough medical staff on all wards and staff were able to easily access them. Medical staffing was compliant with national guidance with children seen by a consultant paediatrician within 14 hours of admission as required. The service increased its consultant body to enable an increased number of consultants on-call in the neonatal unit. At the time of our inspection this was generally staffed with locum consultants. Medical staff were visible on all wards.

The medical staff matched the planned number. Leaders monitored daily medical staffing levels according to patient need to safely care for children and young people. Staff used a split rota between paediatrics and neonates, and we saw no gaps in medical staffing at the time of our inspection. Additional medical staff were added to the on-call rota at peak times to support the management of multiple emergencies out of hours.

Managers could access locums when they needed additional medical staff. The service had 3 locum doctors on the paediatric ward and 1 on the neonatal unit.

The service had a variable sickness rate for medical staff at 1% in September, 3.2% in October and 1.6% in November 2023, respectively.

The service had reducing vacancy rates. Vacancy rates for medical staff were at 16.5% in September, 8.1% in October and 6% in November 2023, respectively.

Managers made sure locums had a full induction to the service before they started work. The service had a good skill mix of medical staff on each shift and senior leaders reviewed this each day to ensure they had a clear oversight.

Managers planned further recruitment to a locum consultant post including rotation to a tertiary centre working in collaboration to develop, support, recruit and retain the medical workforce.

The service always had a consultant on call during evenings and weekends. Nurses informed us they had access to a consultant if a child's condition deteriorated. The trust worked in line with the Royal College of Paediatrics and Child Health guidance.

Records

Staff kept detailed records of children and young people's care and treatment. Records were clear, up-to-date and stored securely. However, they were not easily available to all staff providing care.

Records were stored securely in lockable cupboards on all wards. The staff on all wards were aware of keeping documents safe and secure. This was an improvement from our inspection in December 2022.

Records were a combination of electronic and paper records. While records were comprehensive, completed in full, had a clear treatment plan, and were signed off by a clinical member of staff, not all staff could access all the care records easily. We saw evidence of medical staff looking for nursing notes on Skylark ward. Staff stored the nursing records separately from medical notes. This posed risk of delays in decision making and treatment showing involvement of a multi-disciplinary team approach.

When children and young people transferred to a new team, there were no delays in staff accessing their records. The staff on the wards were able to access records to ensure safety of children.

Staff carried out neonatal documentation audits and the results of the audit from September to November 2023 revealed compliance figures of 96.8%.

Medicines

The service generally used systems and processes to safely prescribe, administer, record and store medicines.

Staff followed systems and processes to prescribe and administer medicines safely. Patient weights and allergies were documented on medicines charts we reviewed. This meant that medicines could be given safely.

Processes were in place to ensure medicine records were accurate and completed correctly. Medicine chart checks had been implemented following our previous inspection to identify errors before the medicine was administered. The service undertook medicine chart quality checks which demonstrated variable compliance with audit standards. For example, in October 2023, the audit showed 78% compliance against a target of 90%. Performance had declined from 88% in September 2023. Where there was non-compliance, the service undertook harm reviews, and no harms were identified. The errors were not recording allergy status, dosing errors, missing units and missing signatures. Whilst the service had not met the compliance target in the 3 months prior to our inspection, the audit process enabled staff to quickly identify the error. During our inspection we saw evidence of learning from these checks being implemented to improve quality. For example, new posters were displayed in key clinical areas as a guide to prescribing medicines prone to errors, such as paracetamol and ibuprofen.

Staff reviewed each child and young person's medicines regularly and provided advice to children, young people and their carers about their medicines. A weekly pharmacy audit was carried out for medicines prescribed, including allergy status and weight. The trust submitted a list of medicines audit but information around action plans and follow up was missing. Therefore, we could not be assured sufficient action was taken following audits.

Medicines were reviewed regularly during daily ward rounds. We saw records for 1 child on the neonatal unit who was due to be discharged with a nasogastric (NG) tube. An NG tube is a thin, soft tube that goes in through the nose, down the throat, and into the stomach. Staff had explained to the parent how to administer medicines and feeds through the NG tube so that they could do this correctly when at home. However, on Skylark ward, we spoke with a parent, who did not feel that they had been listened to or fully involved in the treatment of their child including the use of the NG tube at home.

Staff did not always store all medicines safely. For example, we found 2 bags of 1,000 millilitres sterile water for injection left in an unlocked room where equipment was stored in the neonatal unit. This was accessible to all and posed a risk of unauthorised individuals tampering with them. We raised this with senior staff on the ward at the time of our inspection.

Medicines, such as controlled drugs (medicines requiring additional controls due to their potential for misuse), were stored securely and safely in a secure room with key card access only by authorised persons. There were appropriate systems in place for the safe disposal of medicines and destruction of controlled drugs.

Room and fridge temperatures where medicines were stored were monitored and guidance was available for staff to take action if exceptions occurred.

All medicines and consumable items we reviewed were in date including medicines on emergency trolley's and in anaphylaxis kits.

Staff followed national practice to check children and young people had the correct medicines when they were admitted, or they moved between services. A full medicine history and medicines reconciliation was undertaken on admission to the hospital.

Staff learned from safety alerts and incidents to improve practice. A practice development nurse was in post to facilitate shared learning from incidents. Staff discussed incidents during weekly Grand Rounds, ward meetings and a monthly bulletin for hot topics had been developed. Staff told us that medicines related incidents from other clinical areas were cascaded through trust communication. Furthermore, we also saw evidence of learning being implemented following a medicines administration error in the neonatal unit during an emergency. Emergency medicine calculation charts were available to support staff in the safe administration of medicines when staff were working under pressure.

The service ensured people's behaviour was not controlled by excessive and inappropriate use of medicines. Staff kept a record of patients who had received rapid tranquilisation. Three patients had been administered rapid tranquilisation from 1 December 2022 to 30 November 2023. Records demonstrated rapid tranquillisation was prescribed and administered in a safe manner.

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 children, young people and their families 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 understood their responsibilities to raise concerns and reported incidents and near misses in line with trust policy. Staff we spoke to understood what constituted an incident and required reporting. Staff could provide examples of incidents they had reported. For example, they told us they had reported staffing incidents and medication errors. The service had an electronic reporting system. Staff told us they would report incidents to the nurse in charge or manager on duty as well as on the electronic reporting system.

Staff raised concerns and reported incidents and near misses in line with trust policy. Staff reported incidents and were flagged during meetings for staff to learn from. Leaders monitored incidents for themes and learning. This was shared amongst all staff.

The service had no never events in the 12 months prior to our inspection. Never events are serious patient safety incidents that should not happen if healthcare providers follow national guidance on how to prevent them. Each never event type has the potential to cause serious patient harm or death but neither need have happened for an incident to be a never event.

Services for children and young people

From 22 June 2022 to 24 October 2023 there were 37 Learning from Patient Safety Events (LFPSE) reported by the trust and 35 incidents occurred under paediatric specialities. Of the 37 LFPSE reported, 22 of the events were stated to have incurred no psychological harm (remaining 15 had no data pertaining to psychological harm). Twenty-one of the events were stated to have incurred no physical harm and 1 incurred low psychological harm (remaining 15 had no data pertaining to physical harm).

The themes occurring from the events showed:

- 6 of the events related to a risk around sepsis.
- 6 related to a safeguarding concern or issue.
- 6 related to missing relevant information.
- 4 related to staff training (or lack of sufficient training)
- 3 related to a potential or risk of a data breach.
- 3 relate to staff shortages.
- 3 relate to equipment issues (such as lack of suitable equipment).
- 2 relate to medicine management issues.

Managers shared learning with their staff about never events that happened elsewhere. The trust worked in partnership with a local NHS trust to share learning.

Staff reported serious incidents clearly and in line with trust policy. There had been 9 serious incidents declared across children and young person's services in the 2-year prior to our inspection. Common themes identified were around care, treatment and the management of neonates.

Staff understood the duty of candour and improvements had been made in the service to ensure duty of candour was carried out in line with professional and statutory requirements. We found at the time of our inspection, action had been taken to improve staff understanding and confidence in carrying out duty of candour and having difficult conversations. Learning from 2 serious incidents within the 18 months prior to our inspection had been implemented where the service did not fulfil its responsibilities to carry our duty of candour and be open and honest. During this inspection, we observed staff were open and transparent, and gave children, young people and their families a full explanation if and when things went wrong. For example, we attended a doctor's huddle and staff discussed plans to exercise duty of candour following an incident which was related to a prescription.

Staff received feedback from investigation of incidents, both internal and external to the service. Senior leaders shared feedback with staff. Learning was part of regular discussions in safety huddles and divisional governance meetings. Staff were encouraged to improve through training.

Staff met to discuss the feedback and look at improvements to children and young people's care. Staff discussed incidents at monthly unit meetings and held weekly meetings to discuss incidents reported.

There was evidence that changes had been made as a result of feedback, during governance meetings and newsletters where improvements were made.

Services for children and young people

Managers investigated incidents thoroughly. Children, young people and their families were involved in these investigations. Staff received feedback following investigation of incidents and learning was displayed on huddle boards and discussed at handover.

Managers debriefed and supported staff after any serious incident. Incidents were discussed by ward managers and cascaded to the senior team. Staff took on board when areas required improvement. Staff told us they worked hard to always improve when they got things wrong. The trust supported staff and staff were able to reach out to freedom to speak up guardians.

Is the service effective?

Requires Improvement 

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

Evidence-based care and treatment

The service did not always provide care and treatment based on national guidance and evidence-based practice. Staff protected the rights of children and young people subject to the Mental Health Act 1983.

Staff followed policies and procedures to ensure the service was delivering high quality care according to best practice and national guidance. However, not all policies were up to date. The provider mostly had comprehensive policies, procedures and guidance which were aligned with that of national bodies, such as the National Institute for Health and Care Excellence (NICE) and specialist bodies. Eleven policies we reviewed, such as difficult intubation of neonates, guidelines for neonatal pain management and operational policy for children with diabetes were out of date. We raised this with senior staff who said some of these policies were being reviewed in collaboration with a neighboring trust. Managers told us they had a process for updating policies, including a back log they had been working through.

The service participated in the trust ward accreditation programme. The programme consisted of a set of measures wards should be following in line with trust policy and national guidance. In October 2023, Skylark ward achieved ‘silver’ standard and the neonatal unit achieved a ‘gold’ standard.

Staff protected the rights of children and young people subject to the Mental Health Act and followed the Code of Practice. Managers and staff could clearly articulate processes they followed when the service encountered patients that met the needs of the Mental Health Act. The processes mostly followed the trust’s policies.

The service had processes in place to ensure there was no discrimination, including on the grounds of protected characteristics under the Equality Act, when making care and treatment decisions. Staff told us they followed the trust’s equality, diversity and inclusion policy when making decisions.

At handover meetings, staff routinely referred to the psychological and emotional needs of children, young people and their families. Patient records reviews showed that patients’ psychological and emotional needs were recorded. The service had invested in a senior nurse complex needs for children and young people to support patients with complex needs.

The service had weekly Grand Round meetings where they discussed specific cases and learning from incidents to ensure they were following the service policies and procedures. If any non-compliance was identified, learning was shared.

Nutrition and hydration

Staff gave children, young people and their families enough food and drink to meet their needs and improve their health. The service made adjustments for children, young people and their families' religious, cultural and other needs.

Staff made sure children, young people and their families had enough to eat and drink, including those with specialist nutrition and hydration needs. Patients said they had plenty of food choices and the food was mostly good. Staff confirmed cultural diets were available on request. Parents staying with their child were offered food and drinks. In the neonatal unit there was a kitchen for parents to prepare food and breakfast cereal available.

Staff fully and accurately completed children and young people's fluid and nutrition charts where needed. Patients' notes showed that patients who needed their fluid intake and nutrition monitored had this done by staff.

Patients' notes showed that all patients had their nutritional needs assessed on admission and further assessments carried out as necessary. This included their weight.

Staff mostly met the nutritional needs of patients. However, during our inspection, 2 children waiting to have dental surgery had waited over 3 hours without any update on the time of their surgery. We spoke with them at 3pm and they had been nil by mouth since 7am.

Specialist support from staff, such as dietitians and speech and language therapists, was available for children and young people who needed it.

Pain relief

Staff assessed and monitored patients regularly to see if they were in pain and gave pain relief in a timely way. They gave additional pain relief to ease pain.

Staff assessed children and young people's pain using a recognised tool and gave pain relief in line with individual needs and best practice.

Staff told us pain assessments formed part of their regular observations for patients on the ward and paediatric assessment unit. They used suitable tools that covered both children who could verbalise and those who could not. Staff used specialised pain assessment tools for neonates, and we saw evidence of their use.

Children and young people received pain relief soon after requesting it. We spoke with a patient following surgery. They said their pain was under control and they had received pain relief.

Staff prescribed, administered and recorded pain relief accurately. Patients received pain relief as prescribed.

Patient outcomes

Staff monitored the effectiveness of care and treatment. They used the findings to make improvements and achieved good outcomes for children and young people. The service had been accredited under relevant clinical accreditation schemes.

Services for children and young people

The service participated in relevant national clinical audits. Managers provided examples of audits that were monitored. For example, we saw audit results from the National Asthma and Chronic Obstructive Pulmonary Disease Audit Program 2019/2020, National Clinical Audit for Seizures and Epilepsies in Children and Young People 2021/2022 and the National Paediatric Diabetes Audit 2023. We also reviewed recommendations and actions taken by the trust associated with these results.

Outcomes for children and young people were positive, consistent and met expectations, such as national standards. In national programmes, the trust performed well in most areas. Some sections did need improvement compared to the national average and action plans were available to see how this would be achieved.

Managers and staff used the results to improve children and young people's outcomes. Managers and leaders told us all the national audits fed into the trust's own audit programmes, which were designed to encourage improvement.

The service had a lower-than-expected risk of readmission for elective care than the England average. Emergency readmissions within 30 days for paediatric (0 to 16 years) patients following tonsillectomy under the care of an ear, nose and throat surgeon (12 months to quarter end) was 7.3%, which was above the benchmark. However, the peer median was at 8.4% and better than the benchmark of 4.4% (with Kettering General Hospital being lower than the peer sector).

Managers and staff across all areas carried out a comprehensive programme of repeated audits to check improvement over time. They used information from the audits to improve care and treatment. For example, documentation, risk assessments, consent, management of deteriorating patients, sepsis, fluid balance monitoring and discharge process. Managers shared and made sure staff understood information from the audits and implemented changes in practice when required.

A maternity, newborn and infant clinical outcome review programme took place in 2022. There were 2 metrics examined in this audit, which included stabilised and risk-adjusted perinatal mortality rate per 1,000 births and stabilised and risk-adjusted extended perinatal mortality rate, excluding congenital anomalies per 1,000 births. Kettering General Hospital NHS Foundation Trust presented as slightly lower than the previous audit on the first metric (4.3%) and slightly higher on the second metric (3.61%). Both metrics were slightly lower when compared to the national aggregates of 4.12% and 3.66%. This meant clinical outcomes were better for neonates at the trust compared to others in England.

The service was accredited as baby friendly by UNICEF UK Baby Friendly initiative for excellence in supporting breastfeeding and parent-infant relationships.

Competent staff

The service made sure staff were competent for their roles. Managers appraised staff's work performance and held supervision meetings with them to provide support and development.

The clinical education team supported the learning and development needs of staff. The service ensured all junior doctors had a clinical supervisor and education supervisor, and they worked with the junior doctors to support learning and training. Junior doctors attended lunch time junior doctor led teachings on Tuesdays and Thursdays. Staff also attended regular bimonthly regional teaching days provided by the East Midlands deanery. Junior doctors received a teaching schedule at the beginning of each training programme and received study days to enable them attend.

Consultants demonstrated strong clinical leadership and undertook teaching opportunities to share knowledge with more junior doctors. We attended a multi-disciplinary team huddle on the neonatal unit and staff discussed patients'

clinical needs, learning from incidents, potential plans for care and any outstanding actions. Most medical staff we spoke to across all areas were positive about the teaching and learning opportunities provided to them. The neonatal unit had also undergone a change in how the team operated to improve team working and enable more dedicated time to learning and development.

Staff were experienced, qualified and had the right skills and knowledge to meet the needs of children, young people and their families. Managers told us staff were recruited centrally by the trust and all staff had to provide proof of their registration, Disclosure and Barring Service checks, references, and other relevant recruitment information.

Managers gave all new staff a full induction tailored to their role before they started work. The induction for new starters was a structured and supportive introduction to the trust and ward or department. It included an introduction to the trust values, policies and procedures in addition to an introduction to their role and their immediate work area. All newly qualified staff had access to specific learning opportunities to support them in their role.

We spoke with a psychologist who was new in post. They felt integrated into the team and had monthly supervision with a consultant psychologist.

Managers supported staff to develop through yearly, constructive appraisals of their work. Managers conducted appraisals on an annual cycle. Records reviewed following our inspection showed 88.2% of staff had an up-to-date appraisal.

Managers made sure staff attended team meetings or had access to full notes when they could not attend. Managers promoted meetings through a variety of communication methods. When staff were unable to attend, managers would note this in the minutes which were then sent to all staff by email.

Managers identified any training needs their staff had and gave them the time and opportunity to develop their skills and knowledge. Since our previous inspections in December 2022 and April 2023, the service had made improvements in supporting staff to develop. Staff were allocated time for mandatory training and attended study days every 4 to 5 months for support to improve and maintain their skills. Practice development nurses provided on the job training around specific skills and competencies. Practice educators and managers facilitated a number of skills and drills practice sessions. This included management of a deteriorating child/neonate. These sessions were multidisciplinary (MDT) and were planned in response to specific learning and incidents across all areas we visited. There was a simulation suite on Skylark ward which was used to practice specific emergencies or challenging situations. In the 3 months prior to our inspection, the neonatal unit held several MDT study days and simulation sessions with attendance and support from local specialist hospitals and neonatal network colleagues. These were designed to build competence, confidence and resilience in managing emergency situations with support from other organisations.

Managers made sure staff received any specialist training for their role. Managers introduced training and development opportunities in level 1 and 2 care of the critically unwell child, professional nurse advocate programme, extended skills and leadership training. Managers had a ‘grow your own model’ and seconded 3 nurse associates/healthcare support workers on the conversion course to become registered children's nurses'.

Staff had the opportunity to discuss training needs with their line manager and were supported to develop their skills and knowledge. Staff attended an NHS online mental health training called ‘We Can Talk’ and kept a record of the training on the training matrix.

Services for children and young people

Managers identified poor staff performance promptly and supported staff to improve. Managers monitored staff performance and when required ensured additional training opportunities were available.

Multidisciplinary working

Doctors, nurses and other healthcare professionals worked together as a team to benefit children, young people and their families. They supported each other to provide good care.

During our inspection we observed positive interactions between medical and nursing staff. Nursing staff in the neonatal unit told us working relationships between medical and nursing staff had significantly improved and most staff felt they could escalate to medical staff and felt listened to. Staff were able to provide examples of collaborative working projects which had demonstrated improved joined up working.

Staff held regular and effective MDT meetings to discuss children and young people and improve their care. Leaders ran a sequence of regular MDT committees which combined expertise across the spectrum of services and disciplines associated with children and young people. Meetings ranged from clinical governance, children and young people working groups, through to MDT's involving subject specific themes such as safeguarding and mental health.

Staff worked across health care disciplines and with other agencies when required to care for children, young people and their families. We attended a post-ward round huddle held by doctors and deputy ward sister during our inspection. Staff systematically went through outstanding jobs and plans for each patient, as well as potential admissions from the emergency department. The deputy sister made notes in a communication book and cascaded information to individual nurses looking after patients.

Staff referred children and young people for mental health assessments when they showed signs of mental ill health. The average time a young person waited to be seen by Child and Adolescent Mental Health Services was less than 24 hours.

A paediatric in-patient physiotherapy service was available on Skylark ward with the aim to provide physiotherapy assessments and appropriate treatment plans to optimise patients' functional abilities whilst in the acute setting. Physiotherapists ran 2 clinical sessions per day from Monday to Friday, and this was available for orthopaedic, medical, surgical and respiratory patients.

Seven-day services

Key services were available 7 days a week to support timely patient care.

Consultants led daily ward rounds on all wards, including weekends on call. Children and young people were reviewed by consultants depending on the care pathway. The medical rota showed that consultants were on site 5 days a week and available on call at weekends. Consultants were on site from 9am to 10pm Monday to Friday and from 9am to 5pm at weekends.

Staff could call for support from doctors and other disciplines, including mental health services and diagnostic tests, 24 hours a day, 7 days a week. Staff told us medical support was always available and there were clear processes followed if this was needed.

Health promotion

Staff gave children, young people and their families practical support and advice to lead healthier lives.

The service had relevant information promoting healthy lifestyles and support on wards. A dietitian worked with patients and their families to access healthy eating and bespoke packages for children living with diabetes. A 'Park run with the diabetes' team provided educational support with access to psychologists to children and young people living with diabetes.

The service established a paediatrician MDT led complications in excess weight children's clinic in January 2023. Staff linked in with school nurses, community physiotherapy, community occupational therapy and dietitian as part of supporting healthy lifestyle and preventing obesity.

Staff assessed each child and young person's health when admitted and provided support for any individual needs to live a healthier lifestyle. The service introduced a mobile application as part of promoting healthy lifestyles and to embed the measurement of height and weight along with Body Mass Index for easy visualisation in the ward and outpatient areas. The application facilitated sharing and visualisation and enabled children and young people living with specific diseases to make specific adjustments.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

Staff supported children, young people and their families to make informed decisions about their care and treatment. They knew how to support children, young people and their families who lacked capacity to make their own decisions or were experiencing mental ill health.

Staff understood how and when to assess whether a child or young person had the capacity to make decisions about their care. Staff we spoke with showed understanding of when it was suitable to assess capacity and what things to consider as part of this process.

Staff did not always make sure children, young people and their families consent to treatment. For example, there was no evidence of consent to treatment on 2 child and adolescent mental health service records we reviewed. However, they had knowledge and showed consideration about how they both discussed and confirmed consent especially on surgical procedures.

When children, young people or their families could not give consent, staff made decisions in their best interest, taking into account their wishes, culture and traditions. They gave examples of when it was recognised that patients needed extra support when consenting to treatment, such as when patients had a learning disability.

Staff clearly recorded consent in the children and young people's records. This was done in line with pre surgical checks that were completed.

Staff understood Gillick Competence and Fraser Guidelines and supported children who wished to make decisions about their treatment. The Gillick Competence refers to a young person under 16 years of age with capacity to make any relevant decision for their treatment. Staff we spoke with understood what this meant but could not provide an example of this from the last 12 months.

Staff understood the relevant consent and decision-making requirements of legislation and guidance, including the Mental Health Act (MHA), Mental Capacity Act 2005 (MCA) and the Children Acts 1989 and 2004 and they knew who to contact for advice. Staff told us about any concerns regarding a patient's ability to consent would be escalated to their line manager in the first instance.

Services for children and young people

Clinical staff completed training on the MCA and Deprivation of Liberty Safeguards (DoLs) achieving the trust's target. Compliance was 94% at the time of our inspection.

Managers monitored the use of DoLS and made sure staff knew how to complete them. Managers had not made any applications for DoLs in the past 12 months.

Staff could describe and knew how to access policies and knew where they could get accurate advice on the MCA and DoLS. Staff told us they would escalate any concerns firstly to managers. Managers told us they would then engage specialist input where needed.

Is the service caring?

Good 

Our rating of caring stayed the same. We rated it as good.

Compassionate care

Staff treated children, young people and their families with compassion and kindness, respected their privacy and dignity, and took account of their individual needs.

Staff were discreet and responsive when caring for children, young people and their families. Staff took time to interact with children, young people and their families in a respectful and considerate way. Staff were seen caring for children and their families in a kind manner across all areas we visited.

Children, young people and their families told us staff treated them well and with kindness. We reviewed the November 2023 feedback report for the local neonatal unit which showed 90% of people were satisfied with their care. Feedback provided stated 'The staff were just incredible, helpful, informative and taking care of us as well as our little girl. I cannot praise every member of staff from the cleaners to the doctors enough'.

Staff followed policy to keep care and treatment confidential. Computer screens were locked when not in use and a room was available if patients wished to have a more private conversation on arrival to the wards.

Staff understood and respected the individual needs of each child and young person and showed understanding and a non-judgmental attitude when caring for or discussing those with mental health needs. Patients with mental health needs had a dedicated member of staff to both support them and keep them safe. Interactions between these patients and their families were friendly, inclusive and kind.

Staff understood and respected the personal, cultural, social and religious needs of children, young people and their families and how they may relate to care needs. Staff had access to a chaplaincy service and told us they would respond to the varying needs of patients.

We spoke with a parent who said they were staying in a parents' bedroom, had breast pumps and were offered 3 meals a day.

There was a craft store on Skylark ward which parents could use for breastfeeding. The service had invested into more comfortable chairs for breastfeeding.

Emotional support

Staff provided emotional support to children, young people and their families to minimise their distress. They understood children and young people's personal, cultural and religious needs.

Staff gave children, young people and their families help, emotional support and advice when they needed it. We observed very positive interaction between play staff and children on Skylark ward. A music therapist was available for parents and their children when they needed it.

Staff supported children, young people and their families who became distressed in an open environment and helped them maintain their privacy and dignity. We observed a patient being taken to theatre. They were escorted by a play specialist and were wearing a gown and covered up with a sheet and blanket to maintain privacy, dignity and to keep them warm.

Staff gave an example of how they promoted dignity. Staff were trialling the use of urinary sheaths for appropriate patients with incontinence. This allowed a patient with a genetic disorder to maintain their dignity and independence whilst meeting their continence needs both as an inpatient and in the community.

Staff undertook training on breaking bad news and demonstrated empathy when having difficult conversations. Staff offered bereavement and counselling services and understood the emotional and social impact that a person's care, treatment or condition had on their wellbeing and on those close to them.

Staff understood the emotional and social impact that a child or young person's care, treatment or condition had on them, and their families wellbeing. The service had recently recruited a clinical psychologist to support families within the neonatal service and also to support staff. Chaplains visited wards and provided support to patients, their relatives and staff.

Undersrtanding and involvement of patients and those close to the

Staff supported and involved children, young people and their families to understand their condition and make decisions about their care and treatment. They ensured a family centred approach.

Staff made sure children, young people and their families understood their care and treatment. Children were given choices about treatment options. Staff encouraged children make decisions about or agree to their care and treatment.

Staff talked with children, young people and their families in a way they could understand, using communication aids where necessary. Parents we spoke to on the neonatal unit felt listened to and respected.

Children, young people and their families could give feedback on the service and their treatment and staff supported them to do this. We saw 'voice of a child' posters displayed on Skylark ward. Voice of a child is of paramount importance in testing out whether the apparent outcomes of interventions are having the desired impact for children.

Staff supported children, young people and their families to make informed decisions about their care. Staff gave older children the opportunity talk to a clinician without a parent present.

Services for children and young people

We reviewed the results of the Children and Young People Experience Survey 2020. Of the 608 individuals invited to take part in the survey, 131 completed surveys were received, with a response rate of 22%. This was slightly lower than the national average response rate (24%) and the trust's response rate from the previous year (24%).

The trust performed about the same compared with other trusts for most questions scoring 89%. In 83% of the questions there was no change from the previous results, with 7 questions scoring significantly better, and 2 scoring significantly worse. Patient experience was best on hospital WI-FI, enough things to do, ward suitability, quiet hospital wards and hospital food.

Friends and Family Test feedback received from September to November 2023 was 95.4%. Patient feedback demonstrated high levels of satisfaction for the compassion received from staff and almost all responses were good or very good.

Is the service responsive?

Requires Improvement 

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

Service delivery to meet the needs of local people

The service planned and provided care in a way that met the needs of local people and the communities served. It also worked with others in the wider system and local organisations to plan care.

Managers planned and organised services, so they met the changing needs of the local population. Leaders and managers told us the trust considered feedback from the local population when delivering services. Managers recognised there was an increasing children and young persons population in Northamptonshire and recognised the increase in demand for in-patient services. For example, there was an increase in young people presenting with mental health concerns and with complex needs. In response the service had escalated concerns to commissioners to seek network support to manage these patients. The service had recently invested in a senior complex needs nurse for children and young people, who had oversight of patients and supported children to remain at home, reducing the need to attend hospital. This role also reduced impact on services for patients in hospital by ensuring the child's needs were met.

There were 21,516 children and young people aged 0 to 15 emergency department attendances from 1 October 2022 to 30 September 2023, this was a 4.2% increase compared to 1 October 2021 to 30 September 2022 (20,641).

From 1 October 2022 to 30 September 2023 there were 7,938 admissions of children and young people to Kettering General Hospital. This was a decrease of 1.8% compared to 1 October 2021 to 30 September 2022 (total admissions of 8,082). Elective admissions increased by 5.0% compared to previous year and non-elective admissions decreased by 2.9%.

Staff knew about and understood the standards for mixed sex accommodation and knew when to report a potential breach. Skylark ward had 18 cubicles with ensuite facilities. Most patients used the single cubicles, and the risk of mixed sex accommodation was mitigated.

Services for children and young people

Facilities and premises were appropriate for the services being delivered. Following our inspection in December 2022, the trust reduced the overall bed capacity on Skylark ward to 22 beds to ensure safe staffing guidelines was met and improve the quality of care provided. The Paediatric Assessment Unit (PAU) was co-located on Skylark ward. It had 8 bed spaces and treated patients referred in from their GP, from the paediatric emergency department and other services including planned care procedures. The PAU took pressure off the ward to enable them to care for the sickest patients and enable treatment to be given without the need for a child to be admitted. They also offered open access to patients with complex health conditions who needed assessment and treatment in hospital. PAU operated Monday to Friday from 9am to 9.30pm. The service was in the process of reviewing the PAU to look at ways of improving how it worked.

The neonatal unit was located in close proximity to the delivery suite to enable them to provide timely intervention to babies born in poor condition and enable rapid transfer. There were 16 cots available. However, at the time of our inspection the service had been temporarily downgraded from a level 2 neonatal unit to a level 1. This meant the service was not able to provide care to babies requiring a higher level of medical and nursing support or short-term intensive care. The service considered this was a temporary measure to enable them to meet specific safety standards set by commissioners. Processes were in place to ensure any high-risk pregnancies were diverted to another local hospital to deliver in case this higher level of support was required. Although the service had temporarily downgraded, they continued to provide the equivalent staffing levels and had made some significant improvements in medical availability, leadership and training.

Staff could access emergency mental health support 24 hours a day 7 days a week for children and young people with mental health problems. Staff confirmed they were able to access this but would report to their manager first, to enable them have oversight of the process.

The service had systems to care for children and young people in need of additional support, specialist intervention, and planning for transition to adult services. Staff gave an example of how they promoted independence in a 10-month-old patient who was non-communicative, withdrawn, had no independent feeding, play or core strength. The play team developed a play specialist plan with play sessions being completed in a sensory room on Skylark ward to promote independence of play. This promoted independence of play and mealtime feeding. On discharge, the patient could babble, laugh, play independently, and do finger feeding with improved core strength.

Managers monitored and took action to minimise missed appointments. Outpatient clinics for paediatrics were managed by a separate bookings team.

Managers ensured that children, young people and their families who did not attend appointments were contacted. A standard operating procedure was in place for children who were not brought into an appointment. Staff would send a letter to the GP informing them of the child's non-attendance using the standard notification letter template and detailing why a further appointment was required. Staff shared their concerns with relevant external agencies in the event of concerns regarding a child not being brought in.

The service relieved pressure on other departments when they could treat children and young people in a day. When suitable, treatment of paediatric patients was normally through attendance at the PAU, an outpatient appointment, or a minor surgical procedure (day surgery).

Meeting people's individual needs

The service was inclusive and took account of children, young people and their families' individual needs and preferences. Staff made reasonable adjustments to help children, young people and their families access services. They coordinated care with other services and providers.

Services for children and young people

Staff made sure children and young people living with mental health problems, learning disabilities and long-term conditions received the necessary care to meet all their needs. Patients had their needs assessed as part of their initial assessment. We saw this was always completed in patient records we reviewed. Staff had the knowledge and understanding in mental health and learning disabilities to understand and implement personalised care for these patients.

Wards were designed to meet the needs of children, young people and their families. Skylark ward had a sensory room with a swipe access and an emergency door release on the other side. Staff used this room for children who required distraction therapy and sensory stimulation. A quiet room was also available for private discussions such as difficult conversations or breaking bad news.

Staff used transition plans to support young people moving on to adult services. The service had arrangements in place for children and young people in transition between care in the paediatrics and adults care team. They followed the National Transition Policy that defined the standards of transition for children and young people with chronic illnesses who needed to move from paediatric services to adult services. A lead consultant, a children's nurse for complex needs and a specialist nurse for epilepsy led the transition work as young people transitioning from paediatric to adult services are at risk of experiencing poor health outcomes.

Staff supported children and young people living with complex health care needs. Children who needed echography, blood tests and electrocardiograms had these planned to be delivered as 1 appointment and through the paediatric assessment unit with support from the play team. Pathway managers and ward sisters managed such requests. Staff could seek support from the trust learning disability nurse who provided advice to staff and would assess the needs of specific patients when required and ensure any reasonable adjustments were in place.

A senior nurse complex needs worked with families and young people to develop individualised care plans. This included appropriate adaptations and reasonable adjustments made for those with additional needs to maintain their independence in an acute setting. Staff gave an example of a child who required a magnetic resonance imaging investigation and needed several weeks of preparation and numerous de-sensitisation visits to enable them to maintain their sense of control and needs during the Magnetic Resonance Imaging. The procedure was successfully completed due to this intervention. Staff spoke positively of the senior specialist nurse role which was newly implemented and meant patients with complex needs were better supported.

The trust launched the training on learning disability and autism in September 2023 on a 12-month plan and 73.4% of staff on Skylark ward and the neonatal unit had attended this training. The service was well on track to achieving this target. The Oliver McGowan training is a standardised training on learning disability and autism and was developed to capture the most important skills needed by all staff working across health and social care.

The service had information leaflets available in languages spoken by the children, young people, their families and local community. Information leaflets were available on the trust website and could be translated into different languages when asked.

Managers made sure staff, children, young people and their families could get help from interpreters when needed. Staff knew how to request translators when required.

Children, young people and their families were given a choice of food and drink to meet their cultural and religious preferences.

Services for children and young people

Staff had access to communication aids to help children and young people and their families become partners in their care and treatment. For example, staff developed and co-created communication cards with a patient who was non-communicative. This enabled the patient to better articulate their needs and play requests. This was then adopted by the schoolteacher in hospital to continue the patient's education as an inpatient.

Access and flow

People could not always access the service when they needed it and did not always receive the right care promptly. Waiting times from referral to treatment and arrangements to admit, treat and discharge children and young people were not in line with national standards.

Managers monitored waiting times and made sure children, young people and their families could access services when needed and received treatment within agreed timeframes and national targets. Over half (58%) of patients currently on the waiting list for a first definitive treatment for paediatric services were waiting less than 18 weeks. This meant that 42% of patients' waited longer than 18 weeks.

Managers worked to keep the number of cancelled appointments to a minimum. A standard operating procedure (SOP) was in place which required a minimum of 6 weeks' notice from all clinicians and clinic nurse specialists to cancel or reduce any outpatient or diagnostic sessions for reasons of annual or study leave. The SOP clarified the responsibilities of all staff involved in the management of outpatient clinics when a clinic needed to be cancelled or reduced with less than 6 weeks' notice.

Managers monitored that children and young people's moves between wards/services were kept to a minimum. Staff moved children and young people only when there was a clear medical reason or in their best interest.

Staff did not move children and young people between wards at night.

Managers and staff started planning each child and young person's discharge as early as possible. Staff planned children and young people's discharge carefully, particularly for those with complex mental health and social care needs. Where required there was a multi-disciplinary approach and we saw good examples of this in the records we reviewed.

Managers monitored the number of children and young people whose discharge was delayed, and took action to reduce them. There were regular meetings throughout the day where capacity and flow were discussed, and issues escalated.

Managers monitored patient transfers and followed national standards. Staff supported children, young people and their families when they were referred or transferred between services. From 1 September to 30 November 2023, 10 children and young people were transferred in from external hospitals and 20 children and young people were transferred to external hospitals. Transfers were normally to specialist centres where the child's health needs could be safely met.

Staff sent a discharge summary electronically to GPs and other relevant healthcare professionals within 24 hours and gave the information to the child and their parents and carers.

Learning from complaints and concerns

It was easy for people to give feedback and raise concerns about care received. The service treated concerns and complaints seriously, investigated them and shared lessons learned with all staff. The service included children, young people and their families in the investigation of their complaint.

Services for children and young people

Children, young people and their families knew how to complain or raise concerns. The service clearly displayed information about how to raise a concern in patient areas. There were advice leaflets and posters on how to complain displayed prominently throughout the wards.

Staff understood the policy on complaints and knew how to handle them. Staff we spoke with knew the process for complaints. They were active in complaints management and wanted to see if the problem could be resolved before escalating the complaint further. There was a focus on building staff confidence to deal with complaints at the time to support parents with any concerns they had. Managers recognised this was a work in progress but also recognised improvements made to the service was having a positive impact on patient/family experience.

Managers investigated complaints and identified themes. From 1 September to 30 November 2023, the children and young people service received 9 formal complaints. Examples of complaints received included treatment (medication issues), and attitude and behaviour of medical staff.

Staff knew how to acknowledge complaints and children, young people and their families received feedback from managers after the investigation into their complaint. Managers shared feedback from complaints with staff and learning was used to improve the service.

Staff could give examples of how they used patient feedback to improve daily practice.

Is the service well-led?

Requires Improvement 

Our rating of well-led improved. 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 children and young people (CYP) service was managed under the family health division. It had a triumvirate senior leadership structure which included a Senior Operational Lead, a CYP Clinical Director Lead and a Head of Nursing for CYP. The nursing team was led by 2 matrons who were supported by a team of band 7 nurses who took charge of the daily operational running of the service.

One matron led the neonatal service, and another matron led the inpatient ward (Skylark ward) and the paediatric assessment unit. As the time of our inspection, the matron role for the inpatient ward was vacant. The service was in the process of recruiting into this position and were considering options to increase interest in the role. The leaders were focused on recruiting the right person with the right skills and experience to the role to provide effective nursing leadership and a focus on quality and safety.

Leaders understood the challenges to quality and sustainability and could identify actions needed to address these. During our inspection we interviewed the triumvirate and local leadership team. They were able to tell us about current

challenges and how they were addressing them. Whilst leaders could provide an overview of their challenges, we were aware they did not always have an awareness of issues until external organisations brought them to their attention. For example, concerns were identified with the neonatal unit which led to the service being temporarily downgraded whilst improvements were made. Prior to this, these issues were not identified as a risk or acted on by the service.

Leaders we spoke to were clear about their role and responsibility and they showed good awareness of the priorities and challenges the children and young people faced at the hospital. For example, they were knowledgeable in staffing concerns and were able to explain how they managed risk associated with this.

Staff told us they felt leaders were visible, and patients also commented positively on this through the feedback we received.

The service had strengthened local leadership. For example, they recruited a consultant to work closely with the medical team to support quality improvements, education, and training for medical staff across the service. All doctors we spoke to said they had received ongoing training and development. The service had increased the consultant body across the services and split the neonatal and paediatric rotas to ensure strong clinical leadership for both areas with a focus on improving safety and quality. Furthermore, a band 7 ward manager position and practice development nurse had been added to the establishment in April 2022 to provide more consistent operational leadership and staff training. The service had supported band 6 and 7 nurses to undertake leadership and management training.

Multi-disciplinary leadership had improved. Managers told us work had been undertaken to improve working relationships between medical and nursing leaders. During our inspection we observed effective and positive working relationships between medical and nursing staff. Medical and nursing staff in charge worked well together to manage ward rounds. Lead consultants demonstrated a good level of understanding of both medical and nursing challenges and were able to explain how they would be addressed. We considered there to be a joined-up approach to improve the quality and safety of the service.

Vision and strategy

The service 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 family health division had an integrated business plan in place for 2023/24 which included a strategy and plan to develop children and young people services. The service undertook an analysis of service strengths, weaknesses, opportunities and key threats. They used the outcome to form a list of objectives to enable the service to deliver divisional priorities. The priorities included a redesign of the neonatal unit to improve patient safety and improve the number of skilled neonatal staff. It also included recruiting a supernumerary nurse in charge of both Skylark ward and the neonatal unit. Recruiting a specialist sepsis nurse and a specialist mental health nurse. Developing a digital process, improving allied health professional provision and improving collaboration across the acute healthcare system, to reduce readmissions.

The strategy was aligned to local plans in the wider health and social care economy to meet the needs of the local population. The trust had a group model approach with 2 other local hospitals in Northamptonshire and Leicestershire.

Services for children and young people

The strategy outlined plans to develop a group model for children and young people services including the development of shared paediatric pathways across Northamptonshire hospitals. The service worked with the local integrated care board in developing community and acute paediatric pathways with community services including children and adolescent mental health services.

Culture

Staff felt respected, supported and valued. They were focused on the needs of patients receiving care. The service provided opportunities for career development. The service had an open culture where patients, their families and staff could raise concerns without fear.

Staff were overwhelmingly positive about how they felt supported, respected and valued by both their line managers and more senior staff. Staff were generally positive but were apprehensive about the service returning to how it was when we inspected in December 2022. The main concerns staff had was the high use of agency staff and use of adult trained nurse to cover short term absence. Staff felt this increased the level of pressure they were working under. Staff on the neonatal unit were often asked to provide cover on Skylark ward due to last minute staff shortages. During our inspection we spoke to a community nurse who had previously worked on Skylark ward but left due to the working conditions. The nurse was overwhelmingly positive about the changes that had been made and commented positively about the staff culture now. Staff were focused on the needs of patients receiving care.

The service had a recognition award which allowed staff to nominate individuals. Several awards had been granted to staff who got certificates and were mentioned on the trust's website. A 'Rose Award' was available for non-registered staff, and 'Daisy Award' for registered staff.

We observed the atmosphere on Skylark ward had changed since our previous inspection. We observed positive interactions between staff. Staff appeared happier than when we previously inspected, despite still being under considerable pressure. We could hear children laughing and observed a good rapport between staff and parents. The ward appeared to be much calmer. Staff were clearly focused on ensuring their patients were well looked after and cared for and were proud to tell us what they had achieved.

The service provided opportunities for career development. Managers told us they struggled to recruit specialist children, young people and neonatal staff, therefore they had implemented a grow your own model. This had resulted in opportunities for staff of all grades to develop their skills and progress within their career. For example, the service had introduced registered nurse associates to provide another route into becoming a registered healthcare professional.

Leaders and staff displayed their feedback and were proud of this. Patients and their families who we spoke with knew who to speak with if they wanted to raise concerns. Staff told us they felt safe to approach their line manager if they held concerns.

Governance

Leaders mostly operated effective governance processes, throughout the service. Trust wide deteriorating patients quality improvement plans were mostly embedded within children and young person's governance processes. Staff at all levels were mostly clear about their roles and accountabilities. Leaders gave staff regular opportunities to meet, discuss and learn from the performance of the service.

Governance systems that looked at performance and incidents that occurred were frequent and there were examples of learning and how it was shared with staff. However, governance systems were not always effective in supporting the

delivery of good quality and sustainable services. We found limited progress had been made to improve the quality and safety of the service. For example, 11 policies were not up-to-date, and we were not assured the leadership and governance arrangements in place within the service and the family health division enabled effective oversight and monitoring of policies.

Leaders gave staff regular opportunities to meet, discuss and learn from the performance of the service. Regular ward and unit meetings took place where staff were provided with an update on outcomes of audits, incident investigations and complaints. Weekly Grand Rounds were facilitated on a Friday which was well attended by staff including medical, therapy, nursing and pharmacy. These provided staff with an opportunity to learn from quality and safety audits and discuss incidents and learning. During our inspection in December 2022, nursing representation at divisional governance meetings was inconsistent. Governance meeting minutes we reviewed showed a lack of representation from children and young people managers. This had improved during this inspection. We reviewed the minutes of the governance meetings held in July and August 2023 and found medical staff, matrons paediatric and neonatal managers attended.

Staff held network meetings and patients living with complex asthma were discussed during the meeting. Staff referred severe chronic asthma patients to a neighbouring NHS trust. We reviewed minutes of the governance meeting held in July 2023 and found there was a lack of dedicated paediatric asthma nurse, so the monitoring and in-between assessments did not usually take place.

Management of risk, issues and performance

Leaders and teams did not always use systems to manage performance effectively. Risk assessments to continually identify ward-based risks were not always effective. Leaders identified and escalated relevant risks.

The contract for the provision of children and young people's mental health services at the trust was commissioned by the integrated care system (ICS) from the local mental health trust. There was an Integrated Care Board (ICB) children and young peoples' transformation workstream for mental health and emotional wellbeing which KGH were represented at. This workstream had developed the integrated pathway and assessment document that was in place across Northamptonshire. There were bi-weekly multi-agency meetings where the care and treatment for children with complex mental health presentations was discussed, KGH were represented at this meeting.

We found compliance was not always met in observations being completed within 15 minutes and audits of this compliance showed variable compliance.

Leaders used systems to manage performance effectively. They had oversight of the divisional risk register and clinical audits to monitor performance. The service's main risks were 'Qualified in Specialty' (QIS) training and staff vacancies.

The lack of middle grade paediatric doctors to fully staff the service was rated as a significant risk on the risk register. This could impact on patient flow, timely senior review of patients referred from the emergency department (ED) during the evening and overnight and could compromise patient safety if there was more than 1 medical emergency. Managers mitigated gaps by using long-term locum staff. This was discussed monthly during consultants' meetings with oversight at the paediatric and neonatal governance meetings.

Risks due to staffing was monitored regularly by senior leaders to ensure there were enough nursing staff to keep children, young people, and their families safe from avoidable harm.

There was an improvement board on Skylark ward which was used to share information around the performance matrix and raise staff awareness of good and poor performance. At the time of our inspection, paediatric early warning scores compliance was at 85%. Staff discussed performance during team huddles to drive improvement.

A nurse improvement strategy was in place which included a band 5-6 progression pathway and encompassed the QIS qualification and a foundation course which band 5 registered nurses commenced on to give the essential foundational knowledge and skills in neonates. This had brought improvement to staff retention and recruitment. An Advanced Health Professional and medical workforce improvement strategy had been developed and further recruitment had been planned for locum consultant posts.

Children and young people leaders told us they faced challenges with recruitment as a result of a shortage of children's nurses regionally. They mitigated risk through use of agency staff who were familiar with the service and had worked regularly with the trust.

The service had no transitional care unit but had received funding to support with transitional care. A neonatal nurse in charge allocated staff to take charge of transitional care babies.

Information Management

Staff could not always find the data they needed to make decisions and improvements. The service collected reliable data and analysed it. The information systems were integrated and secure. Data or notifications were consistently submitted to external organisations as required.

The paediatric ED used a different recording system from the paediatric wards. We reviewed medical notes and when we requested assessments carried out by staff in the ED, medical staff were unable to find these as they did not have access to the ED system. We also found 4 different recording systems which included nursing notes, medical notes, handheld devices and care flow. This posed a risk of delay in treatment. We raised this with the senior leadership team who said the digital team had undertaken some work around reducing documentation. System upgrades had been done and the testing phase was expected in January 2024. The digital team had also undertaken some work to have electronic sepsis screening, which would enable medical and nursing staff to have a clearer oversight of sepsis management.

Managers collected data that was relevant to the service for performance purposes. Information was available and accessible from email, newsletters, reports, policies, and notices in staff areas. Leaders encouraged staff to be aware of data associated with incidents, complaints, and feedback.

The information systems used by the service were secure and the trust had policies and processes for the safe and secure storage of data. This included password protected staff accounts. Staff were conscious of data security and the trust had a named Caldicott guardian if they had any queries with data and confidentiality.

Notifications were submitted to external organisations as required.

Staff attended daily handovers with their colleagues and the named nurses of patients they were due to support each day. This provided them with the information they required to meet the specific needs of each patient.

Engagement

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

Staff engaged with parents and children, this included using local schools to review their service in order to identify any areas for improvement. The trust encouraged children surveys to be completed. We saw this displayed on boards. The service used play staff with specific skills to support children while on the wards and feedback was used to improve areas within children's services.

The service had an open culture where patients, their families and staff could raise concerns. This was a significant improvement since our previous inspections. The service had created a washing line drawing on the walls where patients and their families could provide feedback by writing on a piece of paper cut out as items of clothes and placing on the washing line. We saw staff responded to this by saying what they had done in response. There was also evidence of voice of the child with direct feedback being added on. Feedback was generally positive. We reviewed feedback left and a parent stated that there had been an improvement on the ward since their last visit. They felt included and updated in the care planning for their child.

The service had a parent journal which enabled parents and guardians to have their own record of care and somewhere they could document key questions. Parents we spoke with found the journal useful.

This service had a shared decision-making council which raised money to bring children and parents' ideas to life and worked on improvement projects, such as having better parent facilities. The council members worked with parents and local charities to get extra funding.

Play specialists met monthly and planned projects for the ward. They did a lot of fundraising and had funded a sensory room. This sensory room was used for children and young people who needed a safe, quiet space, teenagers who needed to use it as a "chill out" room, as well as supporting those patients with additional needs. A special needs bed had been purchased which could be zipped up to let patients feel enclosed and safe.

The governance team undertook quality visits across the organisation. Specialists from the infection prevention and control, safeguarding and pharmacy teams supported these visits and sought patient feedback as part of the visits.

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 and participation in research.

The service achieved a gold ward accreditation for neonates and silver for skylark ward. The trust had introduced a number of improvement tools which included safety huddles 3 times a day. Staff discussed patients they were concerned about, any recent incidents and any infection prevention and control or safety concerns. This had been successful and had then been rolled out across the organisation.

A shared decision-making council which entailed a group of direct care nurses, healthcare assistants and admin team who had led on a number of improvements and innovations.

A mental health champion had led a co-created display with children and young people to promote mental health being as important as physical health. Evidence such as 'mental health is just as important as physical health; remember you are not alone' was displayed on a board.

An operational huddle had been introduced twice a day on Skylark ward in November 2023 for staff to review demand and capacity, staffing and reflect on what went well over the previous shift and what staff needed to do better.

Services for children and young people

The children and young people service had introduced an improvement board on both the neonatal unit and Skylark ward to aid with sharing of information with teams and families. Staff gathered around the board to discuss what key elements they wanted to focus on to improve. For example, on Skylark ward, figures around infection prevention and control audits, sepsis screening monthly documentation audits were displayed. On the neonatal ward, staff shared details around what went well and what did not go well.

Learning from audits on incidents was shared in the medical and nursing handover room and updated weekly. Staff discussed common themes at the Grand Round on a Friday with the whole multidisciplinary team.

Staff developed 'tops and pants' to ensure they had the voice of the child visible various areas and to share what was important to them based on their care experiences. Staff used this to implement changes to visiting times, play facilities, new TVs for the wards, dairy alternatives and reintroducing 2 hot meals a day.