The Rotherham Foundation NHS Trust

Evidence appendix

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This evidence appendix provides the supporting evidence that enabled us to come to our judgements of the quality of service provided by this trust. It is based on a combination of information provided to us by the trust, nationally available data, what we found when we inspected, and information given to us from patients, the public and other organisations. For a summary of our inspection findings, see the inspection report for this trust.

Facts and data about this trust

A list of the acute hospitals at the trust is below.

<table>
<thead>
<tr>
<th>Name of acute hospital site</th>
<th>Address</th>
</tr>
</thead>
<tbody>
<tr>
<td>The Rotherham General Hospital</td>
<td>Moorgate Road, Rotherham, S60 2UD</td>
</tr>
<tr>
<td>Rotherham Community Health Centre</td>
<td>Greasbrough Road Rotherham S60 1RY</td>
</tr>
</tbody>
</table>

(Source: Routine Provider Information Request (Acute) – Sites tab)

The Rotherham NHS Foundation Trust was awarded foundation status in 2015 and provides a wide range of health services to the people of Rotherham (population approximately 252,000).

The Trust provides the full range of services expected of a District General Hospital including Urgent and Emergency Care, Maternity, Paediatrics, Surgery, Medicine, Critical Care and Community Services for both children and adults.

The Trust employs approximately 4000 staff who predominantly work in either the main hospital site or in one of the community locations. The trust has close connections with a number of...
educational providers including Rotherham College, Sheffield Hallam University and is an Associate Teaching Hospital of the University of Sheffield.

Services are predominantly commissioned for the people of Rotherham by NHS Rotherham Clinical Commissioning Group, who also act as lead commissioner for other Clinical Commissioning Groups. There are a small number of services commissioned by NHS England.

The trust works in close partnership with Rotherham Metropolitan Borough Council, NHS Rotherham Clinical Commissioning Group and Rotherham, Doncaster and South Humber NHS Foundation Trust on developing and implementing the health element of the Rotherham Place Plan and with other health organisations across South Yorkshire and Bassetlaw as part of the Integrated Care System.

(Source: Routine Provider Information Request – Context Acute)

Rotherham Hospital has 418 general and acute beds across 23 wards; there are 23 maternity beds and 15 critical care beds. From June 2017 to May 2018, there were 94,649 attendances in the emergency department and 317,385 patients attended the outpatient department.

(Source: Hospitals Episodes Statistics; NHS England)

Background on Financial Position

Rotherham NHS Foundation Trust has a planned turnover of circa £245m in 2018/19. The trust’s financial position has deteriorated significantly over recent years. The trust had a deficit of £6.5m in 2016/17, £23m in 2017/18 and is forecasting a deficit of £20m in 2018/19. The main reasons for this deterioration are increasing premium pay costs to address some challenging workforce gaps and a loss of contract income.

The trust has declined its financial control total for 2018/19 and therefore is not eligible for provider sustainability funding. The trust will require interim revenue support of £20m in the current year to provide adequate cash flow.

The trust is under regular review from NHS Improvement (NHSI) for finance albeit it is recognised there is an improved position on the status of the trust’s cost improvement programme in 2018/19. The trust is developing a medium term financial plan aimed at improving financial sustainability over a five-year period. This has been drafted and was under review by the board at the time of the inspection in October 2018.
Is this organisation well-led?

Leadership

The trust had an experienced executive and non-executive leadership team, with good skill mix. The board had experienced a period of instability due to a variety of different circumstances. Recent changes had resulted in three interim appointments – chief nurse, medical director and director of workforce. The director of workforce retired at the end of October and the trust was in the process of exploring recruitment of a substantive post working across this and another local trust. The trust was currently in the process of recruiting a chief nurse, the previous chief nurse having left the trust to secure another role in a larger organisation. Interim medical director arrangements were in place to cover the medical director role.

There was an experienced chairman who had been in post since 2014. The non-executive posts were all filled, with the newest appointment joining the organisation in January 2018. The non-executive directors were a cohesive team with a good operational overview of the organisation, and could articulate the risks and priorities.

Of the executive board members at the trust, 0% were British Minority Ethnic (BME) and 40% were female. Of the non-executive board members 0% were BME and 38% were female. This meant that BME were under represented at board level. The trust chair was aware the board was not balanced through a lack of BME representation and was proactively trying to find solutions to bridge the gap.

<table>
<thead>
<tr>
<th>Staff group</th>
<th>BME %</th>
<th>Female %</th>
</tr>
</thead>
<tbody>
<tr>
<td>Executive directors</td>
<td>0%</td>
<td>40%</td>
</tr>
<tr>
<td>Non-executive directors</td>
<td>0%</td>
<td>38%</td>
</tr>
<tr>
<td>All board members</td>
<td>0%</td>
<td>40%</td>
</tr>
</tbody>
</table>

(Source: Routine Provider Information Request (RPIR) – Board Diversity tab)

We reviewed seven directors’ files (three non-executive and four executive) to determine whether appropriate steps had been taken to complete employment checks for executive and non-executive board members in line with the Fit and Proper Persons Requirement (FPPR) (Regulation 5 of the Health and Social Care Act (Regulated Activities) Regulations 2014). This regulation ensures that directors of NHS providers are fit and proper to carry out this important role. Providers are required to ensure that directors are fit and proper to carry out their role. This includes checks on their character, health, qualifications, skills, and experience.

Both executive and non-executive directors were subject to checks including Disclosure and Barring Service checks, references and checks that candidates are not barred from being a director. Fit and proper person checks were in place. In the employment records of the seven directors or non-executive directors we reviewed, we saw evidence of meeting the requirement.

We found that the trust’s process for FPPR was documented within the recruitment policy and met
the requirements of the regulation. Directors completed annual self-declaration forms to confirm that they complied with the regulation. These were all up to date in the files we reviewed.

There appeared to be robust arrangements for board committees and there was evidence that their roles were reviewed and refined through an annual self-assessment process. Appraisal arrangements for non-executive directors were well structured with appropriate involvement of the governors and this was used to inform skill set assessments and training needs analysis.

There was regular protected time for board development and the board was currently undertaking a well led self-assessment which was being supported with external facilitation.

The Trust was a strategically-led and managed organisation, which was focused on delivering the five-year strategy and operational plan. The Board was invested in the external environment and could demonstrate active involvement in the South Yorkshire and Bassetlaw integrated care system (ICS). Executive leaders demonstrated a good understanding of the challenges to sustainability particularly related to the acute hospital services review and the wider ICS priorities. However, the trust needed to demonstrate the priority it was placing on patient safety and patient experience across the hospital and community services.

All board members we spoke with were well sighted on the financial challenges of the trust and there was commitment to deliver on the current year financial plan. A medium term financial plan was currently being developed with clear oversight from the board aimed at delivering a sustainable financial position moving forward. Non-executive directors expressed improved confidence in financial planning and more robust arrangements for the planning and delivery of recurrent cost improvement schemes which is fully identified for the current year.

The trust recognised there was more work to do on talent management and succession planning with a focus on developing the skill set of middle management along with clinical leaders. The trust was making good progress with the roll out of a Leadership Exploration and Discovery (LEAD) programme for middle managers and was soon to commence a clinical leadership development programme, although one non-executive told us only 12 out of 40 places had been filled so far, which was less than expected.

Although the executive leadership team felt they had an ‘open door’ policy and were accessible to all staff, during our core service inspections, some staff told us there was a lack of visibility of the executive leadership team in some areas. For example, following the issues CQC identified at the unannounced inspection in July 2018 in the paediatric emergency department, although executives did attend the unit, some staff reported that they had not seen them regularly. One executive we spoke with acknowledged their own lack of visibility and told us they had a plan to ‘get out’ into the organisation once a month.

Executive and non-executive directors participated in regular board assurance visits, however these were pre-planned. Although senior leaders told us they had received positive feedback from clinical directors in relation to the planned visits, executive directors acknowledged the benefits of visiting wards and departments more frequently and unannounced.

There was a lack of clarity about the approach to workforce planning, in particular, the new emergency department where CQC identified concerns relating to paediatric staffing and the impact this had on patient safety. Although workforce was a work-stream at a monthly programme board, workforce plans had underestimated the impact of changes and had not fully considered the reality of changing to new model of working.
Vision and strategy

The trust had a five-year strategy (2017-2022) which focused on five strategic themes and three core values which had resonance with trust staff. There was good consistency and linkage with the trust’s operational plan which set more specific objectives for the current year. The trust reported it had strengthened operational and financial planning arrangements because of adverse financial performance in the previous year. This included a robust process for tracking the delivery of the operational plan through the trust’s performance management arrangements.

The trust had undertaken a refresh of its strategy linked to the priorities of the wider health economy in South Yorkshire and Bassetlaw and the local health needs within Rotherham. The strategy had been developed with the engagement of the board and the clinical and senior management team within the divisions.

The Rotherham Integrated Health and Social Care Place Plan set out a local vision for the integration of health and social care services. The Plan had been jointly produced by health and social care partners from across Rotherham and demonstrated the commitment across partners in Rotherham to partnership working and to improve the access, quality, affordability and sustainability of services for the population served. The Trust’s strategic plans were aligned with this plan.

Whilst the trust had been actively engaged in the wider health economy acute hospitals services review, this had yet to be concluded. It had generated some uncertainty for clinical services within the trust and had destabilised the consultant workforce in some specialities. The trust was working with health economy stakeholders to secure the necessary clarity on the future clinical service portfolio.

Although there were some supporting enabling strategies, the executive team recognised that more work was required on these to ensure they had targeted delivery plans to address the workforce and clinical service challenges faced by the trust. The trust also lacked some key strategies to support the implementation of its vision, such as patient experience and equality and diversity.

Board members could articulate the reasons for the trust’s underlying financial deficit and this was being fed into the medium term financial strategy aimed at achieving a more sustainable position. This was under development at the time of the inspection.

Cost improvement planning had been strengthened including additional resource within the programme management function. The trust reported they were making good use of benchmarking tools in formulating the efficiency programme including model hospital and “Getting It Right First Time” (GIRFT). These were positive changes and improvement was evident in the well-developed efficiency programme for the current year, confidence in its delivery and a pipeline of initiatives going forward.

All board members articulated the importance of finance and the commitment to deliver on the financial plan, but the overriding priority was patient safety. It was evident that there has been financial improvement and there was a need to further improve quality and safety culture, which is not yet sufficiently embedded across the organisation.

Culture

The culture of the organisation was reported as improving from a low base. The board recognised that changes within the executive team, implementation of the trust’s improvement programme coupled with the acute hospitals clinical services review had generated some element of staff
uncertainty and discontent. However, the board were clear that their priority was openness and transparency, and this was the culture they are working hard to embed within the trust.

Staff told us they did not always feel listened to by their immediate manager or clinical lead. We found evidence of inaction or slow responses from managers when serious concerns had been highlighted. We identified a disconnect between middle managers and executive leaders, who acknowledged they had not been aware of the attempts made by frontline staff to escalate concerns about paediatric nurse staffing and the care of non-invasive ventilation (NIV) patients on medical wards.

The trust had 12 ambassadors to support “freedom to speak up” activity. The was an acting freedom to speak up guardian who was proactive and had lots of ideas for improvement and development, including better engagement with staff.

We reviewed the annual freedom to speak up annual report, presented to the board in May 2018. A total of 17 concerns were raised by staff through this mechanism in 2017/18, one of which included the care and safety of NIV patients. This demonstrated the trust did not always take immediate or timely action in response to staff concerns about patient safety.

The trust had updated its Whistleblowing policy to ensure staff members raising concerns were protected and supported and to prevent any discrimination consequently. The trust had included a new module, ‘raising concerns and whistleblowing’, as part of its programme of mandatory training and an additional ‘managing concerns’ training was in the process of being rolled out across the organisation. However, compliance against the 86% target for ‘raising concerns and whistleblowing’ training was low across all core services.

There was a health and well-being programme in place which included opportunities for staff to participate in fitness activities and the trust had recently launched an employee assistance scheme.

Resources to support equality and diversity arrangements were less well developed. This weakness was recognised by the trust and further work was planned in this area. However, there was no evidence to support how the trust was working to improve the culture amongst the British Minority Ethnic (BME) workforce and other minority staff groups within the organisation.

The trust provided the following breakdowns of medical and dental and nursing and midwifery staff by Ethnic group.

<table>
<thead>
<tr>
<th>Ethnic group</th>
<th>Overall (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>White</td>
<td>31.7%</td>
</tr>
<tr>
<td>Mixed</td>
<td>0.4%</td>
</tr>
<tr>
<td>Asian</td>
<td>2.6%</td>
</tr>
<tr>
<td>Black</td>
<td>0.9%</td>
</tr>
<tr>
<td>Chinese</td>
<td>0.1%</td>
</tr>
<tr>
<td>Other</td>
<td>0.5%</td>
</tr>
<tr>
<td>Unknown / Not Stated</td>
<td>0.4%</td>
</tr>
</tbody>
</table>

(Source: Routine Provider Information Request (RPIR) – Diversity tab)

The trust had no equality and diversity (E&D) strategy. The interim director of workforce was the executive lead however, there was no dedicated operational E&D lead and no regular E&D steering group meetings to evidence clear actions or outcomes. Staff gave examples demonstrating a weak culture in respect of equality and diversity across the whole organisation. This included inconsistency in support from managers for staff with disabilities and no
understanding about reasonable adjustments. We found the organisation did not see E&D as a priority and as a result staff did not feel valued and felt their concerns are not being followed up.

In respect of equality impact assessment, the trust had a process to impact assess all policies which were reviewed by relevant human resources business partners.

The trust held the annual Proud awards to recognise the achievements of staff across the organisation. Following feedback from staff, the trust recognised the importance of celebrating achievement and recognition throughout the year and had introduced a ‘Star Card’, plus ‘You’re a Star’ award and ‘Shining Star’ award, which was presented to a member of staff every quarter.

NHS Staff Survey 2017 – results better than average of acute trusts

The trust has eight key findings that exceeded the average for similar trusts in the 2017 NHS Staff Survey:

<table>
<thead>
<tr>
<th>Key Finding</th>
<th>Trust Score</th>
<th>National Average</th>
</tr>
</thead>
<tbody>
<tr>
<td>KF11 Percentage of staff appraised in last 12 months</td>
<td>94%</td>
<td>86%</td>
</tr>
<tr>
<td>KF20 Percentage of staff experiencing discrimination at work in the last 12 months</td>
<td>8%</td>
<td>10%</td>
</tr>
<tr>
<td>KF28 Percentage of staff witnessing potentially harmful errors, near misses or incidents in last month</td>
<td>25%</td>
<td>29%</td>
</tr>
<tr>
<td>KF16 Percentage of staff working extra hours</td>
<td>65%</td>
<td>71%</td>
</tr>
<tr>
<td>KF22 Percentage of staff experiencing physical violence from patients, relatives or the public in last 12 months</td>
<td>12%</td>
<td>14%</td>
</tr>
<tr>
<td>KF25 Percentage of staff experiencing harassment, bullying or abuse from patients, relatives or the public in last 12 months</td>
<td>23%</td>
<td>27%</td>
</tr>
<tr>
<td>KF26 Percentage of staff experiencing harassment, bullying or abuse from staff in last 12 months</td>
<td>22%</td>
<td>24%</td>
</tr>
<tr>
<td>KF27 Percentage of staff / colleagues reporting most recent experience of harassment, bullying or abuse</td>
<td>49%</td>
<td>47%</td>
</tr>
</tbody>
</table>

NHS Staff Survey 2017 – results worse than average of acute trusts

The trust has 19 key findings worse than the average for similar trusts in the 2017 NHS Staff Survey:

<table>
<thead>
<tr>
<th>Key Finding</th>
<th>Trust Score</th>
<th>National Average</th>
</tr>
</thead>
<tbody>
<tr>
<td>KF12 Quality of appraisals</td>
<td>2.90</td>
<td>3.11</td>
</tr>
<tr>
<td>KF13 Quality of non-mandatory training, learning or development</td>
<td>4.00</td>
<td>4.06</td>
</tr>
<tr>
<td>KF29 Percentage of staff reporting errors, near misses or incidents witnessed in the last month</td>
<td>87%</td>
<td>91%</td>
</tr>
<tr>
<td>KF30 Fairness and effectiveness of procedures for reporting errors, near misses and incidents</td>
<td>3.62</td>
<td>3.73</td>
</tr>
<tr>
<td>KF31 Staff confidence and security in reporting unsafe clinical practice</td>
<td>3.57</td>
<td>3.67</td>
</tr>
<tr>
<td>KF18 Percentage of staff attending work in the last 3 months despite feeling unwell because they felt pressure from their manager, colleagues or themselves</td>
<td>57%</td>
<td>53%</td>
</tr>
<tr>
<td>KF15 Percentage of staff satisfied with the opportunities for flexible working patterns</td>
<td>49%</td>
<td>51%</td>
</tr>
<tr>
<td>Key Finding</td>
<td>Trust Score</td>
<td>National Average</td>
</tr>
<tr>
<td>----------------------------------------------------------------------------</td>
<td>-------------</td>
<td>------------------</td>
</tr>
<tr>
<td>KF1 Staff recommendation of the organisation as a place to work or receive treatment</td>
<td>3.43</td>
<td>3.75</td>
</tr>
<tr>
<td>KF4 Staff motivation at work</td>
<td>3.80</td>
<td>3.91</td>
</tr>
<tr>
<td>KF7 Percentage of staff able to contribute towards improvements at work</td>
<td>64%</td>
<td>70%</td>
</tr>
<tr>
<td>KF8 Staff satisfaction with level of responsibility and involvement</td>
<td>3.83</td>
<td>3.89</td>
</tr>
<tr>
<td>KF9 Effective team working</td>
<td>3.65</td>
<td>3.74</td>
</tr>
<tr>
<td>KF14 Staff satisfaction with resourcing and support</td>
<td>3.19</td>
<td>3.27</td>
</tr>
<tr>
<td>KF5 Recognition and value of staff by managers and the organisation</td>
<td>3.32</td>
<td>3.44</td>
</tr>
<tr>
<td>KF6 Percentage of staff reporting good communication between senior management and staff</td>
<td>24%</td>
<td>33%</td>
</tr>
<tr>
<td>KF10 Support from immediate managers</td>
<td>3.71</td>
<td>3.76</td>
</tr>
<tr>
<td>KF2 Staff satisfaction with the quality of work and care they are able to deliver</td>
<td>3.77</td>
<td>3.90</td>
</tr>
<tr>
<td>KF3 Percentage of staff agreeing that their role makes a difference to patients/service users</td>
<td>86%</td>
<td>90%</td>
</tr>
<tr>
<td>KF32 Effective use of patient / service user feedback</td>
<td>3.62</td>
<td>3.69</td>
</tr>
</tbody>
</table>

(Source: NHS Staff Survey 2017)

Executive and non-executive directors acknowledged the need to further improve communication across the organisation although some felt there were some robust mechanisms in place, such as the monthly team brief. Executive leaders held face-to-face sessions with staff to deliver the brief in the hospital and in the community, and there was an expectation that team brief was disseminated to all teams in the trust.

**Workforce race equality standard**

The scores presented below are the un-weighted question level score for question Q17b and un-weighted scores for Key Findings 25, 26, and 21, split between White and Black and Minority Ethnic (BME) staff, as required for the Workforce Race Equality Standard.

Note that for question 17b, the percentage featured is that of “Yes” responses to the question. Key Finding and question numbers have changed since 2014.

In order to preserve the anonymity of individual staff, a score is replaced with a dash if the staff group in question contributed fewer than 11 responses to that score.
Of the four questions above, the following questions showed a statistically significant difference in score between White and BME staff:

- KF21. Percentage of staff believing that the trust provides equal opportunities for career progression or promotion
- Q17b. In the last 12 months have you personally experienced discrimination at work from a manager/team leader or other colleagues?

(Source: NHS Staff Survey 2017)

When we asked the trust about the concerns, we found there were no clear actions about how improvements would be made.
Friends and Family test

The Friends and Family Test was launched in April 2013. It asks people who use services whether they would recommend the services they have used, giving the opportunity to feedback on their experiences of care and treatment.

The trust scored above the England average for recommending the trust as a place to receive care for most of the time period from August 2017 to July 2018.

(Source: Friends and Family Test)
Sickness absence rates

The trust’s sickness absence levels from March 2017 to February 2018 fluctuated slightly but overall performance was similar to the England average.

(Source: NHS Digital)

General Medical Council – National Training Scheme Survey 2017

In the 2017 General Medical Council Survey the trust performed the same as expected for all of the indicators.

(Source: General Medical Council National Training Scheme Survey)
Governance

There was generally good clarity on the coverage of executive director portfolios albeit the changes in nursing and medical leadership has led to some instability in clinical governance processes. Clinical governance was less well embedded than the arrangements for operational and financial performance. The responsibility for clinical governance and risk sat with the chief nurse whilst the lead for corporate governance sat with the director for corporate affairs/company secretary. The Trust told us of the plan to review this so quality governance and clinical governance would be managed jointly by the chief nurse and medical director.

There was a triumvirate management model within each of the four clinical divisions reporting to the chief operating officer. The model also included human resources and finance business partners. The trust was in the process of supporting those teams with appropriate leadership development training.

Arrangements for board committees were well established and there was an annual process for reviewing the remit of these committees, however, it was not clear how well the committees worked collaboratively to address key concerns, as neither the quality assurance committee or strategic workforce committee had taken ownership of safe staffing across the trust. Through discussions with executive and non-executive directors, it became evident that there was a lot of trust between all board members and a shared commitment to becoming a high performing board, as demonstrated through the trust’s board development programme. The emphasis on ensuring assurance rather than reassurance on key issues was recognised as important.

The cross cover in non-executive membership of the quality, finance and audit committees had been well catered for. Whilst there was a process for the committees to report to the board this was generally through the minutes of the committees and we found these were not fully reviewed. The board should consider whether a regular update report from the committees would provide a more responsive mechanism of reporting.

The finance and performance committee was reported as functioning effectively, and had a structured work plan and arrangements for gaining assurance on operational and financial performance. There was greater confidence in the self-sufficiency of the divisional teams in managing their respective performance agendas and this had been tested by the committee.

There was less assurance in terms of quality and safety governance arrangements. This was evident upon our review of processes around the management and escalation of serious incidents, mortality reviews and complaints. The initial report following a serious incident was brief. Reports did not reflect any immediate learning or actions, and was a repeat of the original Datix entry. We found there were delays in reporting incidents. For example, between April and October 2018, only 14% of all incidents were reported within 14 days while 26% were not reported until 90 days (or more) following the actual event.

The trust had commissioned an externally facilitated review of quality governance. The final report was published in April 2018 and an action plan was developed in response to the findings.

Arrangements for budget setting had been improved and there was a process for budget holder sign off. It was reported that budgets were set on a realistic basis and this included allowing for a realistic level of agency costs given the clinical workforce gaps in some specialities.

Cost improvement planning had been strengthened through use of benchmarking tools and additional senior management capability to manage programme delivery. The cost improvement
plan had been substantially identified for the current year, the majority were recurrent schemes and the trust was already developing schemes on a go forward basis. This was a strong position.

There was a risk-based approach to setting the annual internal audit plan and sound arrangements for tracking the implementation of internal audit recommendations. It was reported that the trust had an effective internal audit function which added value in the organisation. Both the internal and external audit arrangements had been refreshed in the last couple of years.

The board assurance framework was operationally managed by the trust’s head of governance who met with the executives to review the corporate risks.

The board assurance framework was coherent and subject to quarterly review by the board. Strategic risks were aligned to the appropriate board committee for more regular scrutiny with recommendations for change reported to the board for their consideration.

Management of risk, issues and performance

The process for escalating and de-escalating risk within the organisation had been subject to review under the leadership of the chief nurse. The review focused on streamlining operational risk management processes. The trust acknowledged this was work in progress and had yet to be fully embedded.

The trust held monthly performance reviews, chaired by the chief executive and which cover all domains of quality, governance, workforce, operational and financial outcomes, and were referenced within a performance management framework. There were also monthly finance and operational oversight meetings with the divisions, co-chaired by the director of finance and chief operating officer. The arrangements for this meeting seemed robust as evidenced in the generally good operational and financial performance against plan.

Non-executive directors told us the board was regularly sighted on all risks rated 16 or above, however the board had not been sighted on the significant patient safety concerns in the paediatric emergency department or the care of non-invasive ventilation (NIV) patients. There was an acknowledgement across the executive and non-executive directors that escalation processes were not as robust as they could be, and that middle-managers attempted to deal with issues directly without escalating appropriately to the executive leadership team.

The executive team were aware of the risks and priorities of the organisation. Finance and performance was identified by executive and non-executive directors, however, quality and safety priorities needed to be further emphasised throughout the Trust.

The executive team also cited nurse staffing as a risk, and there were 77 whole time equivalent (WTE) vacancies. In recent years, the trust recruited around 100 nurses following an overseas recruitment campaign, however there were no plans to revisit this. Medical staffing had a 25% vacancy rate and the trust had successfully recruited 14 middle grade doctors from overseas.

Within the five-year workforce plan (2017-2022), the trust acknowledged the current challenges in relation to nurse and medical staffing, and identified some new ways of working. This included advanced nurse practitioners (ANP), however the lack of an advanced practice strategy had led to a disjointed introduction of the role across services within the organisation. For example, although senior leaders told us they planned to be strategic in terms of where staff were deployed, we found there were ANPs in surgery and in the ambulatory care unit, but none in the intensive care unit (ICU), which continued to maintain an ICU outreach service.
The plan also reported that 'in order to provide a safe pharmacy service, the Trust will need to increase the number of pharmacists that it employs'. Pharmacy staffing to establishment was achieved in March 2018. However, we found that staffing levels remained such that some wards did not receive a regular clinical pharmacy service, this was compounded by annual leave or sickness absence.

The Carter Review (Operational productivity and performance in English NHS acute hospitals: Unwarranted variations, February 2016) recommended that hospitals increased the number of pharmacist prescribers. However, only one of the eight pharmacist prescribers regularly used their qualification. Capacity was cited as limiting the ability of pharmacy to develop new and extended roles. Additionally, due to lack of capacity pharmacist support was not being provided to the antimicrobial ward rounds. The weekend pharmacy service operated on a rota basis and was described by pharmacy staff as 'skeletal'.

In March 2018 the Medicines Safety Group escalated concerns that their review of medicines incidents was indicative of 'a lack of general knowledge about medicines and processes'. More recently, the engagement of senior nursing staff to provide ward level leadership with regard to medicines omissions and the quality of medicines incident reporting and responses by medical staff was also raised at the Patient Safety Group and Clinical Governance Committee (September 2018). Additionally, administration or supply of a medicine from a clinical area was the third highest reported patient safety incidents within the division of integrated medicine (Q1 2018/19).

Patient harm through non-adherence to medicines standards, policies, processes and guidance was added to the pharmacy and medicines management risk register in August 2018 with an initial and current risk rating of 15 (significant).

The chief nurse and medical director chaired a weekly ‘harm free care’ meeting in which key safety issues were discussed to allow escalation and action as required.

There was an established process in place to ensure that all incidents identified as causing moderate or greater harm were reviewed by the patient safety team and where necessary, discussed at the weekly serious incident panel. However, evidence showed not all incidents were reviewed or escalated appropriately, particularly those raised by staff in relation to staffing and care of deteriorating patients. The deteriorating patient was one of the trust’s quality priorities for 2018/19 and was identified on three occasions by the trust’s mortality review group. A learning from deaths report identified a theme of failure to recognise deterioration in patients but there were no recorded actions.

The trust was active in the learning disabilities mortality review (LeDeR) approach to reviewing deaths. They followed recommendations from the ‘MAZAR’ independent report. This meant they reviewed and challenged practice especially when a death of a person was unexpected to ensure lessons were learned and good practice shared between relevant organisations. There were three assessors within the trust, one of whom was the lead nurse for learning disabilities.

Although the trust aimed to review all mortality cases by using the case record review, this was not currently practice due to the significant resource issue attached to this, particularly in the division of integrated medicine. The division prioritised serious incidents and inquests for review. The
interim medical director spoke of plans to review the process to ensure the mortality review backlog was reduced and the process managed appropriately going forward.

**Finances Overview**

<table>
<thead>
<tr>
<th>Financial metrics</th>
<th>Historical data</th>
<th>Projections</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Previous Financial Year</td>
<td>Last Financial Year</td>
</tr>
<tr>
<td>Income</td>
<td>£248m</td>
<td>£242m</td>
</tr>
<tr>
<td>Surplus (deficit)</td>
<td>(£6.5m)</td>
<td>(£26m)</td>
</tr>
<tr>
<td>Full Costs</td>
<td>£255m</td>
<td>£268m</td>
</tr>
<tr>
<td>Budget (or budget deficit)</td>
<td>(£6.6m)</td>
<td>(£18.6m)</td>
</tr>
</tbody>
</table>

(Source: Routine Provider Information Request (RPIR) – Finances Overview tab)

The deterioration in the trust’s financial performance over the last few years was a concern. However, the board had a good understanding of the underlying deficit and were working on a medium term financial plan which addressed the deficit position going forward. A draft of the plan was undergoing board review. There were positive indications that the financial position had stabilised and there was good traction on the development of recurrent cost improvement plans.

The trust has strengthened the programme management office in respect of cost improvement delivery reporting to the finance director. There is oversight from the executive team and the medical director and chief nurse are involved in quality impact assessments of cost improvement programmes.

**Safeguarding overview**

The chief nurse was the safeguarding lead at board level and sat on the local safeguarding boards. The trust had an integrated adults and children safeguarding team which comprised of 12 members of staff, including the lead nurse for learning disabilities and a specialist nurse for child sexual exploitation (CSE).

A ‘safeguarding vulnerable people’ policy, issued in May 2016 and due for review in February 2019, was in place for adults and children. The policy identified clear lines of responsibility and accountability for safeguarding, as well as the trust’s processes and procedures and pathways.

Safeguarding training compliance was included a monthly integrated performance report which was reviewed at by the strategic safeguarding group and from there to the Board. Managers received information every month through dashboard. It was reported current safeguarding training compliance overall was 87.2%. The Board had also received safeguarding training in August 2018.

However, we found the level three safeguarding children training did not meet the intercollegiate guidance for training. The intercollegiate guidance states staff should receive multi-disciplinary and inter-agency training, delivered internally and externally. It should include personal reflection and scenario-based discussion, drawing on case studies, serious case reviews, lessons from research and audit, as well as communicating with children about what is happening. However, the level 3
safeguarding children’s training was reported to be online. Following discussion with the safeguarding lead it was reported modules such as female genital mutilation, CSE and Prevent were aligned with the intercollegiate recommendations however staff we spoke with during the core service inspection told us they had minimal opportunity to engage in interactive safeguarding training and that multi-disciplinary and inter-agency training was optional.

Staff were aware how and when to make referrals to social care. However, referrals were not copied to the safeguarding team and the quality of those referrals was poor in some services. This meant that there was no oversight of referrals made and there was no quality assurance process or a mechanism for regular audit. Referrals were not routinely attached to children’s records, we heard inconsistencies in staff knowledge as to whether they could save or how to save and attach a copy of the referral. This meant the patient’s record was incomplete.

**Information management**

There was a comprehensive integrated performance report provided to the board which covered key metrics for quality, safety, workforce and operational performance with trend analysis. In addition, there were a range of performance dashboards providing more granular information at a divisional level and these were well regarded in supporting responsive performance management.

The trust had experienced some problems historically with the implementation of an electronic patient record system. However, these problems had been substantially addressed and the trust was now making good progress with its digital agenda. There was robust governance around IT programmes including good clinical engagement.

We saw good examples of technology in use across the trust. For example, the trust had implemented electronic observations. There was a ‘code red’ alert for surgical patients scoring highly on MEWS (modified early warning system) which alerted the cardiac arrest team.

The trust used a third party assured kite marking system of data quality and were compliant with information governance requirements.

The finance report to the board provided summary level financial information on key headings. However, there was a much more detailed report considered by the finance and performance committee which provided comprehensive coverage of income and expenditure including divisional analysis, variance analysis, balance sheet, cash flow, capital expenditure and a risk assessed forecast outturn. This was a strong suite of financial information with a focus on managing risk to the financial position.

The trust was at an early stage of implementing service level reporting and was planning to make greater use of clinical service line profitability analysis in future cost improvement planning.

An ePMA [Electronic Prescribing and Medicines Administration] Project Board had been set up and the trust had successfully secured funding from NHSI for the roll out of ePMA. The project had been scoped and the trust was in a position recruit to a Project Implementation Team.

**Engagement**

The trust had a strong external focus and worked collaboratively with partners within the wider integrated care system and the local delivery system in Rotherham. Executive directors, senior clinicians and managers participated in the work streams associated with those stakeholder programmes. However, whilst working across the wider integrated care system had allowed for and facilitated communication internally and with the public, it is important that this is not to the
detriment of internal engagement. Executive directors recognised there was more work to be done to ensure that this was done regularly, in a structured way and encompassing more groups and individuals.

Through discussions with executive and non-executive directors, there was a sense that engagement with staff was a priority and there were examples of engagement which were both effective and positive. Front line staff also reflected the need for improved engagement.

One executive director acknowledged that staff engagement was an area for improvement and told us managers and staff within the divisions were working to address this through post-staff survey action plans. In the 2017 NHS Staff Survey, only 24% of staff reported good communication between senior management and staff. One of the senior managers told us pulse check surveys were not routine therefore, it was unclear how the trust assured itself in terms of its progress throughout the year.

Frontline staff did not speak positively about the quality of the trust appraisal. In the 2017 NHS Staff Survey, 94% reported they had received an appraisal within the last 12 months. However, only 15% stated it had helped them improve how they did their job, while 24% reported the review left them feeling their work was valued. This was worse than the national average.

Some frontline staff did not feel the trust proactively engaged with them about service improvement and development. For example, although the trust had held a series of workshops with staff groups and key stakeholders as part of a programme of engagement and workforce planning related to the new urgent and emergency care centre, staff from the unit did not always feel involved in decisions about the future of the department. In the NHS Staff Survey 2017, only 25% of staff reported that senior managers tried to involve staff in important decisions.

However, we saw evidence demonstrating where good engagement had been practiced such as the multi-disciplinary team approach applied by the trauma and orthopaedic team for day surgery knee replacements. The initiative included ward staff, therapy services, anaesthetists, surgeons and theatre staff.

There was limited evidence of public and patient engagement. An assistant chief nurse was the trust lead for patient experience and chaired the patient experience group (PEG). The PEG also included the complaints manager, and representatives from sub-groups such as learning disabilities, end of life care and catering, plus Healthwatch. The PEG did not include any patients or governors.

Although the trust had a ‘strategy on a page’ for patient experience, examples of patient engagement were very low level, such as stalls at the hospital main entrance to promote health initiatives.

There was a well-established council of governors and a good fill rate on most membership positions except for staff governors. The trust was in the process of amending its constitution to enable staff governor roles to be more flexible. A small number of governors were nominated to attend board committees in an observer capacity. This had proved to be a useful mechanism to enable governors to discharge their responsibility for holding the non-executive directors to account.
There was a strong tradition of volunteers within the trust and this was a positive reflection of community engagement.

**Learning, continuous improvement and innovation**

The trust used a range of quality improvement tools and recognised it was on a journey of quality improvement, although the trust did not have a specific quality improvement strategy.

The trust cited a range of clinical pathways they were proud of coupled with the resilience and adaptability of their staff in responding to staffing pressures.

The trust had trained over 90 staff in a quality improvement methodology although this was at an early stage of being adopted and implemented at service level. Executive directors told us they were committed to rolling out this programme.

The finance directorate had good engagement in staff development activities. The procurement team had been awarded level 2 accreditation, which indicates a high performing team. There was also an established track record in hosting trainees under the NHS graduate finance training programme and the finance director had an established professional network.

Services and staff across the trust had achieved national recognition for their work. For example, the in-house clinical IT system had won a national award and been invited to showcase the system at national events and conferences.

The lead specialist nurse for acute pain relief was recognised nationally for the work they had done in the trust to introduce Acupin therapy. This therapy reduces post-operative nausea and vomiting, following surgery, particularly those having hysterectomies or knee and hip replacements, and also women experiencing nausea and vomiting in pregnancy.

The tissue viability team were highlighted for their approach to collaborative working in improving the service they deliver to patients. They were highly commended in the annual PrescQIPP Awards in the Service Redesign category; changes to the service in recent years have contributed to a decrease in infection rates, less wastage of wound care products, and an overall improved patient experience.

The trust, led by the estates team, had been awarded The Royal Society for the Prevention of Accidents (RoSPA) gold medal award for health and safety across the trust. The trust could demonstrate evidence of a good health and safety management system against 18 performance questions.

The Care Co-Ordination Centre team had been instrumental in working with partners to refer patients to community beds within two Rotherham care homes. This had led to easing pressure within the hospital and providing patients with a skilled team to look after them while they recuperated and awaited care services in the community. The team had recently been shortlisted in the 2018 Nursing Times Awards ‘Enhancing Dignity in Care’ category.

The trust planned to open a new bespoke surgical assessment unit, located next to the urgency and emergency care centre, at the beginning of 2019. This will improve the way non-elective care is delivered to patients in general surgery and urology, and included a new surgical assessment facility and 12 bedded surgical short stay unit.
The trauma and orthopaedic unit had commenced a day surgery knee replacement trial, recognising that the home environment was better recovery for patients and avoided the need for an overnight stay. Within the trial period, 15 procedures were carried out and a full audit was presented at a national conference.

The trust held an inaugural annual innovation week in 2017 to give staff the opportunity to hear about innovative and transformative work that was taking place across the organisation. It also gave staff the opportunity to share their own ideas for innovation and how the trust could improve efficiency and effectiveness.

**Complaints process overview**

The trust was asked to comment on their targets for responding to complaints and current performance against these targets for the last 12 months.

<table>
<thead>
<tr>
<th>Question</th>
<th>In days</th>
<th>Target percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>What is your internal target for responding to complaints?</td>
<td>3</td>
<td>100%</td>
</tr>
<tr>
<td>What is your target for completing a complaint</td>
<td>30</td>
<td>95%</td>
</tr>
<tr>
<td>If you have a slightly longer target for complex complaints please indicate what that is here</td>
<td>40-60</td>
<td>95%</td>
</tr>
<tr>
<td>Number of complaints resolved without formal process in the last 12 months?</td>
<td>1034</td>
<td>June 2017 – May 2018</td>
</tr>
</tbody>
</table>

*(Source: Routine Provider Information Request (RPIR) – Complaints Process Overview tab)*

**Number of complaints made to the trust**

The trust received 238 complaints from June 2017 to May 2018. Medical care received the most complaints with 57.

<table>
<thead>
<tr>
<th>Core Service</th>
<th>Complaints</th>
<th>% of total</th>
</tr>
</thead>
<tbody>
<tr>
<td>AC - Medical Care (including older peoples care)</td>
<td>57</td>
<td>24%</td>
</tr>
<tr>
<td>AC - Surgery</td>
<td>53</td>
<td>22%</td>
</tr>
<tr>
<td>AC - Urgent and Emergency Services</td>
<td>47</td>
<td>20%</td>
</tr>
<tr>
<td>AC - Outpatients</td>
<td>41</td>
<td>17%</td>
</tr>
<tr>
<td>AC - Maternity</td>
<td>14</td>
<td>6%</td>
</tr>
<tr>
<td>AC - Diagnostics</td>
<td>8</td>
<td>3%</td>
</tr>
<tr>
<td>AC - Gynaecology</td>
<td>8</td>
<td>3%</td>
</tr>
<tr>
<td>AC - Services for Children and Young People</td>
<td>5</td>
<td>2%</td>
</tr>
<tr>
<td>AC - Adults/Community</td>
<td>2</td>
<td>1%</td>
</tr>
<tr>
<td>AC - Critical Care</td>
<td>2</td>
<td>1%</td>
</tr>
<tr>
<td>AC - Other</td>
<td>1</td>
<td>&gt;1%</td>
</tr>
</tbody>
</table>

*(Source: Routine Provider Information Request (RPIR) – Complaints tab)*
We reviewed six complaint files during the inspection. In four of the six complaints, the trust’s response was outside of the target. We found there was no clear investigation trail and no narrative with the expectations from the complainant. There was also inconsistency in offering meetings with the complainant.

Compliments
The trust reported a total of 1,427 compliments between June 2017 to May 2018. The trust has broken down the number of compliments by core service:

<table>
<thead>
<tr>
<th>Core Service</th>
<th>Number of Compliments</th>
</tr>
</thead>
<tbody>
<tr>
<td>AC - Medical care (including older people's care)</td>
<td>1,149</td>
</tr>
<tr>
<td>AC - Gynaecology</td>
<td>118</td>
</tr>
<tr>
<td>AC - Surgery</td>
<td>102</td>
</tr>
<tr>
<td>AC - Maternity</td>
<td>22</td>
</tr>
<tr>
<td>AC - Urgent and emergency services</td>
<td>18</td>
</tr>
<tr>
<td>AC - Diagnostics</td>
<td>13</td>
</tr>
<tr>
<td>AC - Outpatients</td>
<td>4</td>
</tr>
<tr>
<td>AC - Services for children and young people</td>
<td>1</td>
</tr>
</tbody>
</table>

(Source: Routine Provider Information Request (RPIR) – Compliments)

Accreditations
NHS trusts are able to participate in a number of accreditation schemes whereby the services they provide are reviewed and a decision is made whether or not to award the service with an accreditation. A service will be accredited if they are able to demonstrate that they meet a certain standard of best practice in the given area. An accreditation usually carries an end date (or review date) whereby the service will need to be re-assessed in order to continue to be accredited.

The table below shows which of the trust’s services have been awarded an accreditation.

<table>
<thead>
<tr>
<th>Accreditation scheme name</th>
<th>Service accredited</th>
</tr>
</thead>
<tbody>
<tr>
<td>Joint Advisory Group on Endoscopy (JAG)</td>
<td>Endoscopy , Accredited October 2015</td>
</tr>
<tr>
<td>Clinical Pathology Accreditation and it's successor Medical Laboratories ISO 15189</td>
<td>Laboratory Medicine accredited to Clinical Pathology Accreditation following inspection by UKAS in July</td>
</tr>
</tbody>
</table>

(Source: Routine Provider Information Request (RPIR) – Accreditations tab).
Acute services

Urgent and emergency care

Facts and data about this service

The Urgent and Emergency Care Centre (UECC) serves a population of around 250,000. It is a co-located, integrated service for patients that provides primary care services and type 1 emergency care. It cares for people with a variety of conditions ranging between injury, minor illness and urgent care. The leadership team also manages the GP out of hours service for the community of Rotherham. A full range of services are provided including paediatrics, trauma and orthopaedics, stroke, acute medicine, obstetrics and gynaecology, surgery, specialist surgery (maxilo facial, ent, ophthalmology). The trust works in collaboration with Mental Health colleagues at Rotherham, Doncaster and South Humber NHS Foundation Trust to ensure that patients with mental illness are assessed and an appropriate plan of care is put in place.

(Source: Routine Provider Information Request (RPIR))

Activity and patient throughput

Total number of urgent and emergency care attendances at The Rotherham NHS Foundation Trust compared to all acute trusts in England, July 2017 to June 2018

From July 2017 to June 2018 there were 94,649 attendances at the trust’s urgent and emergency care services as indicated in the chart above.

(Source: NHS England)
Urgent and emergency care attendances resulting in an admission

The percentage of A&E attendances at this trust that resulted in an admission decreased in 2017/18 compared to 2016/17. In 2016/17, the proportions were higher than the England averages.

(Source: NHS England)

Urgent and emergency care attendances by disposal method, from June 2017 to May 2018

- Admitted to hospital: 4,782
- Discharged*: 58,318
- Referred*: 4,900
- Transferred to other provider: 1,403
- Died in department: 91
- Left department#: 5,990
- Not known: 19,161

* Discharged includes: no follow-up needed and follow-up treatment by GP
^ Referred includes: to A&E clinic, fracture clinic, other OP, other professional
# Left department includes: left before treatment or having refused treatment

(Source: Hospital Episode Statistics)
Is the service safe?

By safe, we mean people are protected from abuse* and avoidable harm.

*Abuse can be physical, sexual, mental or psychological, financial, neglect, institutional or discriminatory abuse.

Mandatory Training

Mandatory training completion rates

The trust set a target of 85% for completion of mandatory training.

Trust level

A breakdown of compliance for mandatory training courses from April 2017 to May 2018 at trust level for qualified nursing staff in urgent and emergency care is shown below:

<table>
<thead>
<tr>
<th>Training Course</th>
<th>Number of eligible staff</th>
<th>Number of staff trained</th>
<th>Percentage Completed</th>
<th>Trust target (85%) met?</th>
</tr>
</thead>
<tbody>
<tr>
<td>Dementia Awareness (inc Privacy &amp; Dignity standards)</td>
<td>70</td>
<td>66</td>
<td>94%</td>
<td>Yes</td>
</tr>
<tr>
<td>Infection Prevention (Level 1)</td>
<td>70</td>
<td>65</td>
<td>93%</td>
<td>Yes</td>
</tr>
<tr>
<td>Conflict Resolution</td>
<td>70</td>
<td>57</td>
<td>81%</td>
<td>No</td>
</tr>
<tr>
<td>Information Governance</td>
<td>70</td>
<td>54</td>
<td>77%</td>
<td>No*</td>
</tr>
<tr>
<td>Preventing Radicalisation (Levels 1 and 2)</td>
<td>70</td>
<td>51</td>
<td>73%</td>
<td>No</td>
</tr>
<tr>
<td>Hand Hygiene</td>
<td>70</td>
<td>50</td>
<td>71%</td>
<td>No</td>
</tr>
<tr>
<td>Equality and Diversity</td>
<td>70</td>
<td>47</td>
<td>67%</td>
<td>No</td>
</tr>
<tr>
<td>Fire Safety</td>
<td>70</td>
<td>40</td>
<td>57%</td>
<td>No</td>
</tr>
<tr>
<td>Infection Prevention (Level 2)</td>
<td>67</td>
<td>38</td>
<td>57%</td>
<td>No</td>
</tr>
<tr>
<td>Raising concerns and whistleblowing</td>
<td>70</td>
<td>13</td>
<td>19%</td>
<td>No</td>
</tr>
<tr>
<td>Health, Safety and Welfare</td>
<td>70</td>
<td>12</td>
<td>17%</td>
<td>No</td>
</tr>
</tbody>
</table>

* The trust target for Information Governance training compliance is 95%

Nursing staff were not meeting the trust standard of mandatory training for nine out of 11 subjects with only dementia awareness and infection prevention exceeding the 85% target.

We spoke with staff about accessing training. They told us it was difficult to access e-learning due to the demands of the department.

We looked at the statutory training for nursing staff in the department such as Mental Health Act training. Only one nurse was eligible for training this year and they had not completed the training. Additionally, staff were only expected to complete this training once in their career. We were concerned about this, particularly for an emergency department (ED) where patients with mental health needs often attend and need support. Refresher training ensures staff are following best practice and reminds staff what best practice is.
We found that zero nurses were eligible to attend DNACPR (do not attempt cardio pulmonary resuscitation) training and only three nurses eligible to attend risk management training.

We were concerned to find that zero nurses were eligible to attend safe use of insulin training, particularly in light of concerns raised previously by CQC about the management of DKA (diabetic ketoacidosis) in July 2018.

We found that 73% of nursing staff had completed preventing radicalisation training, against a trust wide target of 85%.

We highlighted concerns about the levels of mandatory training at our last comprehensive inspection in October 2016 and at our previous comprehensive inspection in February 2015.

A breakdown of compliance for mandatory training courses from April 2017 to May 2018 at trust level for medical staff in urgent and emergency care is shown below:

<table>
<thead>
<tr>
<th>Training Course</th>
<th>Number of eligible staff</th>
<th>Number of staff trained</th>
<th>Percentage Completed</th>
<th>Trust target (85%) met?</th>
</tr>
</thead>
<tbody>
<tr>
<td>Information Governance</td>
<td>18</td>
<td>17</td>
<td>94%</td>
<td>No*</td>
</tr>
<tr>
<td>Infection Prevention (Level 1)</td>
<td>18</td>
<td>15</td>
<td>83%</td>
<td>No</td>
</tr>
<tr>
<td>Hand Hygiene</td>
<td>18</td>
<td>12</td>
<td>67%</td>
<td>No</td>
</tr>
<tr>
<td>Equality and Diversity</td>
<td>18</td>
<td>10</td>
<td>56%</td>
<td>No</td>
</tr>
<tr>
<td>Infection Prevention (Level 2)</td>
<td>14</td>
<td>7</td>
<td>50%</td>
<td>No</td>
</tr>
<tr>
<td>Fire Safety</td>
<td>18</td>
<td>8</td>
<td>44%</td>
<td>No</td>
</tr>
<tr>
<td>Conflict Resolution</td>
<td>18</td>
<td>8</td>
<td>44%</td>
<td>No</td>
</tr>
<tr>
<td>Dementia Awareness (inc Privacy &amp; Dignity standards)</td>
<td>18</td>
<td>7</td>
<td>39%</td>
<td>No</td>
</tr>
<tr>
<td>Preventing Radicalisation (Levels 1 and 2)</td>
<td>18</td>
<td>6</td>
<td>33%</td>
<td>No</td>
</tr>
<tr>
<td>Health, Safety and Welfare</td>
<td>18</td>
<td>3</td>
<td>17%</td>
<td>No</td>
</tr>
<tr>
<td>Raising concerns and whistleblowing</td>
<td>18</td>
<td>1</td>
<td>6%</td>
<td>No</td>
</tr>
</tbody>
</table>

* The trust target for Information Governance training compliance is 95%

(Source: Routine Provider Information Request (RPIR) – Training tab)

Medical staff were not up to date with their mandatory training requirements.

Medical staff told us it was difficult to complete mandatory training due to the demands of the department.

We looked at the non-mandatory training for medical staff and found that completion levels were consistently below the trust standard of 85%. For example, zero medical staff were eligible for Mental Health Act training. As with nursing staff, medical staff were only expected to complete this training once in their career. We were concerned about this, particularly for an ED where patients with mental health needs often attend and need support. Refresher training reminds staff what best practice is and ensures staff are following best practice.
Medical staff can make decisions about whether a DNACPR is given to a patient however we found that only 6 of 15 eligible doctors were up to date with this training. We had concerns about this because of the significance of placing a patient on a DNACPR notice.

Only 36% of medical staff had completed Preventing radicalisation training at either level 1, 2, 3, 4 or 5 and there were zero medical staff eligible for Risk management or Safe use of insulin training. The trust advised that the safe use of insulin training was introduced in July 2018 and the department had a training schedule in place.

We raised concerns about mandatory training levels at our last comprehensive inspection in October 2016 and at our previous inspection in February 2015.

### Safeguarding

#### Safeguarding training completion rates

The trust set a target of 85% for completion of safeguarding training.

**Trust level**

A breakdown of compliance for safeguarding training courses from April 2017 to May 2018 at trust level for qualified nursing staff in urgent and emergency care is shown below:

<table>
<thead>
<tr>
<th>Training Course</th>
<th>Number of eligible staff</th>
<th>Number of staff trained</th>
<th>Percentage Completed</th>
<th>Trust target (85%) met?</th>
</tr>
</thead>
<tbody>
<tr>
<td>Safeguarding Adults (Level 2)</td>
<td>53</td>
<td>44</td>
<td>83%</td>
<td>No</td>
</tr>
<tr>
<td>Safeguarding Children (Level 3)</td>
<td>68</td>
<td>40</td>
<td>59%</td>
<td>No</td>
</tr>
</tbody>
</table>

A breakdown of compliance for safeguarding training courses from April 2017 to May 2018 at trust level for medical staff in urgent and emergency care is shown below:

<table>
<thead>
<tr>
<th>Training Course</th>
<th>Number of eligible staff</th>
<th>Number of staff trained</th>
<th>Percentage Completed</th>
<th>Trust target (85%) met?</th>
</tr>
</thead>
<tbody>
<tr>
<td>Safeguarding Adults (Level 2)</td>
<td>14</td>
<td>7</td>
<td>50%</td>
<td>No</td>
</tr>
<tr>
<td>Safeguarding Children (Level 3)</td>
<td>17</td>
<td>7</td>
<td>41%</td>
<td>No</td>
</tr>
</tbody>
</table>

(Source: Routine Provider Information Request (RPIR) – Training tab)

According to information provided to us by the trust, no members of staff in the department were eligible for level 4 safeguarding vulnerable children training.

We had concerns about safeguarding training, not only because of the low level of compliance but also because safeguarding children level three did not meet intercollegiate guidelines. This was because it was an e-learning module and the guidelines state that level three safeguarding children should be delivered face to face. Staff told us they were not receiving any face to face safeguarding training.
As part of our inspection process, we looked closely at the safeguarding process in the department. An inspector from our specialist children’s inspection team joined us. They found that in four of eight cases sampled, basic safeguarding questions had not been completed by the clinician and there was no separate children’s assessment documentation to prompt the nurse or doctor to explore additional risks and vulnerabilities. This meant there was an over reliance on professional curiosity and that children and young people did not routinely receive an assessment of their holistic needs.

However, we did find evidence that all children who attended the department were cross checked on a national safeguarding system to find out if they had any existing safeguarding concerns, were frequent attenders at ED, had a social worker or were under the care or supervision of the local authority. This made sure clinicians were aware of the patient’s safeguarding history, if there was any.

We found one example of very good practice. The clinician in adult ED had sought the advice of a registered sick children’s nurse (RSCN), checked the national system for the patient’s dependents, recorded the names of the dependents within the record and made a safeguarding referral in a timely manner. They also made sure other relevant professionals such as the paediatric liaison nurse were aware of the referral.

However, we had concerns about the quality of the majority of safeguarding referrals made. This was because they contained limited information regarding the reason for referral and did not demonstrate analysis of risk to the person or any dependents. Without sufficient information, other agencies could fail to safeguard vulnerable people appropriately.

Children and young people were not sufficiently safeguarded whilst in the children’s waiting room because the waiting room was not overlooked by either reception staff or nursing staff. Although a CCTV had been installed, with a viewing screen at the nurse’s station, due to low staffing levels, this was not always observed by a member of staff.

We found there was no formal safeguarding children supervision arrangements in place to support registered sick children’s nurses (RSCNs) however nursing staff could access support from the trust wide safeguarding team during office hours.

The paediatric department senior ED staff held a weekly safeguarding meeting with the trust named nurse for safeguarding however this meeting did not include CAMHS (child and adolescent mental health services), adult mental health teams or substance misuse services. This meant there was little opportunity to share good practice and identify and improve poor practice.

Staff told us that RSCNs were not supported to access regular updates for FGM (female genital mutilation) and CSE (child sexual exploitation) therefore we were not assured that staff were working within the most up to date guidance. One member of staff told us they had accessed training ‘some years ago’ but had not had any refreshers or updates. We found no evidence of multi agency training being delivered at the time of the inspection.

Staff told us that they were not offered training to support patients living with a mental health condition and we saw that mental health training was not mandatory. Additionally, mental health
act training was not routinely offered to staff. This was corroborated by the trust who sent us information showing there were zero staff in the ED eligible for Mental Health Act training.

The evidence we found demonstrated that the trust did not support a confident and competent workforce to be fully able to meet the safeguarding needs of vulnerable people visiting the department.

When adults visited the department, we found there was little evidence that children were considered. There were no prompts to ask about family composition or children the adult may be responsible for. This was a missed opportunity to ensure the safety of children. For example, we looked at the records of one patient who had been assaulted by their parent. There was no evidence that the clinician had asked about other siblings who may have been at risk.

Overall, we found staff were not supported by the systems in place to consider patient safeguarding needs. This was particularly apparent in the children’s area of the ED. Risk assessment pro formas had not been developed and a child sexual exploitation (CSE) risk assessment was only carried out when a patient was deemed as being at risk. However, it was unclear, without doing the risk assessment in the first place how that risk level was calculated.

We had concerns that the level of staffing in the department was having a high impact on the ability of nursing staff to complete safeguarding tasks as thoroughly as they needed to. Low staffing levels meant staff could not spend time carrying out safeguarding work because they needed to look after their patients’ immediate needs.

**Cleanliness, infection control and hygiene**

When we visited the department, we found it to be visibly very clean. Patient rooms were cleaned between patients and waiting area floors and seating were in excellent order. Patient toilets were clean.

Staff could call cleaners to the department if required however, cleaners worked across the trust and the department had to wait until one was available.

However, we did note that one toilet with bodily fluids on the floor was closed for more than an hour whilst waiting for the cleaning staff to come and wash the floor.

We found the environment was compliant with infection prevention and control guidelines and there was no dust below, or on top of surfaces. The cleaning staff were very thorough.

There were cleaning schedules in place and we saw completed paperwork confirming that cleaning had been carried out. They were signed and dated. We saw staff completing the required tasks in line with schedules.

Health care assistants were responsible for general cleaning and wiping of patient equipment such as blood pressure machines. We witnessed staff carrying out cleaning of equipment between patients.
There was sufficient personal protective equipment (PPE) such as aprons and masks available to
staff. We routinely saw staff using this, latex gloves and other equipment and disposing of it
correctly during our inspection.

We noted all staff were bare below the elbow in line with infection prevention and control policies.

In the paediatric waiting area, toys were infection control compliant because they were made from
washable and wipe clean materials however they had not been cleaned thoroughly regularly.
There was some uncertainty amongst staff about who was responsible for doing this. We found no
cleaning rotas in place. The cubicles in the paediatric area were well stocked, tidy and uncluttered.

Neither medical nor nursing staff were meeting the trust’s training target of 85% for infection
prevention and control. Nursing staff were at 57% and medical staff at 50% compliance.
Compliance for hand hygiene was at 71% for nurses and 67% for medical staff. This was worse
than the trust standard of 85%

The department had solid walled cubicles with en suite facilities for patients who required isolation
for the prevention and management of actual or potential infection.

We looked at the areas where equipment was cleaned and these were visibly clean and there
were cleaning schedules in place for all equipment. Equipment in this area was clean and had ‘I’m
clean’ stickers in place.

Mattresses we checked were in good condition and met infection prevention and control
standards.

**Environment and equipment**

Both the adult and paediatric EDs were located in a purpose-built building that had only been in
use for 10 months. It was clean, light and airy, with wide spacious corridors.

Consulting and treatment cubicles were a generous size and contained the necessary patient
equipment. All cubicles had solid walls. Cubicles were a mixture of solid and glazed doors with
curtains inside each cubicle to maintain privacy.

All rooms had emergency buzzers although we noted that some buzzers were inaccessible to
patients during the course of our inspection.

The department had a room that could be used in the event of chemical, biological, radiation or
nuclear (CBRN) contamination. We spoke with one consultant who did not know the code for the
door. When we checked the room, it was clean and tidy and ready for use. The department stored
major incident equipment outside the main entrance to the department in a locked storage area.
There was a tent, protective clothing and necessary medication.

We found that equipment in the department had been safety checked. All the electrical equipment
we checked had up to date tests.
Equipment was serviced and maintained in line with manufacturer’s guidelines, as there were maintenance contracts in place. To ensure accuracy, equipment was regularly calibrated.

We saw there were sufficient supplies of all equipment. This meant that if one suffered a mechanical breakdown, a spare machine was available.

We checked some of the stock held in the store rooms. We found defibrillator pads that had passed their expiry date. We brought the item to the attention of staff who disposed of and replaced them. All other stock we checked was in date.

We looked at resuscitation trolleys. The theatres department were responsible for all resuscitation trolleys throughout the organisation. They recorded when medication was due to expire and replaced the entire trolley with a new one. If a resuscitation trolley was used, the theatres team were notified and a replacement trolley was brought immediately to replace the used trolley. All trolleys were sealed and numbered. This meant that staff in the department did not have to carry out resuscitation trolley checks.

The waiting areas used by patients were spacious with sufficient seating for patients and relatives. The adult area had natural light making it a more pleasant environment for patients.

There was a separate secure waiting area suitable for children and young people. It was decorated in a child friendly way. Cubicles had some decoration however staff told us they intended to decorate the cubicles in a more child friendly way thus presenting an interesting environment for children and young people.

The department had a specific room suitable for adult and paediatric patients with mental health conditions. The room was ligature point free, had heavy furniture that could not be used as a weapon and met PLAN (psychiatric liaison accreditation network) standards.

The adult department layout meant that sicker patients were accommodated in the red zone, close to the staff work station, with the staff station in the centre. Less sick patients were accommodated in the blue zone which was more linear in design. The blue zone had two cubicles containing comfortable chairs for patients who did not need to be in a hospital bed.

The children’s ED was next door to the adult ED but was separated by a locked door.

**Assessing and responding to patient risk**

**Emergency Department Survey 2016**

The trust scored worse than other trusts for one question and “about the same” as other trusts for the remaining four questions.

<table>
<thead>
<tr>
<th>Question</th>
<th>Score</th>
<th>RAG</th>
</tr>
</thead>
<tbody>
<tr>
<td>Q5. Once you arrived at the hospital, how long did you wait with the ambulance crew before your care was handed over to the emergency department staff?</td>
<td>8.3</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>Q8. How long did you wait before you first spoke</td>
<td>4.8</td>
<td>Worse than other trusts</td>
</tr>
</tbody>
</table>
Q9. Sometimes, people will first talk to a nurse or doctor and be examined later. From the time you arrived, how long did you wait before being examined by a doctor or nurse?

<table>
<thead>
<tr>
<th>Question</th>
<th>Rating</th>
<th>Comparision</th>
</tr>
</thead>
<tbody>
<tr>
<td>Q9. Sometimes, people will first talk to a nurse or doctor and be examined later. From the time you arrived, how long did you wait before being examined by a doctor or nurse?</td>
<td>5.6</td>
<td>About the same as other trusts</td>
</tr>
</tbody>
</table>

Q33. In your opinion, how clean was the emergency department?

<table>
<thead>
<tr>
<th>Question</th>
<th>Rating</th>
<th>Comparision</th>
</tr>
</thead>
<tbody>
<tr>
<td>Q33. In your opinion, how clean was the emergency department?</td>
<td>8.2</td>
<td>About the same as other trusts</td>
</tr>
</tbody>
</table>

Q34. While you were in the emergency department, did you feel threatened by other patients or visitors?

<table>
<thead>
<tr>
<th>Question</th>
<th>Rating</th>
<th>Comparision</th>
</tr>
</thead>
<tbody>
<tr>
<td>Q34. While you were in the emergency department, did you feel threatened by other patients or visitors?</td>
<td>9.4</td>
<td>About the same as other trusts</td>
</tr>
</tbody>
</table>

(Source: Emergency Department Survey (October 2016 to March 2017; published October 2017)

Median time from arrival to initial assessment (emergency ambulance cases only)

The median time from arrival to initial assessment was worse than the overall England over the 12-month period from July 2017 to June 2018. Initial assessment means the first time a patient is seen and assessed by a nurse or doctor in the department. The trust time was around double the England average for every month over the period.

Ambulance – Time to initial assessment from July 2017 to June 2018 at The Rotherham NHS Foundation Trust

(Source: NHS Digital - A&E quality indicators)

Percentage of ambulance journeys with turnaround times over 30 minutes for this trust

Rotherham Hospital

From July 2017 to July 2018 there was a slight upward trend in the monthly percentage of ambulance journeys with turnaround times over 30 minutes at Rotherham district general hospital.

Ambulance: Number of journeys with turnaround times over 30 minutes - Rotherham Hospital
Ambulance: Percentage of journeys with turnaround times over 30 minutes - Rotherham Hospital

Jul-17

(Source: National Ambulance Information Group)

Number of black breaches for this trust

A “black breach” occurs when a patient waits over an hour from ambulance arrival at the emergency department until they are handed over to the emergency department staff. From May 2017 to June 2018 the trust reported 437 “black breaches”.

(Source: Routine Provider Information Request (RPIR) - Black Breaches tab)
The department had experienced a high number of black breaches. These peaked in March 2018 when 80 patients waited longer than 60 minutes before being handed over to hospital staff. Delayed handover poses a risk to patients who usually have to wait in a corridor or ambulance. Delayed handover also means ambulances have to wait with patients, taking them off the road.

During our inspection, staff told us about a special system they used to assess ambulance patients called RAT (rapid assessment and treatment). This aimed to address delays in time to initial assessment, reduce the length of handover and tackle the problem the department had with black breaches. However, staff also told us that it could only be used when there were sufficient staff in the department because it needed a doctor and nurse to manage it effectively. Over the three days of our inspection in the department, it was in use for a limited period on one day.

We also noted during the inspection that patients arriving on foot had long waits to be initially assessed (triaged) by a clinician, usually a nurse. For example, from the 21 records we looked at, children waited between seven minutes and two hours 11 minutes for initial assessment and adults waited between 13 and 58 minutes. The national standard is patients should receive an initial assessment within 15 minutes of arrival whether they arrive as a walk in patient, or are brought in by ambulance.

During the inspection we spot checked initial assessment times displayed in the department on the IT system they used and these were consistently longer than 15 minutes.

We were very concerned about the length of time patients, particularly children had to wait for initial assessment. We found an example of a patient who waited more than 90 minutes for initial assessment who was diagnosed as septic. Sepsis is a time critical condition and national guidance states that any patient suspected of being septic should receive intravenous antibiotics within 60 minutes of arrival at hospital. This particular patient waited more than two hours from arrival to receiving antibiotics.

The department used MEWS (modified early warning score) for adults and PEWS (paediatric early warning score) to assess how unwell patients were. PEWS was introduced in the department after our last focussed inspection in July. In general, the higher the score the sicker the patient. MEWS and PEWS should be monitored regularly and the sicker the patient, the more frequent the observations should be. When we looked at the clinical records of patients, we found that these scores were either not completed, not reviewed or not reviewed as frequently as they should be. Of the 15 paediatric records we spot checked, PEWS was recorded in eight and not recorded in seven. One paediatric patient had their PEWS recorded on an adult chart. This was inappropriate. MEWS was recorded in four of six adult records. Neither MEWS or PEWS were fully embedded in practice at the time of our inspection.

We checked to make sure the frequency of observations was appropriate. We found that one adult sepsis patient had no observations carried out for over two hours, two adult patients had initial observations carried out and then no further observations, one adult patient had been in the department for almost two hours before having any observations recorded.

We checked to make sure the frequency of observations on paediatric patients was appropriate. We found frequency of observations was appropriate for eight children, one patient had a two hour gap between observations, one had no observations carried out after initial assessment despite being in the department for eight hours, one had observations inappropriately recorded on an adult
MEWS chart and four had no PEWS chart generated. This showed that recording of observations was sporadic and supporting documentation not consistently used.

We were concerned that deteriorating patients were not recognised and escalated appropriately. Of the 15 records, three showed escalation was not necessary, five showed escalation had been documented and six had no documented evidence that a deteriorating patient had been escalated.

We looked at incidents recorded about the department. Some of these were raised by other departments about ED. We found 46 incidents classified as delay/failure to monitor/delay or difficulty obtaining clinical assistance/delay in diagnosis. Seventeen were delay or failure to monitor.

We spoke with staff about assessment, monitoring and escalation procedures. They could describe to us the action they should take however they also said that due to staffing levels in the departments and the levels of acuity of the patients, they were unable to take appropriate actions in a timely way to ensure patients were safe whilst in the department.

During our review of notes and incidents we found evidence that patients were not consistently assessed, monitored and escalated within the department in a timely manner. We were therefore concerned about the safety of patients in the department.

**Nurse staffing**

The trust reported the following qualified nursing staff numbers for March 2018 and June 2018 for urgent and emergency care by site:

<table>
<thead>
<tr>
<th>Staffing Group</th>
<th>Planned staff - WTE - Jun 18</th>
<th>Actual staff - WTE - June 2018</th>
<th>Fill Rate - Jun 18</th>
<th>Planned staff - WTE - Mar 18</th>
<th>Actual staff - WTE - Mar 18</th>
<th>Fill Rate - Mar 18</th>
</tr>
</thead>
<tbody>
<tr>
<td>Qualified nursing &amp; health visiting staff (Qualified nurses)</td>
<td>71.6</td>
<td>72.7</td>
<td>102%</td>
<td>69.6</td>
<td>71.1</td>
<td>102%</td>
</tr>
</tbody>
</table>

(Source: Routine Provider Information Request (RPIR) – Total staffing tab)

The department employed registered nurses, registered sick children’s nurses, emergency nurse practitioners and advanced clinical practitioners. Each had a different role in treating and caring for patients throughout the department.

We observed handovers between senior nurses and between staff nurses and saw that staff effectively communicated information about why patients were attending and care needs of patients to colleagues starting the new shift or taking over responsibility for care.

We found the staffing levels and skill mix within the department were not always appropriate to meet the needs of patients who attended. For example, some emergency department assistants (EDA) and HCA had not received training to work in the children’s department. This meant that they could not take bloods or carry out other tasks when they were allocated to the paediatric ED.
When we spoke with the management team, they acknowledged that workforce planning for the new department had not fully factored in an increase in demand caused by the closure of a local walk in centre. They told us there was a shortfall in both nurse and medical staffing. Therefore, although the table above shows a fill rate of over 100%, when we spoke, the team suggested the planned number of staff may be less than the department needed to function safely.

We spoke with the clinical lead about staffing levels. They told us the trust had carried out a piece of work looking at capacity and demand in the department. We asked to look at the work, however, at the time of writing this report, the trust was not able to share it with us as the report had not gone through appropriate governance and review processes.

We spoke with staff in both the adult and paediatric ED. Both told us they were concerned about staffing levels being low. They told us that sometimes when shifts remained uncovered, staff were brought from other departments to offer support. Bank and agency staff were also used however they did not always have the skills or competencies needed.

Staff told us they escalated occasions of unsafe staffing to the site coordinator. We saw incidents reported when there were unsafe staff levels. For example, there were four patients in the resuscitation area, all of whom required monitoring, with one qualified nurse and one emergency department assistant (EDA) (unqualified) to care for them. We found another similar example where four patients, including one very seriously ill, were cared for by one registered nurse and one EDA. Another example of a full resuscitation department, one patient who had cardiac arrested, again cared for by one qualified nurse and an EDA. We found an example when a patient could not receive the treatment they needed (sedation for joint manipulation) because there were not sufficient staff. A further incident reported that there was only one qualified nurse in the paediatric ED looking after 25 patients. The impact of this was delayed initial assessment (2.5hrs), patients waiting for pain medication to be administered and clinical observations not being carried out. These examples demonstrated times when the department was unsafe. Some of these incidents were as recent as September 2018.

Staff told us that when the department was under high pressure, some senior nurses did come to the department to help, however this help was not always in the form of delivering patient care, where there was most need. However, staff also told us that sometimes they felt left to cope, despite raising concerns. This was corroborated by an incident we saw reported.

Staff told us and incidents showed that it was not unusual to only have one nurse in the resuscitation area with the support of an EDA to manage multiple patients. We saw this during our inspection when there were multiple patients in the resuscitation area and only one qualified member of staff and an EDA.

We were concerned about the staffing levels in the paediatric ED. At our unannounced inspection in July 2018 we raised concerns about this.

At this inspection we looked at the staffing rota for the paediatric department, spoke with staff and spoke with managers. The trust had planned that the department should always have at least two qualified RSCNs on duty at any time, day and night. Rotas showed that from July 30th to August 23rd, 2018, there were 22 nights when only one RSCN was on duty, one night when no RSCN was on duty and two nights when there was no RSCN on duty between 05.30 and 07.00.
We asked staff about the impact of only one RSCN in the department. They told us they were very concerned about the safety of patients. They gave us examples of times when the department was unsafe and when they had been responsible for triaging patients, looking after patients in cubicles and also managing a patient in the resuscitation area at the same time. The impact of being short staffed was that patients waiting to be triaged had long waits. We saw evidence of this when we looked at incidents and when we looked at patient records. Some paediatric patients had long waits for initial assessment.

We asked staff if they received support from either the paediatric ward, or the adult trained nurses in ED. They told us the paediatric ward did not have capacity to spare staff to help and that adult nurses were already stretched looking after adult patients and also sometimes reluctant to look after children because they had not had the appropriate training or were not confident in doing so.

We spoke with the trust about the findings of the focused inspection in July in relation to staffing in the paediatric ED. They told us they were working hard to recruit additional RSCNs, offering training to adult qualified staff and offering vacant shifts to bank nurses. However, evidence we gathered showed that although medium term plans were in progress, with interviews scheduled soon after our inspection, the immediate shortfall was not being sufficiently addressed to ensure the safety of patients in the paediatric ED. At the time of the inspection, we asked the trust to take immediate action to ensure staffing levels were maintained at two RSCN in the paediatric ED at all times.

We asked the trust for information about their fill rates. This is the number of shifts in a month filled as a percentage of the total number of shifts. Between June 2017 and May 2018 an average of 10.3% of shifts were unfilled across the year.

**Vacancy rates**

From July 2017 to June 2018, the trust reported a vacancy rate of 1.1% for qualified nursing staff in urgent and emergency care. The trust has not supplied a vacancy target rate.

*(Source: Routine Provider Information Request (RPIR) – Vacancy tab)*

**Turnover rates**

From July 2017 to June 2018, the trust reported a turnover rate of 4.5% for qualified nursing staff in urgent and emergency care.

*(Source: Routine Provider Information Request (RPIR) – Turnover tab)*

**Sickness rates**

From July 2017 to June 2018, the trust reported a sickness rate of 2.5% for qualified nursing staff in urgent and emergency care. This was better than the trust target of 4.0%.

*(Source: Routine Provider Information Request (RPIR) – Sickness tab)*

**Bank and agency staff usage**
From June 2017 to May 2018, the trust reported a bank and agency usage rate of percentage in urgent and emergency care services.

A breakdown of locum and agency usage and unfilled shifts is shown below:

<table>
<thead>
<tr>
<th>Locum and agency</th>
<th>Number of shifts</th>
<th>% of total shifts</th>
</tr>
</thead>
<tbody>
<tr>
<td>Locum</td>
<td>1,529</td>
<td>10.6%</td>
</tr>
<tr>
<td>Agency</td>
<td>1,056</td>
<td>7.3%</td>
</tr>
<tr>
<td>Not filled</td>
<td>1,486</td>
<td>10.3%</td>
</tr>
</tbody>
</table>

(Source: Routine Provider Information Request (RPIR) - Nursing bank agency tab)

The trust provided nurse bank and agency staffing information for the period 1 September 2017 to 31 August 2018.

During this time, the percentage of nursing bank cover ranged from 1.6% to 23.5%.

The percentage of agency cover was much lower, peaking at 6.3% in December 2017. However, over the seven months to August 2018 there was zero agency nurse use.

Staff and managers told us vacant shifts were offered to bank staff however, for paediatric ED, take up of these shifts was currently at 38% meaning some shifts went uncovered. This corroborated the evidence we found when we looked at staffing rotas for August 2018.

**Medical staffing**

Doctors staffed the department 24 hours a day seven days a week. Emergency department consultant presence was on site between 08.00 and 22.30, seven days a week. This meant Royal College of Emergency Medicine (RCEM) rule of thumb standards were not met. However, due to gaps in the rota, there were occasions when consultants worked over night. When this happened, the rule of thumb standards were met.

We observed doctors discussing patients and handing over relevant information to colleagues. We had no concerns about this process.

We spoke with junior and middle grade doctors and they told us they were happy with the clinical training and support they received in the department. They spoke of consultants sharing knowledge and experience and were able to ask questions and learn in a supportive environment.

The trust reported the following medical staffing numbers for March 2018 and June 2018 for urgent and emergency care by site:

<table>
<thead>
<tr>
<th>Staffing Group</th>
<th>Planned staff - WTE - Jun 18</th>
<th>Actual staff - WTE - June 2018</th>
<th>Fill Rate - Jun 18</th>
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<th>Actual staff - WTE - Mar 18</th>
<th>Fill Rate - Mar 18</th>
</tr>
</thead>
<tbody>
<tr>
<td>Medical &amp; Dental staff - Hospital</td>
<td>14.2</td>
<td>15.1</td>
<td>107%</td>
<td>15.1</td>
<td>13.7</td>
<td>91%</td>
</tr>
</tbody>
</table>
When we looked at incidents reported by staff, we found that 307 of 907 were categorised as ‘lack of suitable trained/skilled staff’. When we investigated this further, we found that 293 of these related to medical staffing. The incidents reported lack of junior doctor cover, middle grade cover and/or registrar cover. The action taken was to allocate workload to other medical staff.

Vacancy rates

From July 2017 to June 2018, the trust reported a vacancy rate of -12% for medical staff in urgent and emergency care. This indicates that there was a level of overstaffing. However, the information above does not accurately reflect what we found reported as incidents. We found 293 incidents of medical short staffing reported in a 365 day period.

When we spoke with management about this they informed us workforce planning had not considered the impact of the closure of a local walk in centre. Additionally, there was a shortfall of 14 junior doctors. This was because the department hoped to use advanced clinical practitioners (ACP) in place of junior doctors. This had not been possible because there were not enough skilled and qualified ACPs to cover the junior doctor rota. As a result, the department had been left with a shortfall of junior doctors whilst ACPs were being trained.

Information below shows the national average percentage of junior doctors in the medical workforce is 23% however, at this trust the junior doctor workforce only makes up 5% of the workforce.

We also found consultant staff were covering gaps in the middle grade rota. After 22.30 the plan was for the department to be managed by a middle grade doctor. Royal College of Emergency Medicine (RCEM) guidelines state this should be a doctor of ST4 or above. This is a doctor who has been a specialist trainee in urgent and emergency care medicine for at least four years. They should have a minimum of advanced life support and advanced paediatric life support training.

Turnover rates

From July 2017 to June 2018, the trust reported a turnover rate of 28% for medical staff in urgent and emergency care. This included rotation of junior doctors through the department.

(SOURCE: Routine Provider Information Request (RPIR) – Turnover tab)

Sickness rates

From July 2017 to June 2018, the trust reported a sickness rate of 0.1% for medical staff in urgent and emergency care. This was lower than the trust target of 4%.

(SOURCE: Routine Provider Information Request (RPIR) – Sickness tab)

Locum and agency staff usage
Information provided by the trust showed that the department used locum staff to cover gaps in the medical staffing rotas.

Information provided by the trust showed that there were no consultant shifts left uncovered over the twelve month period from June 2017 to May 2018. There were 65 middle grade shifts left uncovered and 144 doctor in training shifts left uncovered for the same period.

Over the same 12 month period, 83 consultant shifts were covered by bank (internal) staff and 131 were covered by locum staff. Bank staff covered 224 middle grade shifts and locum staff covered 1079. Agency staff covered 595 doctor in training shift with none being covered by bank staff.

The evidence showed the department had a heavy reliance on locum staff, particularly junior doctor staff, which corroborated what we were told about the shortfall of junior doctors.

When we spoke with medical staff, including consultants, they told us that the department used regular locum staff whenever possible because this made sure all staff were familiar with the environment, ways of working and each other. It also meant there were fewer problems with accessing IT systems for information such as test results.

**Staffing skill mix**

From June 2017 to May 2018, the proportion of consultant staff reported to be working in the UECC was higher than the England average and the proportion of junior (foundation year 1-2) staff was lower.

**Staffing skill mix for the 20 whole time equivalent staff working in urgent and emergency care at The Rotherham NHS Foundation Trust.**

<table>
<thead>
<tr>
<th></th>
<th>This Trust</th>
<th>England average</th>
</tr>
</thead>
<tbody>
<tr>
<td>Consultant</td>
<td>43%</td>
<td>29%</td>
</tr>
<tr>
<td>Middle career^</td>
<td>23%</td>
<td>15%</td>
</tr>
<tr>
<td>Registrar group~</td>
<td>29%</td>
<td>33%</td>
</tr>
<tr>
<td>Junior*</td>
<td>5%</td>
<td>23%</td>
</tr>
</tbody>
</table>

^ Middle Career = At least 3 years at SHO or a higher grade within their chosen specialty  
~ Registrar Group = Specialist Registrar (StR) 1-6  
* Junior = Foundation Year 1-2

(Source: NHS Digital Workforce Statistics)

**Records**
All members of staff were required to attend information governance training. We found 94% of medical staff and 77% of nursing staff had completed this training against a trust target of 95%.

Medical records management training was not included as mandatory training.

The electronic record system in the ED had the facility to alert staff about specific needs of patients such as those living with a learning disability or mental health needs. There were also alerts for violent patients and patients with previously diagnosed conditions.

The department used an electronic system to record patient attendances. This was on display in the nurse’s stations away from the sight of the public. This ensured that patients’ personal information was not seen by other patients in the department.

Staff used paper and electronic records to record patient information.

Once a patient was discharged from the department, the patient’s GP was sent a copy of the patient’s record about the admission. This included their treatment plan and any medication changes. Reception staff sent these out to each practice in a bulk mail each day.

We looked at the records of 21 patients in detail. Fifteen were children’s records and six were adult records. We found completion of records was inconsistent. We found there were some gaps in recording of information. For example, pain scores were not always recorded (9/21 not recorded), comfort rounds were not always documented (14/21 not documented), allergies (7/21 not recorded), food and hydration (17/21 not documented).

We found six records where observations were not documented at the required frequency and there were long gaps in time between sets of observations being carried out or observations had only been carried out once and not repeated despite the patient remaining in the department.

We were not satisfied that the standard of record keeping was sufficient to keep patients safe and protect them from errors or harm.

**Medicines**

Staff were not required to attend medicine management training as part of their mandatory training. Additionally, despite some medication errors, staff were not required to attend safe use of insulin training. The department had indicated no members of staff were eligible for the training, despite patients attending the department, occasionally needing insulin. Incidents showed there had been 50 medication incidents in the previous 12 months.

Staff told us they disposed of controlled drugs (medicines that have very strict policies and procedures in relation to their management) in the trust approved way. Controlled drugs were strictly managed and recorded and we saw evidence of this in drugs books.

We asked a CQC pharmacy inspector to visit the ED to look at the processes in place. They had no significant concerns about the department however noted there was no dedicated pharmacy support in place. Supplies were replaced three times each week by staff from pharmacy however,
specific patient requests were taken to the pharmacy by ED staff along with the medication chart and patient’s medical records. This meant that the records were out of the department whilst the supply was completed. Additionally, there was no porter service to take the medicines back to the department and therefore a member of the ED team had to go to pharmacy to retrieve the medicines. This was not an ideal situation for a busy department that was often under pressure with patients.

We looked at the storage of medicines within the department and found some stock was not locked away as it should have been.

Medication fridge temperatures were not regularly checked and recorded as such. Staff were required to record maximum and minimum temperatures to ensure that medicines were consistently stored within the correct temperature range.

Patient group directives (PGD), which allow some registered health professionals, such as nurses, to give specified medicines (such as painkillers) to a predefined group of patients without the patient having to see a doctor, were used in the department. Eligible staff had signed to say that they understood them and were working within their guidance. One of the PGDs was out of date.

Advanced care practitioners, who were originally trained paramedics, used a combination of PGDs and medicines they were allowed to use as qualified paramedics until they were fully-qualified non-medical prescribers. We checked PGDs to make sure all relevant staff had signed and were deemed competent.

Medical gases were stored safely.

**Incidents**

**Never Events**

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.

From August 2017 to July 2018, the trust reported no incidents classified as never events for urgent and emergency care.

*(Source: NHS Improvement - STEIS)*

**Breakdown of serious incidents reported to STEIS**

In accordance with the Serious Incident Framework 2015, the trust reported 13 serious incidents (SIs) in urgent and emergency care which met the reporting criteria set by NHS England from August 2017 to July 2018.
There were some common themes in the serious incidents we looked at. There had been four related to delays in treatment, three related to diagnostic incidents and two alleged abuse.

The department reported 907 incidents in a 12 month period. Of these, five resulted in death of a patient, two were classed as severe, resulting in long term or permanent harm, 21 were classified as moderate harm, 132 were of low harm and 736 caused no harm. Eleven had not been given a classification however five of these related to patient deaths in the department.

The most commonly reported incidents were Blood Cultures contamination (161) medication incidents (50), delays to treatment (47) and communication failure (23).

We looked to see if there were any common themes in the incidents. We found 22 incidents where sepsis or septic were mentioned, seven where a stroke was mentioned and five where diabetes or DKA (diabetic ketoacidosis) were a factor.

We spoke with staff about their responsibilities around duty of candour. Providers of healthcare services must be open and honest with service users and other ‘relevant persons’ (people acting lawfully on behalf of service users) when things go wrong with care and treatment, giving them reasonable support, truthful information and a written apology. Staff were familiar with the phrase, ‘being open and honest’. Senior staff in the department took responsibility for the formal duty of candour process. They could describe it and give examples of when they had used the process.

Information the trust gave us showed that the department had taken action as a result of incidents requiring use of Duty of Candour appropriately and fed back to staff when errors had been made. We looked at the root cause analyses and action plans to assure ourselves action was being taken.

Staff we spoke with told us they received some feedback about incidents they had reported at handovers and some information about lessons learned.

Managers told us that all staff groups took responsibility for reporting incidents and were encouraged to do so. Managers also told us there was a strong self-reporting culture.
We discussed incidents with staff. All the staff we spoke with were aware of the process for reporting incidents and had access to the electronic reporting system. At our last inspection, we identified that some medical staff expected nursing staff to report incidents. We spoke with both groups of staff about this matter at this inspection. Nursing staff told us the situation had improved however not all medical staff reported incidents as they should.

Senior staff in the department attended mortality and morbidity meetings and fed back information to staff at team meetings and huddles.

**Safety Thermometer**

The Safety Thermometer is used to record the prevalence of patient harms and to provide immediate information and analysis for frontline teams to monitor their performance in delivering harm free care. Measurement at the frontline is intended to focus attention on patient harms and their elimination.

Data collection takes place one day each month. A suggested date for data collection is given but wards can change this. Data must be submitted within 10 days of the suggested data collection date.

Data from the Patient Safety Thermometer showed that the trust reported no new pressure ulcers, no falls with harm and three new urinary tract infections in patients with a catheter from July 2017 to July 2018 within urgent and emergency care.

**Prevalence rate (number of patients per 100 surveyed) of catheter-acquired urinary tract infections The Rotherham NHS Foundation Trust**

3 Catheter acquired urinary tract infection level 3 only

(Source: NHS Digital - Safety Thermometer)

Is the service effective?

**Evidence-based care and treatment**

Staff in the department used a comprehensive variety of pathways and NICE guidelines together with Royal College of Emergency Medicine (RCEM) guidance to support them to achieve effective outcomes for patients in their care. However, there were occasions when staff did not adhere to
the timings of pathways, such as the sepsis pathway. Additionally, records did not always provide evidence of following guidelines.

We saw guidance on the trust’s intranet which staff had access to, for instance, around the identification and management of sepsis, which was based on NICE guidance. There were links to trust wide policies, standard operating procedures, checklists and additional support information. This meant staff could access guidance to ensure patients were receiving best practice care and treatment.

New NICE guidelines were reviewed, reported on, and approved by the clinical governance committee and disseminated to staff via the noticeboard, huddles and staff meetings.

Patient safety and medication alerts were brought to staff attention via huddles and practice guidelines were changed in accordance.

**Nutrition and hydration**

**Emergency Department Survey 2016**

In the CQC Emergency Department Survey, the trust scored 6.7 for the question “Were you able to get suitable food or drinks when you were in the emergency department?” This was the same as other trusts.

(Source: Emergency Department Survey (October 2016 to March 2017; published October 2017)

We spoke with nine patients and their relatives about hydration and nutrition needs. Only one family told us they had been offered a drink. Some of the patients had been in the department for more than two hours.

We did not see patients being offered food or drinks however staff told us that if patients needed to eat for medical reasons, food was available.

In the waiting area there were vending machines selling drinks and food. There were shops on site where people could buy drinks and snacks.

If a patient had special dietary needs, for instance a child patient, staff told us help could be obtained from the children’s ward, or alternatively the patient was admitted and then seen by a specialist dietitian on the appropriate ward.

If a patient was assessed as requiring fluid management, for example following vomiting, diarrhoea or dehydration, fluid balance charts were used to monitor and assess the need for additional fluids. During the inspection we did not see any patients on intravenous fluids therefore we could not corroborate this.

**Pain relief**

**Emergency Department Survey 2016**
In the CQC Emergency Department Survey, the trust scored 5.0 for the question “How many minutes after you requested pain relief medication did it take before you got it?” This was the same as other trusts.

The trust scored 7.2 for the question “Do you think the hospital staff did everything they could to help control your pain?” This was the same as other trusts.

The department had systems and processes in place to support staff to assess and record the pain patients had, including for patients who had difficulty communicating. We saw staff had access to appropriate pain relief medication.

We observed triage and witnessed patients being given pain relief if they needed it.

We looked at 21 patient records (adults and children) and in eight records we saw pain scores were not recorded on the patient’s record at initial assessment or reassessed subsequently, dependent upon the patient’s NEWS score or how often their repeat observations were required.

We asked five patients in the department if they had been asked about pain or offered pain relief and they all told us they had.

**Patient outcomes**

**RCEM Audit: Moderate and acute severe asthma 2016/17**

In the 2016/17 Royal College of Emergency Medicine (RCEM) Moderate and acute severe asthma audit, Rotherham Hospital emergency department failed to meet any of the national standards.

The department was in the upper UK quartile for four standards:

- **Standard 3** (fundamental): High dose nebulised β2 agonist bronchodilator should be given within 10 minutes of arrival at the emergency department. This department: 56.9%; UK: 25%.
- **Standard 5**: If not already given before arrival to the emergency department, steroids should be given as soon as possible as follows:
  - Adults 16 years and over: 40-50mg prednisolone PO or 100mg hydrocortisone IV
  - Children 6-15 years: 30-40mg prednisolone PO or 4mg/kg hydrocortisone IV
  - Children 2-5 years: 20mg prednisolone PO or 4mg/kg hydrocortisone IV
- **Standard 5a** (fundamental): within 60 minutes of arrival (acute severe). This department: 46.2%; UK: 19%.
- **Standard 5b** (fundamental): within 4 hours (moderate). This department: 49%; UK: 28%.
- **Standard 9** (fundamental): Discharged patients should have oral prednisolone prescribed as follows:
  - Adults 16 years and over: 40-50mg prednisolone for 5 days
  - Children 6-15 years: 30-40mg prednisolone for 3 days
  - Children 2-5 years: 20mg prednisolone for 3 days

This department: 80%; UK: 52%.
The department was in the lower UK quartile for one standard:

- **Standard 2a (fundamental):** As per RCEM standards, vital signs should be measured and recorded on arrival at the emergency department. This department: 15.4%; UK: 26%.

The department’s results for the remaining two standards were all within the middle 50% of results.

(Source: Royal College of Emergency Medicine)

**RCEM Audit: Consultant sign-off 2016/17**

The trust did not take part in this audit.

(Source: Royal College of Emergency Medicine)

**RCEM Audit: Severe sepsis and septic shock 2016/17**

In the 2016/17 Severe sepsis and septic shock audit, Rotherham Hospital emergency department failed to meet any of the national standards.

The department was in the lower UK quartile for two standards:

- **Standard 4:** Serum lactate measured within one hour of arrival. This department: 28.9%; UK: 60%.
- **Standard 7:** Antibiotics administered: Within one hour of arrival. This department: 19.6%; UK: 44.4%.

(Source: Royal College of Emergency Medicine)

We asked staff, both nursing and medical, about clinical audit within the department. Although most staff were unaware that clinical audit took place, the trust provided us with additional evidence after the inspection to demonstrate clinical audit was undertaken. By the time of the inspection, three clinical audits had been completed. A further 15 were in progress however 12 of these had not been completed within their allocated timescales. None were re-audits of RCEM audits. This meant we had no assurance about improvements in performance against RCEM clinical audits. It was unclear how the trust was assured through governance processes.

However, when we read the departmental clinical governance meeting minutes we noted that although clinical audits were discussed, there was no specific information about which audits these were.

We saw staff had access to a sepsis screening tool and a pathway to support them in identifying and managing a patient with sepsis. Information about sepsis was readily available to staff via the electronic patient record. The trust had sepsis policies for adults and children.

Staff described how they had treatment plans for regular attenders to the department, particularly those with mental health diagnoses to support them in achieving the best outcome for such patients.
Unplanned re-attendance rate within seven days

The trust’s unplanned re-attendance rate to A&E within seven days was worse than the national standard of 5% and better than the England average, despite a notable reduction in performance in July 2017.

Unplanned re-attendance rate within seven days - The Rotherham NHS Foundation Trust

(Source: National Episode Statistics)

Competent staff

Appraisal rates

From April 2017 to March 2018, 26% of staff within urgent and emergency care at the trust received an appraisal compared to a trust target of 90%.

<table>
<thead>
<tr>
<th>Staff Group</th>
<th>Appraisals required</th>
<th>Appraisals completed</th>
<th>Percentage completed</th>
<th>Trust Target (90%) met?</th>
</tr>
</thead>
<tbody>
<tr>
<td>Support to doctors and nursing staff</td>
<td>73</td>
<td>22</td>
<td>30%</td>
<td>No</td>
</tr>
<tr>
<td>Qualified ambulance service staff</td>
<td>4</td>
<td>1</td>
<td>25%</td>
<td>No</td>
</tr>
<tr>
<td>Qualified nursing &amp; health visiting staff (Qualified nurses)</td>
<td>72</td>
<td>18</td>
<td>25%</td>
<td>No</td>
</tr>
<tr>
<td>NHS infrastructure support</td>
<td>10</td>
<td>0</td>
<td>0%</td>
<td>No</td>
</tr>
<tr>
<td><strong>Grand Total</strong></td>
<td><strong>159</strong></td>
<td><strong>41</strong></td>
<td><strong>26%</strong></td>
<td><strong>No</strong></td>
</tr>
</tbody>
</table>

(Source: Routine Provider Information Request (RPIR) - Appraisal tab)

A mentor was allocated to newly registered staff who joined the department as part of their preceptorship and all staff joining the department for the first time also received an induction.
The induction programme included checking of competencies, such as, for airways, breathing, ventilation and oxygenation. Staff reported that the induction to the department was useful.

The department had doctor teaching sessions where specific topics such as equipment, medical conditions or treatments were discussed. This ensured staff were up to date with new developments or techniques.

The department had a clinical nurse educator and an education plan to ensure staff increased their skills and knowledge however, the workload and staffing levels made it a challenge to release staff to attend training sessions. The plan included supporting adult trained nurses to look after sick children and life support training with input from other departments and organisations. The department had already carried out two paediatric study days and introduced workbooks to support staff in recording of vital signs.

The department carried out simulation training for staff to ensure they were able to work confidently in unknown scenarios. This was a learning exercise but also gave staff confidence in real life situations. This included CBRN scenarios when staff practiced locating and erecting the decontamination tent and wearing hazardous material protection outfits. At our second inspection visit in October, we observed staff putting this practice in to real life action when two patients exposed to a chemical arrived at the department.

Some staff in the department spoke about additional competency training they had done such as masters degrees or advanced clinical practitioner training. However, other staff felt there was little to no opportunity to progress through the department.

Staff were competent in identifying vulnerable patients and referring them for specialist advice, such as from the psychiatric liaison team.

Senior staff told us that informal monitoring of the competency of staff was undertaken within the department and any concerns were addressed quickly with the staff involved.

**Multidisciplinary working**

The department operated 24/7 and staff we spoke with reported no issues with response times for diagnostic or pathology results that had been ordered.

Staff confirmed that they had 24/7 access to diagnostic services such as x-rays or computerised tomography (CT), which was available within an hour from the dedicated radiology suite.

Pathology support, such as blood testing was available 24/7 and staff reported no issues with the accessibility of the service or its response times which we were told was usually within an hour.

The department could also carry out its own point of care testing for some blood tests.

The department worked closely with the frailty team to support patients who had additional health and social care needs. They were able to arrange access to equipment such as walking aids and could organise short term social care for patients. This meant that patients who were medically
well enough to go home were supported to do so. Admission avoidance was better for the patient and assisted with bed availability and flow through the ED.

Staff were able to access patient information using an electronic system. This included information such as previous clinic letters, test results and x-rays. Staff could also access patient GP records with the agreement of the patient. This meant that staff had information about the most up to date medications, health conditions and symptoms to enable them to make a better diagnosis and treatment plan.

Staff could access support for patients living with autism or a learning disability via the trust wide learning disability team.

Patients could access support for addiction and substance misuse via the psychiatric liaison service.

The trust worked closely with local care providers such as community health teams to provide a 24/7 team who could support patients in their own homes and prevent admission and reattendance at the department.

Staff told us the paediatric liaison nurse was visible and visited the department daily however, we did not see her during our inspection.

**Health Promotion**

Staff told us they offered health promotion advice to patients relating to smoking, weight loss and healthy lifestyles as well as specific advice about the patient’s condition.

There were some posters and leaflets advising patients about support services like drug and alcohol services around the department.

Staff were able to refer patients to support services if they thought patients needed additional help or support.

The frailty team could identify patients who were frail or elderly and who may need extra support to ensure a safe and effective discharge. This team worked closely with outside agencies to ensure that patients leaving the department were looked after so promoting better health amongst those vulnerable patients who had visited the department.

**Consent, Mental Capacity Act and Deprivation of Liberty safeguards**

**Mental Capacity Act and Deprivation of Liberty training completion**

The trust reported that from April 2017 to May 2018 Mental Capacity Act (MCA) training was completed by 0% of staff in urgent and emergency care compared to the trust target of 85%. Only one member of staff was listed as being eligible for this training which has resulted in such a stark result.

(Source: Routine Provider Information Request (RPIR) – Statutory and Mandatory Training tab)
However, following the inspection the trust clarified that MCA training was included in the training delivery for Safeguarding Adults Level 2. Compliance was 83% for nursing staff and 50% for medical staff.

Staff understood the importance of consent when delivering care to their patients and displayed a good understanding of the requirements of the Mental Capacity Act (2005) or knew where to obtain expert help, such as from the psychiatric liaison team.

Staff sought consent from patients prior to examination and treatment. In the majority of cases this was implied consent and not documented however when an intervention was required, formal written consent was sought. We saw in records of patients that staff had completed capacity assessments and used the correct forms to consent patients who were unable to consent. We saw an example of this being used with a patient who had fractured their femur and required surgery. The correct documentation was used.

Staff told us they explained procedures to patients and made sure they understood any risks and possible complications before asking them to sign. Consent forms were held within medical records.

Consent training was not recorded as a separate mandatory training module; therefore it was unclear from the Routine Provider Information Request (RPIR) whether staff had undertaken consent training as part of another module of mandatory training or had not had consent training. Staff confirmed consent and Mental Capacity Act training were part of Safeguarding Adults Level 2 training.

Staff in the department, particularly the RSCNs were able to accurately describe the tests for assessing competence to consent to treatment for patients aged under 16 years.

Staff understood who could give consent on behalf of a patient and when an advocate or best interest decision should be used.

The Deprivation of Liberty Safeguards (DoLS) provide legal protection for those vulnerable people aged 18 and over who are, or who may become, deprived of their liberty. The safeguards exist to provide a proper legal process and suitable protection in circumstances where deprivation of liberty appears to be unavoidable, in a person’s own best interests.

The trust offered Mental Health Act training however, despite the likelihood of patients detained under the mental health act, or with serious mental health conditions being brought to the department, this was not mandatory training for ED staff. We were therefore concerned about patients detained under the Mental Health Act as we were not assured staff were up to date with the latest practice and guidance.

When we spoke with staff, they told us they would look to the senior clinicians on duty or the psychiatric liaison team for guidance.

**Is the service caring?**

**Compassionate care**
Friends and Family test performance

The trust's urgent and emergency care Friends and Family Test performance (% recommended) was better than the England average from July 2017 to June 2018.

A&E Friends and Family Test performance - The Rotherham NHS Foundation Trust

![Graph showing Friends and Family Test performance from July 2017 to June 2018.](image)

(Source: NHS England Friends and Family Test)

When we discussed care of patients with staff, there was a consistent message that staff wanted patients to feel safe and cared for. Staff were working very hard and were dedicated to looking after patients throughout their ED journey however when they were under pressure, we saw it was not always easy to dedicate time to patients. There were occasions when staff were more task oriented than patient oriented.

During our inspection, we spoke with 11 patients and their relatives, most of whom were happy with the care they received. They provided us with positive feedback about the attitude of staff saying they were pleasant and professional. However, some patients and their relatives thought staff did not always show compassion or empathy to patients.

During our time in the department, we saw patients being treated with dignity and respect. Staff were conscious of the cultural needs of patients and made sure this was respected whilst delivering their medical care.

Staff respected people's dignity and cubicle doors and curtains were closed when care and treatment was being given.
In the patient led assessment of the care environment survey undertaken in April 2017, Rotherham Hospital scored 72.08% for privacy, dignity and wellbeing against a national average of 83.7%. There were no figures specifically for the emergency department.

During the inspection, we heard one elderly patient close to the red nursing station who had previously been quiet, shouting out for help. All staff, medical and nursing, senior and junior, ignored the patient and carried on their work discussions and other tasks for approximately 10 minutes until a member of CQC staff intervened. The patient could not reach their call bell and needed to go to the toilet. As soon as they had been assisted, they stopped shouting for help. The department was not particularly busy at the time.

One patient’s relative spoke with us and told us they were not happy with their family member’s care because he had been left without food and nutrition or any comfort round and when staff had been asked for help, they had to be asked more than once to help the patient go to the toilet.

We were concerned that despite their best efforts, staff were struggling to deliver compassionate care due to their workload.

**Emotional support**

Staff told us about how they would support patients who were distressed, by chatting to them and trying to distract them however, they told us this was not always possible depending upon how busy the department was and the staffing demands in the department.

Patients told us staff reassured them and tried to stay with them until they felt reassured.

Staff told us they sometimes found it difficult to support people as much as they wanted to when the department was busy.

We observed all staff talking with patients and relatives in a calm way and offering reassurance to both concerned patients and their family members.

Staff offered support and gave information about support services available if this was required.

There was pastoral support available for patients of any or no religious belief.

**Understanding and involvement of patients and those close to them**

**Emergency Department Survey 2016**

The trust scored about the same as other trusts for all 24 questions.

<table>
<thead>
<tr>
<th>Question</th>
<th>Trust 2016</th>
<th>2016 RAG</th>
</tr>
</thead>
<tbody>
<tr>
<td>Q10. Were you told how long you would have to wait to be examined?</td>
<td>4.2</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>Q12. Did you have enough time to discuss your health or medical problem with the doctor or nurse?</td>
<td>8.2</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>Q13. While you were in the emergency department, did a</td>
<td>8.2</td>
<td>About the same as</td>
</tr>
<tr>
<td>Question</td>
<td>Trust 2016</td>
<td>2016 RAG</td>
</tr>
<tr>
<td>-----------------------------------------------------------------------</td>
<td>------------</td>
<td>--------------</td>
</tr>
<tr>
<td>doctor or nurse explain your condition and treatment in a way you could understand?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Q14. Did the doctors and nurses listen to what you had to say?</td>
<td>8.7</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>Q16. Did you have confidence and trust in the doctors and nurses examining and treating you?</td>
<td>8.3</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>Q17. Did doctors or nurses talk to each other about you as if you weren't there?</td>
<td>9.2</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>Q18. If your family or someone else close to you wanted to talk to a doctor, did they have enough opportunity to do so?</td>
<td>7.4</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>Q19. While you were in the emergency department, how much information about your condition or treatment was given to you?</td>
<td>8.6</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>Q21. If you needed attention, were you able to get a member of medical or nursing staff to help you?</td>
<td>7.6</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>Q22. Sometimes in a hospital, a member of staff will say one thing and another will say something quite different. Did this happen to you in the emergency department?</td>
<td>8.7</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>Q23. Were you involved as much as you wanted to be in decisions about your care and treatment?</td>
<td>7.6</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>Q44. Overall, did you feel you were treated with respect and dignity while you were in the emergency department?</td>
<td>8.6</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>Q15. If you had any anxieties or fears about your condition or treatment, did a doctor or nurse discuss them with you?</td>
<td>6.6</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>Q24. If you were feeling distressed while you were in the emergency department, did a member of staff help to reassure you?</td>
<td>5.7</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>Q26. Did a member of staff explain why you needed these test(s) in a way you could understand?</td>
<td>8.2</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>Q27. Before you left the emergency department, did you get the results of your tests?</td>
<td>8.5</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>Q28. Did a member of staff explain the results of the tests in a way you could understand?</td>
<td>8.5</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>Q38. Did a member of staff explain the purpose of the medications you were to take at home in a way you could understand?</td>
<td>9.2</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>Q39. Did a member of staff tell you about medication side effects to watch out for?</td>
<td>5.6</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>Q40. Did a member of staff tell you when you could resume your usual activities, such as when to go back to work or drive a car?</td>
<td>5.2</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>Q41. Did hospital staff take your family or home situation into account when you were leaving the emergency department?</td>
<td>4.8</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>Q42. Did a member of staff tell you about what danger signals regarding your illness or treatment to watch for after you went home?</td>
<td>5.5</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>Q43. Did hospital staff tell you who to contact if you were worried about your condition or treatment after you left the emergency department?</td>
<td>7.0</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>Q45. Overall... (please circle a number)</td>
<td>7.6</td>
<td>About the same as other trusts</td>
</tr>
</tbody>
</table>
We saw patients being given information and supported to make decisions about the treatment they would like to receive. Most of the patients we spoke with told us their families had been involved at their request and kept fully informed about progress through the department.

Parents told us that both they and their children were involved in discussions about treatment options.

During our inspection, we witnessed good interactions with patients. Staff tried to explain to them why they were waiting or what the next stage of their treatment or care was. However, some patients and relatives told us they had been kept waiting, were unsure why they were waiting and didn’t know what was going to happen next.

Staff supported patients to make decisions about their treatment. People’s emotional and social needs were considered by staff.

Staff made sure information they gave was in a language that the patient and their family could understand without complicated medical terminology. Staff gave patients and relatives the chance to ask questions and time to think before making any decisions. Patients and relatives had no complaints about how information was presented to them.

Staff tried their best to help people and those close to them to cope emotionally with their care and treatment.

Is the service responsive?

Service delivery to meet the needs of local people

The trust had recently reconfigured the services delivered by the department and moved into a new purpose-built department with separate adult and paediatric EDs. This reconfiguration took place with the support of the local Clinical Commissioning Groups and local stakeholders.

Rotherham Hospital ED was a trauma centre. The department was staffed by consultants between 8am and 10.30pm every day. The department was not always meeting the RCEM ‘rule of thumb’ recommendations for consultant cover of 16 hours each day although nursing and medical staff told us consultants frequently stayed later than 10.30pm even though they were not rostered to. All staff told us that consultants often worked beyond their contracted hours when the department was busy.

At the time of the inspection, Rotherham Hospital accepted a wide range of patients including those suffering stroke, trauma, cardiac arrest, surgical emergencies and obstetrics and gynaecology emergencies.
There was a co-located paediatric ED therefore the hospital accepted babies, children and young people. There were two distinct waiting areas, one for children and one for adults. The department worked with the children’s ward to make sure children were in the most appropriate location.

There were some patients such as those having a heart attack, or victims of major burns or major trauma who were taken to their nearest major trauma centre or specialist unit.

The department had developed some pathways for patients to enable them to go directly to the most appropriate area, such as gynaecology however these were not fully up and running at the time of the inspection.

The department had acknowledged the mental health needs of the local population. Patients had access to mental health support services on site via the psychiatric liaison team and the children and adolescent mental health services (CAMHS) team.

The hospital had a team of staff dedicated to supporting patients who had additional care needs, to ensure patients were only admitted to hospital if their health required so and to assist patients in accessing equipment and social care.

In the case of a child needing to be in the resuscitation department, the department had a dedicated paediatric resuscitation bay.

The paediatric unit had five cubicles and a triage room. These were pleasant and comfortable.

All staff were aware of the type of patients who attended the department and the potential incidents that could occur locally. Managers ensured that the department had the necessary equipment and trained staff to manage such situations.

During our follow up inspection, the department had to declare a major incident as two patients had been contaminated with chemicals. We observed this department and others work together to quarantine the waiting room, decontaminate the patients and ensure other patients in the department were kept safe. This was done in an efficient and coordinated way.

**Meeting people’s individual needs**

**Emergency Department Survey 2016**

The trust scored about the same as other trusts for the all three questions.

<table>
<thead>
<tr>
<th>Question – Responsive</th>
<th>Score</th>
<th>RAG</th>
</tr>
</thead>
<tbody>
<tr>
<td>Q7. Were you given enough privacy when discussing your condition with the receptionist?</td>
<td>7.0</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>Q11. Overall, how long did your visit to the emergency department last?</td>
<td>6.9</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>Q20. Were you given enough privacy when being examined or treated?</td>
<td>8.8</td>
<td>About the same as other trusts</td>
</tr>
</tbody>
</table>

(Source: Emergency Department Survey (October 2016 to March 2017; published October 2017)
The waiting room for adults could accommodate wheelchairs and mobility aids and there were dedicated disabled toilets available. The children’s waiting area was smaller but could still accommodate wheelchairs and pushchairs.

There were facilities, such as chairs and wheelchairs, for bariatric patients and trolleys designed for larger patients were available. Specialist bariatric equipment such as hospital beds were stored as part of the trust’s equipment library and could be requested when needed.

There were vending machines present in the department which relatives and carers could access and the hospital had a number of shops and places to purchase food.

There were breast-feeding facilities available to allow privacy if required.

The trust had access to interpreting services for people whose first language was not English. Staff we spoke with told us family members were sometimes used however; interpreting services were available if required via telephone. It is not best practice to use family members for a number of reasons including reliability of interpretation and patient confidentiality. Most staff were aware of how to access telephone interpreters.

The department had access to sign language interpreters for people living with hearing impairment.

There was a private relatives’ room near the entrance to the department. This was a pleasant environment with a telephone, tea and coffee making facilities and literature for families dealing with a bereavement.

When a patient passed away, whenever possible, they were moved to a room adjacent to the relatives’ room so family could have privacy to visit.

Staff were aware of the possible cultural and religious differences within the local community when patients passed away. They were sensitive to the needs of the family and the community in those circumstances and understood what was required.

The staff we spoke with about patients living with dementia, or a learning disability all told us they would treat patients as individuals and would try to involve family and carers in discussions about care needs. Dementia was a mandatory training module. Medical staff were 39% and nursing staff 94% compliant with training against a trust standard of 85%.

Some patients with learning disabilities had patient passports. When the patient or carer presented this at the department, staff used the information to assist them in making decisions about patient needs and wishes.

There was access to chaplaincy services for patients and relatives of different faiths or none.

Patients with only mental health needs waited in the mental health room or a cubicle close to the nursing station. These rooms had been risk assessed at the time of inspection and were safe for patients at risk of self-harm or suicide. The designated mental health room had no ligature points, fixed furniture that could not be used as a weapon and a viewing glass pane in to the room. Staff told us they risk assessed every mental health patient who used the room.
Staff in the department had access to 24/7 psychiatric liaison support or child and adolescent mental health services (CAHMS). Young people needing support from CAMHS often had long waits to be seen. Any patients who presented with a mental health condition were referred to one of these teams.

Patients could access addiction services and there was an alcohol withdrawal pathway in place. We saw this being used during our inspection.

The trust offered staff training in conflict resolution as mandatory training however compliance figures were worse than the trust target with only 81% of nursing staff and 44% of medical staff having undergone the training against a target of 85%.

The trust had a specific team who carried out a comprehensive assessment of frail or elderly patients in the department with a view to carrying out a holistic assessment of their physical, mental and social needs and arranged safe discharge for them. The team was based outside of the department and attended on request.

**Access and flow**

At the time of our inspection, we spoke with staff about waiting times. The department used rapid assessment and treatment (RAT) for patients arriving by ambulance however it was not possible for the department to staff it all the time because it needed a consultant, nurse and health care assistant and there was not always spare capacity. The department had not considered using RAT to see walk in patients in the same way. Using RAT can improve the flow of patients through the department and make sure the most poorly patients are seen quickly whilst less poorly patients can be sent to other departments or services, seen quickly, treated and discharged. Preliminary tests can also be requested so results are available when the patient is seen by a clinician.

Patients arriving on foot often experienced delays from arrival to initial assessment. We found evidence of patients waiting more than two hours for initial assessment and during the inspection, we observed patients waiting up to 1 hour 40 minutes for initial assessment.

Staff spoke with us about the problems they experienced with flow through the department. They explained that patients often had long waits within the department to be moved to a bed on a ward. This was because the hospital could not always discharge patients from wards efficiently when the patients were well enough to do so. Staff also believed the hospital did not always have enough beds to meet the number of patients needing to be admitted or did not have a bed on the correct type of ward. Other examples of patients experiencing long waits included when the patient needed to be assessed for a mental health condition.

When patients remained in the department in this way, it caused delays for new patients coming in because there were no cubicles for them to be examined or receive treatment.

Staff told us patient waits to be seen by specialist staff such as surgeons or from other disciplines and departments could be long. However, physicians visited the department regularly to clerk in patients so patients were ready for transfer to the medical wards. The department also had some
pathways in place so patients could be sent to other departments more quickly once a bed was available.

Staff also told us the department had good links with the intensive care unit and anaesthetists and intensivists came to the department if needed.

We saw some patients who had been waiting a long time had been moved from ED trolleys to hospital beds. This reduced their risk of developing pressure damage.

**Median time from arrival to treatment (all patients)**

The Royal College of Emergency Medicine recommends the time patients should wait from time of arrival to receiving treatment should be no more than one hour. The trust did not meet the standard for the entire 12 month period from July 2017 to June 2018.

**Median time from arrival to treatment from July 2017 to June 2018 at The Rotherham NHS Foundation Trust**

![Graph showing median time from arrival to treatment from July 2017 to June 2018.](source: NHS Digital - A&E quality indicators)

**Percentage of patients admitted, transferred or discharged within four hours (all emergency department types)**

The Department of Health’s standard for emergency departments is that 95% of patients should be admitted, transferred or discharged within four hours of arrival in the emergency department.

From August 2017 to July 2018 the trust failed to meet the standard.

From August 2017 to July 2018 performance against this metric showed a trend of gradual improvement interspersed with declines in performance, most notably in November 2017 and March 2018. There was a decline in Jul 2018 at the end of the reporting period.

Each day, a designated person within the department looked at the number of patients who had breached the four-hour target and carried out an analysis of the reasons. Themes were identified and if other departments were identified as part of the delays, such as long waits for specialty doctors to assess patients, this was reported to the Clinical Governance Committee for follow up action.

**Four hour target performance - The Rotherham NHS Foundation Trust**

![Graph showing four hour target performance.](source: NHS Digital - A&E quality indicators)
Percentage of patients waiting more than four hours from the decision to admit until being admitted

From August 2017 to July 2018 the trust’s monthly percentage of patients waiting more than four hours from the decision to admit until being admitted was similar to the England average.

Percentage of patients waiting more than four hours from the decision to admit until being admitted - The Rotherham NHS Foundation Trust

(Source: NHS England - A&E Waiting times)

Some patients who were fit to sit, were moved to recliner chairs. All patients were treated in the department until a bed on a ward became available.

When we spoke with staff, flow out of the department was one of the biggest concerns. During our inspection we saw staff from all departments managing bed use to try to get patient flow moving and stop overcrowding in the ED.
Some senior staff told us specialty doctors were not always quick to come to the department due to other responsibilities throughout the hospital and this impacted in the ED because patients had to stay in ED until a specialty, for example, orthopaedics or respiratory medicine, had agreed to accept the patient under their care.

**Number of patients waiting more than 12 hours from the decision to admit until being admitted**

Over the 12 months from August 2017 to July 2018, six patients waited more than 12 hours from the decision to admit until being admitted. The highest numbers of patients waiting over 12 hours were in December 2017 and March 2018, with two patients waiting more than twelve hours for admission in each month respectively.

<table>
<thead>
<tr>
<th>Month</th>
<th>Number of patients waiting more than four hours to admission</th>
<th>Number of patients waiting more than 12 hours to admission</th>
</tr>
</thead>
<tbody>
<tr>
<td>Aug-17</td>
<td>204</td>
<td>1</td>
</tr>
<tr>
<td>Sep-17</td>
<td>267</td>
<td>0</td>
</tr>
<tr>
<td>Oct-17</td>
<td>182</td>
<td>0</td>
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<td>Nov-17</td>
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<tr>
<td>Dec-17</td>
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<tr>
<td>Jan-18</td>
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</tr>
<tr>
<td>Feb-18</td>
<td>253</td>
<td>0</td>
</tr>
<tr>
<td>Mar-18</td>
<td>383</td>
<td>2</td>
</tr>
<tr>
<td>Apr-18</td>
<td>91</td>
<td>1</td>
</tr>
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<td>66</td>
<td>0</td>
</tr>
<tr>
<td>Jun-18</td>
<td>67</td>
<td>0</td>
</tr>
<tr>
<td>Jul-18</td>
<td>134</td>
<td>0</td>
</tr>
</tbody>
</table>

(Source: NHS England - A&E Waiting times)

When a patient breached the 12-hour waiting time, this was reported as an incident and investigated to look for trends and reasons why. A designated person also checked to make sure the patient received all of their necessary medication, food and hydration and was placed on a hospital bed to minimise the risk of pressure damage.

**Percentage of patients that left the trust’s urgent and emergency care services before being seen for treatment**

From July 2017 to June 2018 the monthly percentage of patients that left the trust’s urgent and emergency care services before being seen for treatment was worse than the England average.

**Percentage of patient that left the trust’s urgent and emergency care services without being seen - The Rotherham NHS Foundation Trust**

[Graph showing percentage comparison]
Each day, a designated person within the department looked at the number of patients who had left without being seen and assessed whether they, due to their presenting symptoms, needed to be contacted and asked to return. This safety net meant any children were followed up and any patients who had potentially serious conditions were alerted to the concerns and could make a decision about whether to return to see a doctor.

**Median total time in A&E per patient (all patients)**

From August 2017 to July 2018 the trust's monthly median total time in A&E for all patients was higher than the England average. This means that patients waited longer to be seen than the England average.

**Median total time in A&E per patient - The Rotherham NHS Foundation Trust**

(Source: NHS Digital - A&E quality indicators)

**Learning from complaints and concerns**
Summary of complaints

From June 2017 to May 2018 there were 47 complaints about urgent and emergency care services. The trust took an average of 52 working days to investigate and close complaints. This is not in line with their complaints policy, which states complaints should be resolved within 30 days unless complex. The highest proportion of complaints related to clinical treatment with 13 complaints.
(Source: Routine Provider Information Request (RPIR) – Complaints tab)

In the six months prior to inspection, the service had received 16 complaints and all were answered within the agreed timescales.

The trust advised that extensions to the 30-day deadline could be granted when the nature of the complaint was complex. This meant some complaints could be resolved within the agreed extension time frame. However, we did not receive any data which highlighted how many of the 47 complaints had been granted an extension and, if so, whether they had been resolved within the agreed timescale.

Patients and relatives we spoke with were aware of how to make a complaint to the trust although none of the people we spoke with had made a complaint about the department. Patients were very complimentary about the department.

There was information about how to raise concerns about the department or the trust on display in the department and there were leaflets available for patients to take away with them.

Staff were able to describe to us the action they would take if a patient or relative complained to them. Staff would attempt to resolve any concerns but escalate to their line manager when this was unsuccessful.

Staff and managers told us that feedback was given to staff when they were part of a complaint. Additional training was offered as a way of supporting staff when the issue related to clinical care.

It was unclear from the information sent to us by the trust what action the trust took to address any specific issues emerging from complaints, such as speaking with individual staff or changing practice or procedures.

General information about complaints and incidents was discussed with staff at team meetings.

Number of compliments made to the trust

From June 2017 to May 2018 there were 18 compliments in urgent and emergency care.
(Source: Routine Provider Information Request (RPIR) – Compliments tab)

Is the service well-led?

Leadership

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The emergency department (ED) was part of the division of medicine which was led by a director of clinical services, general manager and head of nursing. The ED was overseen by a matron, associate general manager and clinical lead. The team told us they were very proud of the resilience of the ED staff who worked very hard to deliver the best care they could to patients.

When we spoke with the management team, they were aware of some of the problems the department was experiencing however, we were concerned they had not recognised the department was unsafe due to staffing levels, particularly in the paediatric ED. This was despite incidents of short staffing being reported, our focussed inspection in July 2018 and some patients coming to harm due to delays in triage or initiation of treatment in a timely manner. It was also despite CQC taking enforcement action against the department in July 2018. When we returned in October 2018, we saw the same problems. Little had changed in the short term to ensure patients and staff were safe and protected from harm.

Although the management team, along with other senior staff including the head of nursing for medicine and the chief nurse, had long term plans in place to improve staffing levels by recruiting additional staff, and were advertising extra shifts to cover gaps in the rota, there was a lack of awareness of how important it was to cover those gaps, to ensure the department remained safe.

We were concerned about a disconnect between the department leadership team and the executive team because some very senior members of the organisation did not appear to be fully sighted on the serious situation in the department.

Staff we spoke with in the ED gave a mixed response when asked about the visibility of the senior leadership team (SLT), with some describing them as very visible, and others saying they were mostly absent from the ED and focused on other parts of the trust.

When vacant shifts were not covered by bank staff, there was a lack of innovative thinking to explore other ways to make sure the paediatric ED was safe, such as working with neighbouring trusts or managing paediatric patients in the main ED when there was only one RSCN on duty.

Nursing staff we spoke with gave us mixed feedback about leadership in the department because some felt they were not listened to, or their concerns not always taken as seriously as they thought they should be. We therefore had concerns nursing leadership in the department and at a more senior level were not listening to all staff and addressing their concerns.

The ED had senior nurse coordinators who oversaw the daily management and requirements of the department on each shift. We found they were clearly focused on the challenges of the department in respect of performance and demand. They led a hard-working team committed to the ED and its patients.

Staff told us they did not always feel kept up to date with developments and changes to the department and were sometimes unsure if there would be any changes as a result of their concerns. They felt communication needed to be improved.

Medical staff told us their local leadership was supportive, inclusive, and provided good direction within the department. Junior doctors were supported by their senior colleagues, mentors and education supervisors.
We returned to visit the department one month after our initial inspection to find out what action had been taken. We spoke with staff at different levels and of different disciplines. We found the management team both within and above the department had acted upon our notice of enforcement action. They had recruited additional staff and were fast tracking their pre-employment checks to ensure all new staff were ready to start immediately after their notice period finished. The department was continuing to recruit RSCNs at both band 5 and band 6 level and had already recruited a senior paediatric nurse at band 7 for the department.

We told the department they must ensure two RSCN were on duty in the paediatric ED at all times. The department was not always able to meet this requirement with internal staff, however, it was now working with the paediatric ward and other local trusts to fulfil the requirement.

We told the trust it must provide us with information about staffing levels and fill rates across the department as assurance. This information was not always forthcoming immediately after our inspection although provision has now improved and the department is able to provide CQC with the assurances we require about staffing levels.

We noted not all appropriate staff were trained to EPLS level and the trust had since secured additional training places for staff.

Since our enforcement notice, the trust is now fully sighted on the risks to patients and staff and has taken action to improve the safety of patients in the department.

**Vision and strategy**

The department had developed objectives and aims for the future. The business manager spoke with us about their plans (pending board approval) for an independent paediatric ED due to the number of children being seen in the department. However, we saw senior managers had focussed on the medium and long-term plans for the department and had lost sight of the short term needs of the department.

We additionally found workforce planning had greatly underestimated the needs of the new department and had not fully considered the impact of the closure of the local walk in centre. As a result, the department had been left sometimes dangerously understaffed for junior doctors and RSCNs.

Recently implemented plans included the provision of minor injury and GP support in to the department to manage patients who would have previously attended the now closed, local walk in centre. Managers in the ED were aware of the changing and increasing demands on the department and the types of issue patients accessing the department were presenting with.

The management team in the emergency department (ED) told us they wished to make the department an outstanding provider of urgent and emergency patient care for Rotherham and the surrounding areas.

However, staff did not always feel involved in decisions about the future of the department. For example, staff we spoke with told us they were not consulted for ideas about the design of the new department. Staff felt as though they had some valuable ideas to contribute but had not been able to do so. This made staff feel excluded and undervalued.
Culture

We had concerns about the culture of the department at our last inspection. Some staff felt the department was fragmented and they were not made to feel welcome by some staff in the department. At this inspection, we received mixed responses from staff about the culture in the department, similar to those previously expressed. For example, due to the physical barrier between the adult and paediatric ED, there was little crossover or interaction between staff.

Some staff also reported to us it was still a fragmented department with certain staff perceived to be receiving preferential treatment for shifts and annual leave because they were part of the “in crowd”. Some staff did not feel that everybody was treated fairly.

On the whole, junior and middle grade medical staff told us the department had a learning culture that supported them to progress in their career.

From what we observed, all staff were very patient oriented and communicated professionally to ensure patients received care in an efficient way.

Staff we spoke with were passionate about the care they delivered. They were proud of the department, and described their commitment to deliver the best possible care and their frustration at not always being able to.

Most staff felt their hard work was recognised however some staff felt managers were not always concerned about their physical and mental health or the stress and pressure they were under as part of their role. Some staff told us they felt under extreme pressure, which had a detrimental impact on their health. When we spoke with departmental managers about this, they were unaware of how much of an impact stress was having on some staff. This may be because of the low level of staff appraisals throughout the department.

We were concerned some staff may choose to leave the department because they felt unsupported in their own health needs and unable to speak with managers or request support.

Staff told us they felt unable to suggest new ways of working or to try new things to improve patient experience or the efficiency of the department.

Staff we spoke with told us they could report concerns and incidents without fear of reprisals. They were less confident that when concerns were raised, they were dealt with quickly or addressed.

If staff made errors they could report them and were confident they would be supported and managed fairly. Managers told us there was a strong culture of self-reporting within the department.

Governance

The senior management described the governance process to us and we saw a diagram demonstrating how each committee and meeting contributed to the overall governance of the department and the trust. Clinical governance meetings took place regularly. The risk register,
incidents, complaints, and lessons learned were discussed. Matron and senior clinicians, both nursing and medical attended. Information was disseminated to staff at handover and huddles.

We observed two handovers and two huddles. Some performance information was disseminated to staff however staff also had a responsibility to read meeting minutes. These were posted on staff boards along with other important information.

We reviewed minutes from departmental governance meetings. These covered risks and action plans, NICE guidance, standard operating procedures, incidents and complaints. Action plans were revisited as a standing agenda item at subsequent meetings. Risks were presented at alternative meetings, assessed and discussed before being added or removed from the risk register.

We had concerns there was a disconnect between senior management arrangements and the frontline staff working daily in the department. We found senior management were not fully sighted on the challenges faced by front line staff and governance did not flow to and from front line staff. Senior and executive staff were not fully sighted on the safety impact of not having sufficient qualified and experienced staff in the department.

Management of risk, issues and performance

We reviewed the emergency department (ED) risk register. Senior managers confirmed the risk register was a live document subject to ongoing review. There were currently four risks identified on the risk register. These were related to loss of permanent staff, patient threats to harm staff, security of controlled stationery and failure of the telephone system.

The risks recorded did not reflect the current risks in the department such as timeliness of triage of patients, RSCN staffing rota gaps, failure to manage deteriorating patients, failure to meet the four-hour standard, flow through the department, mandatory training or gaps on the junior doctor rota. Therefore, we were not assured the risk register was robust.

The risks on the risk register did not reflect the risks staff spoke about as their greatest areas of concern.

The risk register needed to be refreshed and reviewed to make sure it accurately reflected the actual risks the department faced.

We also noted on our first late night inspection, the consultant in charge at the time did not have clear oversight of the department, the patients within, those waiting for assessment and those needing to be seen by a doctor. We noted the nursing coordinator on duty at the time had to direct the Dr to a particular area where patients had been waiting over four hours to be seen by a doctor.

Information management

The trust had information governance policies and procedures in place to ensure that information was stored securely and protected patients’ privacy and security. Information governance was a module of mandatory training. Nursing staff were 77% compliant and medical staff were 94% compliant against a trust target of 95%.
The department collected information used to monitor and manage performance. There were measures in place to monitor and manage the performance of the department against local and national indicators. These were closely observed by the management team. We carried out checks to make sure information recorded reflected actual activity accurately and found it did.

The department used a number of IT systems to collect and share information such as test and x-ray results, admission and discharge times and ambulance handover times as well as patient records. This information was collated by an overarching system called SEPIA. SEPIA was developed internally by the health informatics development team and was constantly evolving and improving. It was used across the hospital and community and not just in ED.

SEPIA allowed staff to access patient records such as previous clinic letters and discharge summaries as well as patient records in the community and allowed community staff to access wards and know if patients on their caseload were currently inpatients. This meant community staff did not make unnecessary home visits.

SEPIA allowed staff working in ED and managerial and executive staff outside of ED to monitor the status of the department, such as bed status, waiting times and number of patients in the department.

Some information such as test results and discharge letters were shared with GPs with the consent and agreement from patients.

Patients transferred to other services or sites took photocopies of their medical records with them.

Staff were aware of their responsibilities in relation to data protection and making sure information was accurate and managed securely.

Overall, data protection principles were followed however, we did witness terminals logged on, left unattended on three occasions.

Information governance including data protection and confidentiality was monitored and any incidents reported appropriately.

Engagement

At our last inspection we told the department it should look at improving staff and patient engagement. At this inspection we found the situation had not improved and staff felt disengaged.

The department participated in the friends and family test and CQC surveys.

Patients and those close to them could provide feedback on the ED via the friends and family test (FFT). They could also leave feedback on comments cards. Staff told us they promoted these methods of feedback to patients where possible. Information about giving feedback, including via the patient experience team, was also displayed in the waiting areas, provided in leaflets, and available on the trust website.

Staff told us they did not feel engaged with. They gave us examples such as not being involved or included in the plans for the design of the refurbishments in the department. Staff of all disciplines
told us they were shown the plans once they had been finalised as were not consulted with about whether they thought the design would work or needed to be modified.

Staff also told us they did not feel as though information about developments in the department such as recruitment were shared with them.

After our first visit to the department, the newly appointed interim chief nurse held some listening events for staff. When we returned to the department four weeks after our initial inspection, staff told us engagement had improved and they felt listened to. They felt as though senior management were finally listening to them and taking in to consideration their opinions.

Since our initial inspection, staff were provided with information updates from senior managers.

**Learning, continuous improvement and innovation**

In July 2017 the new urgent and emergency care centre (UECC) opened. The UECC brought together the primary care services and the emergency care services traditionally provided by an ED. The UECC allows patients to access the most appropriate person for their needs, including GPs, minor injury specialists and traditional A&E services.

The aim is that patients will receive the right treatment at the right time from the right person.

The department has been through a difficult period of change and work is underway to firstly make sure the department is safe and then look at how the department can improve, become sustainable, effective and efficient.
The medical care service at the trust provides care and treatment for cardiology, cardiac devices, respiratory, healthcare of the elderly, gastroenterology, diabetes and endocrinology, haematology stroke services and dermatology. There are 215 medical inpatient beds.

Inpatient acute medical care is provided in the main Rotherham Hospital site on Moorgate Road. The Acute Medical Unit (AMU) cares for acutely ill adult patients with varying complex needs. The majority of patients are from the Emergency Department and GP admissions. Patients are assessed, a plan of care provided and subsequently are transferred to a relevant pathway / ward or discharged home.

The Ambulatory Care Unit (within the AMU) provides same day emergency ambulatory care facilities to optimise the patient journey and utilise appropriate patient pathways. Integrated Medical Specialities cover inpatient and outpatient facilities in relation to cardiology, cardiac devices, respiratory, healthcare of the elderly, gastroenterology, diabetes and endocrinology, haematology (collaborative working with Weston Park Hospital in terms of the delivery of oncology chemotherapy), stroke services, dermatology. These services are delivered on Cardiac Catheter Suite, Coronary Care Unit, Wards A1, A2, A4, A5, A7, A6 Stroke Unit and Dermatology department.

(Source: Routine Provider Information Request AC1 - Acute context)

The trust had 24,463 medical admissions from June 2017 to May 2018. Emergency admissions accounted for 14,165 (57.9%), 1,008 (4.1%) were elective, and the remaining 9,290 (37.9%) were day case.

Admissions for the top three medical specialties were:

- General medicine – 13,425 admissions
- Clinical haematology – 4,170 admissions
- Gastroenterology – 2,808 admissions

(Source: Hospital Episode Statistics)
Mandatory Training

The service provided mandatory training in key skills to all staff. Staff were required to complete mandatory training in topic areas such as infection prevention, dementia awareness and information governance.

Staff we spoke with told us they were up to date with most of their mandatory training and were booked onto sessions they still needed to complete. Staff said that sometimes they were pulled off mandatory training to help out when there were staff shortages on the wards.

Training was provided by either eLearning or face to face. Staff told us they received an email when they were due to complete mandatory training.

Staff told us they had no specific training regarding mental health. Although, they had some training on patients support needs which covered viewing the patients’ individual needs. The adult psychiatric liaison team had a regular slot on the essential nurse training programme accessed by nurses from across the hospital.

Mandatory training completion rates

The trust set a target of 85% for completion of mandatory training. Information provided by the trust showed that the compliance rates with mandatory training for nursing and medical staff working in medical care services did not meet the target in seven out of nine mandatory training modules.

Trust level

A breakdown of compliance for mandatory training courses from April 2017 to May 2018 at trust level for qualified nursing staff in medicine is shown below:

<table>
<thead>
<tr>
<th>Training Course</th>
<th>Number of eligible staff</th>
<th>Number of staff trained</th>
<th>Percentage Completed</th>
<th>Trust target (85%) met?</th>
</tr>
</thead>
<tbody>
<tr>
<td>Dementia Awareness (inc Privacy &amp; Dignity standards)</td>
<td>159</td>
<td>147</td>
<td>92%</td>
<td>Yes</td>
</tr>
<tr>
<td>Infection Prevention (Level 1)</td>
<td>159</td>
<td>146</td>
<td>92%</td>
<td>Yes</td>
</tr>
<tr>
<td>Information Governance</td>
<td>159</td>
<td>134</td>
<td>84%</td>
<td>No*</td>
</tr>
<tr>
<td>Fire Safety</td>
<td>159</td>
<td>128</td>
<td>81%</td>
<td>No</td>
</tr>
<tr>
<td>Hand Hygiene</td>
<td>159</td>
<td>129</td>
<td>81%</td>
<td>No</td>
</tr>
<tr>
<td>Equality and Diversity</td>
<td>159</td>
<td>121</td>
<td>76%</td>
<td>No</td>
</tr>
<tr>
<td>Infection Prevention (Level 2)</td>
<td>147</td>
<td>110</td>
<td>75%</td>
<td>No</td>
</tr>
<tr>
<td>Preventing Radicalisation (Levels 1 and 2)</td>
<td>159</td>
<td>115</td>
<td>72%</td>
<td>No</td>
</tr>
<tr>
<td>Conflict Resolution</td>
<td>159</td>
<td>104</td>
<td>65%</td>
<td>No</td>
</tr>
<tr>
<td>Raising concerns and whistleblowing</td>
<td>159</td>
<td>36</td>
<td>23%</td>
<td>No</td>
</tr>
<tr>
<td>Health, Safety and Welfare</td>
<td>159</td>
<td>31</td>
<td>18%</td>
<td>No</td>
</tr>
</tbody>
</table>
The trust target for Information Governance training compliance was 95%.

Nursing staff exceeded the 85% completion rate for two out of 11 mandatory training modules.

A breakdown of compliance for mandatory training courses from April 2017 to May 2018 at trust level for medical staff in medicine is shown below:

<table>
<thead>
<tr>
<th>Training Course</th>
<th>Number of eligible staff</th>
<th>Number of staff trained</th>
<th>Percentage Completed</th>
<th>Trust target (85%) met?</th>
</tr>
</thead>
<tbody>
<tr>
<td>Infection Prevention (Level 1)</td>
<td>113</td>
<td>106</td>
<td>94%</td>
<td>Yes</td>
</tr>
<tr>
<td>Information Governance</td>
<td>113</td>
<td>97</td>
<td>86%</td>
<td>No*</td>
</tr>
<tr>
<td>Conflict Resolution</td>
<td>113</td>
<td>83</td>
<td>73%</td>
<td>No</td>
</tr>
<tr>
<td>Hand Hygiene</td>
<td>113</td>
<td>83</td>
<td>73%</td>
<td>No</td>
</tr>
<tr>
<td>Preventing Radicalisation (Levels 1 and 2)</td>
<td>113</td>
<td>77</td>
<td>68%</td>
<td>No</td>
</tr>
<tr>
<td>Infection Prevention (Level 2)</td>
<td>104</td>
<td>67</td>
<td>64%</td>
<td>No</td>
</tr>
<tr>
<td>Fire Safety</td>
<td>113</td>
<td>70</td>
<td>62%</td>
<td>No</td>
</tr>
<tr>
<td>Equality and Diversity</td>
<td>113</td>
<td>69</td>
<td>61%</td>
<td>No</td>
</tr>
<tr>
<td>Dementia Awareness (inc Privacy &amp; Dignity standards)</td>
<td>113</td>
<td>62</td>
<td>55%</td>
<td>No</td>
</tr>
<tr>
<td>Health, Safety and Welfare</td>
<td>113</td>
<td>30</td>
<td>27%</td>
<td>No</td>
</tr>
<tr>
<td>Raising concerns and whistleblowing</td>
<td>113</td>
<td>7</td>
<td>6%</td>
<td>No</td>
</tr>
</tbody>
</table>

The trust target for Information Governance training compliance was 95%.

Medical staff exceeded the target completion rate for one out of 11 mandatory training modules.

**Safeguarding**

Staff had a good knowledge and understanding of the trusts safeguarding policies and their role and responsibilities in relation to protecting patients from abuse. Staff knew how to contact the safeguarding team for advice and had access to the team’s details on the intranet. Information about safeguarding with flowcharts for staff to follow, were also available on the intranet.

Staff could give examples of what constituted a safeguarding concern and how they could raise an alert. Staff gave examples of safeguarding referrals they had made and alerts they had raised in relation to vulnerable adults and children.

Patients and relatives we spoke with did not highlight any concerns about aspects of safeguarding. They said they were well looked after and they felt safe on the medical wards.

**Safeguarding training completion rates**

The trust set a target of 85% for completion of safeguarding training. Information provided by the trust showed that the compliance rates with safeguarding training for nursing and medical staff working in medical care services did not meet the target of 85%.

**Trust level**
A breakdown of compliance for safeguarding training courses from April 2017 to May 2018 at trust level for qualified nursing staff in medicine is shown below:

<table>
<thead>
<tr>
<th>Training Course</th>
<th>Number of eligible staff</th>
<th>Number of staff trained</th>
<th>Percentage Completed</th>
<th>Trust target (85%) met?</th>
</tr>
</thead>
<tbody>
<tr>
<td>Safeguarding Adults (Level 2)</td>
<td>133</td>
<td>95</td>
<td>71%</td>
<td>No</td>
</tr>
<tr>
<td>Safeguarding Children (Level 2)</td>
<td>155</td>
<td>101</td>
<td>65%</td>
<td>No</td>
</tr>
</tbody>
</table>

A breakdown of compliance for safeguarding training courses from April 2017 to May 2018 at trust level for medical staff in medicine is shown below:

<table>
<thead>
<tr>
<th>Training Course</th>
<th>Number of eligible staff</th>
<th>Number of staff trained</th>
<th>Percentage Completed</th>
<th>Trust target (85%) met?</th>
</tr>
</thead>
<tbody>
<tr>
<td>Safeguarding Adults (Level 2)</td>
<td>83</td>
<td>53</td>
<td>64%</td>
<td>No</td>
</tr>
<tr>
<td>Safeguarding Children (Level 2)</td>
<td>74</td>
<td>39</td>
<td>53%</td>
<td>No</td>
</tr>
<tr>
<td>Safeguarding Children (Level 3)</td>
<td>25</td>
<td>8</td>
<td>32%</td>
<td>No</td>
</tr>
</tbody>
</table>

(Source: Routine Provider Information Request (RPIR) – Training tab)

Cleanliness, infection control and hygiene

All ward areas we visited were visibly clean and all equipment we inspected was clean. However, we did see a small number of electric fans in ward areas which were dusty.

We saw that personal protective equipment, such as gloves and aprons, were available for staff and used appropriately. Handwashing facilities and alcohol gel were available either within each bay and side room or next to the entrance. We saw staff washing their hands and they adhered to the trust policy of bare below the elbows. However, we observed five staff on the acute medical unit (AMU) who did not decontaminate their hands between every patient contact.

Disposable aprons were available for staff which followed the national coding scheme for hospital cleaning materials and equipment. Blue for providing standard care in the ward areas, yellow for known or suspected infection, red for cleaning bathrooms and toilets and green for serving and assisting with meals. However, we observed that staff did not always remove and replace these before they attended another patient when providing clinical care.

Patients with infections were barrier nursed in side rooms and appropriate signage was in place on the door. There were different signs for respiratory risk and general risk so staff knew if they needed to wear a facemask. We saw two cubicles on AMU that had signs saying the patient was being barrier nursed but the doors were left open. One patient being barrier nursed on Ward A1
was actively unwell. Staff had completed an open-door risk assessment so that the patient could be easily observed.

Staff were required to attend infection prevention training as part of their mandatory training. Compliance with level one training was 92% for nursing staff and 94% for medical staff working in medical care services. For level two training compliance was lower at 75% for nursing staff and 64% for medical staff.

The trust carried out monthly ‘saving lives’ audits. This included staff compliance with bare below the elbows, microbial decontamination, peripheral cannula care and urinary catheter care. Wards displayed their results for the previous month on a notice board. The overall results for the clinical support unit for August 2108 showed scores of between 90% and 100% for all areas apart from peripheral cannula care (ongoing) which was 83%. Wards also displayed the number of cases of Clostridium difficile (C. diff) and Meticillin-resistant Staphylococcus aureus (MRSA) over the year. AMU had two cases of C. diff and no cases of MRSA. Each ward had a saving lives champion who was responsible for updating staff on the ward with information relating to infection prevention and control.

Disposable curtains were in place around patient beds on most wards. These were changed every six months and had the date they were last changed written on a label attached to the curtain. However, Ward A1 had material curtains around patients’ beds. We inspected them and they were visibly clean.

We saw appropriate segregation of clinical waste and disposal of sharps. Sharps bins were correctly assembled, dated and signed with a temporary closure in place. Some sharps bins were on wheels; therefore, sharps could be safely disposed of close to the point of use.

We saw staff cleaning used commodes in the dirty utility room. Staff were using different wipes for this task on different wards. Some staff were using detergent wipes from a white topped plastic container for all commodes (AMU, A4) and others were using 70% disinfectant wipes from a red topped plastic container (A1, A5). On the coronary care unit and the stroke ward staff told us they used detergent wipes unless there was a suspected or known infection, in which case they used disinfectant wipes. The trust standard operating procedure (SOP) for commode cleaning stated that staff should clean all commodes with detergent wipes and if the commode had been used for a patient with known or suspected infection then disinfection using hypochlorite solution must be carried out following removal of all dirt by cleaning. Some staff we spoke with were not aware of this and were not following the SOP.

**Environment and equipment**

All wards we visited were tidy, well organised and visibly clean. Cleaning was in progress in the areas we visited with safety signage displayed.

We checked 33 pieces of equipment which included hoists, blood pressure monitors, syringe drivers and chair scales. We found they were in good working order and had been tested for electrical safety. However, nine pieces of equipment were overdue for maintenance checks according to the labels.
Staff carried out daily checks of emergency equipment on wards. Resuscitation trollies were covered and sealed and staff were required to check that the seal was intact. If the trolley was used and opened in an emergency staff would immediately take the trolley to theatres and it would be replaced with a fully stocked trolley. Theatres had a process in place to log the location of each trolley and record the expiry date of the emergency drugs. However, they did not have a system in place for recording the expiry date of other equipment on the trolley. We checked the contents of one resuscitation trolley and found that emergency drugs and equipment were within their expiry date. We also checked the contents of the tracheostomy and chest drain trolley on AMU and found that many items had passed their sterile expiry date. This included forceps, an ET tube, sterile drapes, gauze swabs and dressings which expired in 2016. We raised this issue with the trust and when we revisited on 18 October this had been rectified.

There were drip hooks on the wall at the back of patients’ beds on AMU which may pose a risk to a patient with mental health issues as it could be used as a ligature point. Staff were aware this was a risk to patients and told us there was no formal risk assessment. Staff managed the risk on a case by case basis. Access to ligature points in AMU was on the divisional risk register. Actions to mitigate the risk were to provide patients at risk with one to one supervision, using a safe observation framework where appropriate, and the use of intentional rounding. Patients at risk would be nursed in an easily observable area.

Most of the sluice rooms were unlocked (except for the sluice on CCU). Products such as bleach were safely stored away in a locked cupboard marked Control of Substances Hazardous to Health (COSHH) within the sluice. However, we noticed on Ward A1 that the COSHH cupboard was left unlocked and the room was unattended which may pose a risk to vulnerable patients. We brought this to the attention of the ward manager who promptly found the padlock and secured the cupboard.

Staff on the stroke unit told us the environment and the location of the unit was not ideal. The bathroom facilities were not easily accessible for patients recovering from a stroke and the unit was on a different floor to the other medical wards and the emergency department. The senior management team told us they had plans to relocate the stroke ward to a more suitable location.

The decontamination facilities for endoscopy equipment were not meeting the standards set by Joint Advisory Group on Endoscopy (JAG). This was on the risk register and plans were in place to upgrade the facilities.

Equipment for the management and prevention of pressure ulcers was available such as specialist mattresses and cushions.

**Assessing and responding to patient risk**

Measures were in place to ensure that staff assessed and responded to patient risk. Nursing staff completed a range of patient risk assessments on admission to the hospital/ward. These included falls, moving and handling, nutrition and hydration and pressure damage risk.

The trust used a Modified Early Warning Score (MEWS) to measure whether a patient's condition was improving, stable or deteriorating indicating when a patient may require a higher level of care. MEWS was recorded in the patient’s paper notes on most wards but some wards had piloted an electronic recording system and this was being rolled out to all medical wards. We saw nursing
staff on the endoscopy unit using the new system and instructing other staff who had not yet used it.

Nursing staff we spoke with were aware of the importance of detecting and acting quickly if a patient’s condition deteriorated. Patients at risk of deterioration were put in beds closer to the nurses’ station. Staff told us that if a patient’s MEWS increased they would escalate this to nurse in charge and a medical review would be requested. If the overall score was six or above or there was a score of three in one parameter staff declared a code red. Nursing staff escalated this by ringing 222 and declaring a code red. This alerted the critical outreach team who were required to respond within five minutes. The electronic system alerted nursing staff if the patient’s MEWS changed and if action needed to be taken.

Improving the time between the identification of the need to screen a patient for sepsis and the administration of the first dose of intravenous antibiotics for those patients that require treatment for sepsis was a quality priority for the trust for 2018-2019. Staff we spoke with had a good awareness of sepsis and the guidelines for detection. A sepsis screening tool was used for patients with fever symptoms or who were clearly unwell with abnormal observations. If the patient was found to meet the criteria for sepsis they were immediately put on the sepsis pathway. We saw two patients on the pathway and both had received antibiotics within an hour of diagnosis. Nurses said they were more aware of sepsis and how to recognise the symptoms. Think delirium posters were displayed on notice boards on all wards we visited.

Measures were put in place for patients deemed to be at risk of pressure damage. These included the provision of pressure relieving equipment, regular position change and nutritional assessments. Staff referred patients to the tissue viability specialist nurse if they needed advice on how to manage a high-risk patient. Each ward had a tissue viability link nurse. Their role was to carry out ‘stop the pressure’ audits, provide training for staff and keep an information board on the ward for staff and patients up to date.

All patients were assessed for risk of falls on admission. A falls care plan was triggered and completed for patients who had fallen in the last 12 months, were anxious about falling, had problems with balance or scored less than eight out of ten in the mini mental test. Patients identified as at risk of falls had a magnetic symbol of a red falling man placed next to their name on the board. If a patient had a fall whilst in the hospital, nursing staff completed a post falls checklist which included assessing vital signs, informing medical staff and patients relatives and reporting the incident on the electronic reporting system. Each ward had a falls champions and we saw falls prevention information displayed on ward notice boards.

The registrar in AMU explained that patients were ‘clerked in’ in order of clinical priority following advice from colleagues in the emergency department.

On AMU there was a laminated sheet at the entrance to the bay which clearly showed which patients needed pressure care and the time the next intervention was due. The time was wiped off and replaced with a new time following care being provided.

Psychiatric liaison services for adults were provided by an agreement with Rotherham Doncaster and South Humber NHS Trust. The team provided both adult and older peoples liaison services across the emergency department and the wards. The service was available between 7am and 10pm seven days a week and outside of these times support was available through the mental
Staff told us the liaison team were easy to contact and were available to provide advice and support in the management of patient’s mental health needs, and provide guidance on managing risk prior to their assessment of the patient.

Staff told us they did not have any specific mental health assessment or risk assessment documentation. Assessment of a patients’ mental health would be completed under the psychosocial section of the nurse assessment. The documentation we saw did not reflect any specific assessment or intervention plan relating to patients’ mental health.

Staff told us although they did not have a specific risk assessment tool to identify/manage risks associated with a patient’s mental health, this was partially captured under the ‘patient who may require support observation’ form which staff used to identify where additional staffing may be required to provide one to one observations. The form was behaviour focused and had a list which identified the behaviours a patient may exhibit which would require additional support. For example, violence, harming others/self or challenging behaviour. The purpose of the form was to identify the use of additional resources to provide extra staffing and did not identify any subsequent risk management plans to address the behaviours.

Patients who presented with mental health difficulties would be asked if they agreed to a referral to the liaison service. Staff told us if they had concerns about a patient’s capacity to agree to a referral, they would assess their capacity and may make a decision in the patients best interest. Where a patient was deemed not to have capacity and was refusing a referral for a mental health assessment and trying to leave the hospital, staff said if they felt the patient would be a risk to themselves or others they would ask security to prevent the patient from leaving until they had been seen by the liaison team.

If patients required one to one care to keep them safe, the ward manager submitted an exception report to request an additional health care assistant. Staff said that this was normally approved.

**Nurse staffing**

We had concerns about the level of registered nurse staffing on medical wards. During our inspection nurse staffing levels were sufficient, however, evidence showed that nurse fill rates were very low between February 2018 to July 2018. For this period registered fill rates ranged from 55% to 100%. Wards with the lowest fill rates were the stroke unit, Ward A1, A2, A4 and A5. For example; fill rates on the stroke unit and Ward A5 were below 60% for two months and below 70% for the remaining four months. Ward A1 had fill rates below 70% for all six months.

Fill rates for health care assistants (HCAs) in the day were above 100% for all medical wards. This was to help mitigate for the shortage of registered nurses on the wards.

Fill rates on the coronary care unit for both registered nurses and HCAs were good for both day and night time, ranging from 85% to 100%.

Staff we spoke with all said that lack of staff was an ongoing issue.

At the time of our inspection AMU had 14 registered nurse vacancies. The stroke ward had 11 registered nurse vacancies and five HCA vacancies. Bank and agency staff were used to fill gaps in the rota.
The trust used the safer nursing care tool to calculate ward staffing levels and establishments. This tool takes into account the acuity and dependency of patients on the ward. Establishment reviews took place every six months. Staff told us this was still being embedded in the organisation but they anticipated that this tool would be used daily to facilitate movement of staff to ensure wards are staffed safely.

Ward staffing levels were reviewed daily at the staffing huddle led by a head of nursing. Representatives from each speciality attended the huddle to provide an overview of staffing within their ward areas and to identify support required including bank and agency requirements. To ensure minimum staffing levels were achieved, staff were asked to move to different wards. Bank and agency nursing staff would be overbooked then allocate on arrival to areas most in need.

To reduce the risk to patient care, wards without a sufficient number of registered nurses on duty were given additional HCAs. New roles were being developed within the unqualified nursing staff group to bridge gaps in staffing and ensure patients were safe. This included advanced care support workers and assistant practitioners (Band 4). In addition, wards had discharge coordinators to assist the nursing staff with tasks related to discharging patients home. We saw ward managers and matrons supporting staff on the wards with patient care.

The Division of Integrated Medicine acknowledged the risk that low levels of nurse staffing presented and this was on the divisional risk register. The division was participating in the trust’s active recruitment programme and were also concentrating their efforts to improve staff retention. There were supported development opportunities at band 6 level to encourage staff retention.

Nurse handover was twice daily at 7am and 7pm. We observed an evening nurse handover on AMU and found that an effective, comprehensive review and update of each patient and their needs was provided to the staff that had come on duty. There was a nurse co-ordinator on AMU who was not included in the staffing numbers. Co-ordinators handed over to each other at every shift change to give an overview of patients currently on the unit. Staff held a paper version of an electronic handover sheet, which was updated daily to ensure accurate information about each patient was included.

There were four beds allocated on the stroke ward for patients requiring close monitoring in the hyper acute stages of a stroke or following thrombolysis. The stroke ward had seven specialist stroke nurses who provided care for these patients 24 hours a day. Staff on the stroke ward told us the stroke specialist nurses often helped to care for other patients on the general stroke ward because it was often short of registered nurses.

The Trust provided a tuberculosis (TB) service through a standalone post. There was a risk identified on the divisional risk register about the ability to deliver the service in line with national guidelines due to the concern about providing a critical service through one member of staff. A business case had been developed as part of the actions to manage the risk.

The trust has reported their staffing numbers below for the period March 2018 and June 2018 for medicine.
<table>
<thead>
<tr>
<th>Staffing Group</th>
<th>Planned staff - WTE - Jun 18</th>
<th>Actual staff - WTE - June 2018</th>
<th>Fill Rate - Jun 18</th>
<th>Planned staff - WTE - Mar 18</th>
<th>Actual staff - WTE - Mar 18</th>
<th>Fill Rate - Mar 18</th>
</tr>
</thead>
<tbody>
<tr>
<td>Qualified nursing &amp; health visiting staff (Qualified nurses)</td>
<td>247.2</td>
<td>198.8</td>
<td>80%</td>
<td>262.6</td>
<td>204.1</td>
<td>78%</td>
</tr>
</tbody>
</table>

(Source: Routine Provider Information Request (RPIR) – Total staffing tab)

**Vacancy rates**

From 1 July 2017 to June 2018, the trust reported a vacancy rate of 19% for nursing staff in medicine. The trust does not have a vacancy rate target.

(Source: Routine Provider Information Request (RPIR) – Vacancy tab)

**Turnover rates**

From July 2017 to June 2018 the trust reported a turnover rate of 8.1% for nursing staff in medicine; the trust have not reported a target rate.

(Source: Routine Provider Information Request (RPIR) – Turnover tab)

**Sickness rates**

From July 2017 to June 2018, the trust reported a sickness rate of 5.5% for nursing staff in medicine; higher than the trust target of 4%.

(Source: Routine Provider Information Request (RPIR) – Sickness tab)

**Bank and agency staff usage**

From July 2017 to June 2018, the trust reported a bank and agency usage rate of 21.5% in medicine with 13.7% of shifts not filled.

A breakdown of bank and agency usage and unfilled shifts is shown below:

<table>
<thead>
<tr>
<th>Bank and agency</th>
<th>Number of shifts</th>
<th>% of total shifts</th>
</tr>
</thead>
<tbody>
<tr>
<td>Bank</td>
<td>3,426</td>
<td>9.5%</td>
</tr>
<tr>
<td>Agency</td>
<td>4,371</td>
<td>12.1%</td>
</tr>
<tr>
<td>Not filled</td>
<td>4,965</td>
<td>13.7%</td>
</tr>
</tbody>
</table>
Medical staffing

Medical handovers occurred twice daily at 8am and 8pm. We observed a morning medical handover on the acute medical ward (AMU). The handover was thorough and efficient with all information clearly communicated and recorded on an electronic handover sheet. Patients who had been poorly overnight were discussed in detail and handed over to the day team.

Out of hours medical cover for the hospital was one registrar (based on AMU) and three junior doctors (two FY2s and one FY1). There was support from the hospital at night team (one nurse and one health care assistant) and an on-call consultant. Two junior doctors we spoke with told us they felt well supported when covering medical wards at night.

An acute physician was present in AMU from 8am until 6pm Monday to Friday and was responsible for reviewing patients admitted from the emergency department. Outside of these hours a general medicine physician was on call and was present on site until 9pm then contactable by phone from 9pm until 8am Monday to Friday. At weekends two general medicine physicians were on call, one of which was on site 8am to 12pm and the other 8am to 4pm. After these times the consultants were available by telephone and would re-attend at the request of the registrar.

There were a total of four respiratory consultants and four cardiology consultants. Ward A1 was covered by at least one respiratory consultant and one cardiology consultant. Cardiology also had one consultant for CCU. The trust had not been able to recruit a substantive consultant for the stroke service or the gastroenterology service and locums were currently filling these posts. This presented a challenge in terms of the continuity and resilience of these services. However, one of the current locums for stroke had been with the service long-term and had committed to working for the Trust into 2019. The locum was taking a lead role for the stroke unit. Staff working on the unit said this had a positive impact on the service.

All clinical areas for medical staff had a set minimum staffing level. Gaps in the medical rota were covered by bank and agency staff. However, not all gaps could be filled and wards were often below the minimum level for junior doctors. Information provided by the trust showed that from April 2018 to September 2018 there were 85 days overall when the junior doctor staffing was below the minimum staffing level. The highest number of days was for cardiology with a total of 34 days over this period.

Medical staffing was on the risk register and the trust were actively recruiting to vacant posts. A recruitment drive had been successful in India and 14 doctors were due to commence working at the trust for a period of two years. In addition, the trust had several nurse consultants and advanced nurse practitioners (ANPs) and were in the process of recruiting and training more ANPs.

The trust has reported their staffing numbers below for the periods March 2018 and July 2018 for medicine.
<table>
<thead>
<tr>
<th>Staffing Group</th>
<th>Planned staff - WTE - Jun 18</th>
<th>Actual staff - WTE - June 2018</th>
<th>Fill Rate - Jun 18</th>
<th>Planned staff - WTE - Mar 18</th>
<th>Actual staff - WTE - Mar 18</th>
<th>Fill Rate - Mar 18</th>
</tr>
</thead>
<tbody>
<tr>
<td>Medical &amp; Dental staff - Hospital</td>
<td>51.3</td>
<td>28.1</td>
<td>55%</td>
<td>47.7</td>
<td>28.2</td>
<td>59%</td>
</tr>
</tbody>
</table>

*(Source: Routine Provider Information Request (RPIR) – Total staffing tab)*

**Vacancy rates**

From July 2017 to June 2018, the trust reported a vacancy rate of 0% for medical staff in medicine which does not fit with the fill rate information above. The trust does not have a vacancy rate target.

*(Source: Routine Provider Information Request (RPIR) – Vacancy tab)*

**Turnover rates**

From July 2017 to June 2018 reported a turnover rate of 60.2% for medical staff in medicine; this is caused by a large spike in turnover rate in August 2017. This may indicate the movement of junior doctors on rotation.

*(Source: Routine Provider Information Request (RPIR) – Turnover tab)*

**Sickness rates**

From July 2017 to June 2018 reported a sickness rate of 5.5% for medical staff in medicine; higher than the trust target of 4%.

*(Source: Routine Provider Information Request (RPIR) – Sickness tab)*

**Bank and agency staff usage**

The Trust was not able to supply this data as they did not use e-Rostering for doctors. Therefore, they could not supply data on total shifts. The only data they maintained was shifts requested to cover rota gaps and the fill rate for agency locums and internal.

*(Source: Routine Provider Information Request (RPIR) - Medical agency locum tab)*

**Staffing skill mix**

In May 2018, the proportion of consultant staff reported to be working at the trust was lower than the England average and the proportion of junior (foundation year 1-2) staff was higher.
Staffing skill mix for the 69 whole time equivalent staff working in medicine at The Rotherham NHS Foundation Trust

<table>
<thead>
<tr>
<th></th>
<th>This Trust</th>
<th>England average</th>
</tr>
</thead>
<tbody>
<tr>
<td>Consultant</td>
<td>40%</td>
<td>43%</td>
</tr>
<tr>
<td>Middle career^</td>
<td>11%</td>
<td>6%</td>
</tr>
<tr>
<td>Registrar group~</td>
<td>18%</td>
<td>28%</td>
</tr>
<tr>
<td>Junior*</td>
<td>30%</td>
<td>22%</td>
</tr>
</tbody>
</table>

^ Middle Career = At least 3 years at SHO or a higher grade within their chosen specialty  
~ Registrar Group = Specialist Registrar (StR) 1-6  
* Junior = Foundation Year 1-2

(Source: NHS Digital - Workforce Statistics - Medical March 2018)

Records

Most patient records were in paper format. Paper records were stored in moveable trolleys with lockable lids. We saw that the lids were closed when not in use, however, most of the trolleys were not locked. Trolleys were located either near to the nurse’s station or in the corridor next to the patient bay which may present a risk of records being accessed by unauthorised people. Some paper records were kept at the patient’s bedside. These included intentional rounding charts, food and fluid charts and fluid balance charts.

We looked at sample of 10 patient records which included nursing and medical notes. We found that care plans and risk assessments were completed appropriately in most records. We found that patient records were very organised on Ward A5 with dividers used for different sections which made information easy for staff to find.

The electronic patient system was used to flag specific patient information, for example, a flag was used to identify patients with a learning disability.

Staff told us they sometimes had to record information twice in different parts of the record and this was inefficient and time consuming. Staff thought moving onto electronic record keeping would be much better.

We found an intentional rounding document had not been completed for a patient on AMU, however, there was documentation of the patient being regularly turned and personal cares being given documented in the nursing notes.
The trust carried out a yearly audit of nursing records. We reviewed the most recent audit for medical wards which highlighted some areas for improvement such as the patient name or unique identifying number being included throughout all documentation. There were some positive areas identified for example, good evidence of individualised care plans with clear concise evaluations. There was an action plan for each ward which would be shared with ward staff by the practice development team.

We found a bag of patient confidential waste stored in the dirty utility on Ward A1 and Ward A5. The room was unlocked and the bag was left open so the contents could be seen.

**Medicines**

We had concerns about the high level of missed doses and gaps in medicines administration charts. We looked at 30 prescription charts and found 17 had multiple gaps in administration records where staff had not signed or entered a code to indicate the reason a medicine had not been given.

Omitted or missed doses included medication such as clopidogrel and apixaban which were on the trusts list of critical medicines. One patient had missed a dose of insulin. When we asked why the dose had been missed staff told us this was because it was out of stock on the ward. One chart had been incorrectly re-written and the patient had missed three doses of VTE prophylaxis medication. A patient with suspected chest sepsis on Ward A1 had missed five doses of antibiotics. For two of the doses, nursing staff had marked the chart with a reason code to explain they had not been given at the nurse’s discretion, however, there was no reason given for the remaining three missed doses.

Medicines were stored securely with access restricted to authorised staff members. Medicines rooms were tidy and well organised. Controlled drugs were ordered appropriately and stock checks were completed each day on all wards we visited.

We reviewed the prescription charts of seven patients who were receiving oxygen. We found four out of seven patients who were receiving oxygen had not had it prescribed and there were no target blood oxygen levels documented. Oxygen cylinders were stored appropriately and were within their expiry date.

We found that all patients we reviewed had been prescribed appropriate prophylaxis for Venous Thromboembolism (blood clots) where this was indicated. However, medical staff did not always fully complete the risk assessment included with the medicines chart.

Pharmacists checked (reconciled) patients’ medicines on admission to hospital, and we saw this generally occurred in a timely manner. However, when discrepancies were identified, there was no handover system in place to ensure these were followed-up, particularly when patients moved between different wards.

Pharmacy support to wards varied. Staff on the stroke ward told us that the service had deteriorated recently and they had to ring up to see if support was available. Often health care staff would need to take the prescription charts to the dispensary and this caused delays and meant a member of staff being off the ward for a period of time.
There was no consistent method used on wards for checking the temperature of drug fridges and staff had not recognised or taken action when fridge temperatures were out of range. Staff on some wards recorded the current temperature only whilst others recorded the minimum and maximum temperature in addition to the current. We saw that staff recorded maximum temperatures of more than eight degrees on most wards but no action had been taken to report or address this. Staff we spoke with did not know when to take action or what to do despite there being clear instructions on some wards.

The treatment room for medicines storage was very warm on Ward A1 and there was no procedure to measure and monitor the room temperature. This meant staff did not know if the temperature exceeded 25 degrees. Staff told us they used a fan to cool the room when it was hot.

We found variation in the checking of Hypo boxes. Documentation showed that checks had been completed daily on some wards but were incomplete on others. We could not find a method for recording checks on the acute medical unit (AMU). We also found variation in the storage and labelling of insulin pens. We found pens stored in a cupboard on AMU were not labelled with the patient’s name and the date of opening was not recorded. On Ward A5, insulin pens were named and dated and kept in individual patient’s lockers at bedside.

Patients’ own drugs were kept in a locked cabinet by their bed. Staff told us they administered patients own medicines and topped up from stock medicines in treatment room if needed.

There was a standard operating procedure for the administration of medicines which included a section on self-administration by patients. However, most nurses we spoke with were not aware of this policy. During the inspection we found one patient self-administrating their medicines but there was no assessment or consent form in the patient’s notes.

Where patients had been prescribed urgent antibiotics for sepsis (a serious complication of an infection), these were administered within an hour in accordance with guidance. A Patient Group Directive (PGD) was in use on the Haematology ward to facilitate timely access to urgent antibiotics. The PGD was within review date and had been signed by all staff using it. However, training records were not available to demonstrate annual refresher training had been completed by all staff in accordance with the terms of the PGD. We saw that intravenous antibiotics for the treatment of sepsis were stored in a locked cupboard on the haematology ward with clear signage in yellow so staff could access this quickly.

Ward staff told us the process for checking discharge medicines sometimes caused delays because the discharge letter did not state what had been supplied by the pharmacy. Pharmacy staff told us they could not amend the letter to indicate what had been supplied. This meant patients did not always receive all the medicines they needed and ward staff had to chase up missing items. In some cases, patients left the ward without their medicines and had to return later to collect them.

The trust had taken steps to ensure appropriate antimicrobial use to optimise patient outcomes and to reduce the risk of antimicrobial resistance. There was an antimicrobial pharmacist in place who worked as part of a multidisciplinary team to improve antimicrobial stewardship. When patients had been prescribed intravenous antibiotics, these were regularly reviewed and changed to oral alternatives in a timely manner. However, we found prescribers did not always record an indication or stop date when prescribing antibiotics.
The chief pharmacist told us that currently there was no mandatory medicines management training programme for nursing staff, however, there were plans to introduce this in future. They were looking to include a one or two-hour session on the nurse essential training days.

There were a high number of medication errors reported by staff at this trust. The trust had set out a medication safety aim for 2018/2019 which included objectives to improve the percentage of medication administrations signed for or, a reason for non-administration recorded on the medication chart, from 96% to 100% by 31 March 2019. It also aimed to improve the percentage of patients leaving the organisation with a discharge letter, their medication and having received information about their medication from the discharging ward/nurse from 80% to 100% by 31 March 2019.

Incidents

Staff were aware of the importance of incident reporting and how to report an incident using the electronic reporting system. Staff we spoke with told us they received feedback from incidents. Feedback and learning from incidents was cascaded to staff both individually and via team meetings. Staff could request to receive feedback via an email linked to the electronic reporting system. Staff knew how to report and could request feedback.

Learning from incidents was shared with nursing staff at the safety briefing which occurred before morning and evening handover. The information shared at the safety brief was also recorded on a whiteboard for staff to read and was repeated for one week to ensure as many staff as possible received the information. This included information on incidents from other areas of the trust.

All wards displayed their top three reported incidents. For AMU the top three incidents were lack of suitably trained/skilled staff, patient falls and medicines not administered.

Incidents were discussed at specialist governance meetings. The top five themes from incidents reported were discussed at medicine clinical service unit governance meeting.

Staff we spoke with knew of the Duty of Candour (DoC) requirements. They understood that this involved being open and honest with patients when things go wrong. Ward managers were aware of the DoC and some staff explained to us that they had been involved in investigating and responding to patients and families under this duty. DoC was incorporated into the incident reporting system.

However, the medicine performance dashboard for the trust showed that for August 2018, there were 134 overdue incident reports.

Never Events

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.
From August 2017 to July 2018, the trust reported no incidents classified as never events for medicine.

(Source: Strategic Executive Information System (STEIS))

**Breakdown of serious incidents reported to STEIS**

In accordance with the Serious Incident Framework 2015, the trust reported 11 serious incidents (SIs) in medicine which met the reporting criteria set by NHS England from August 2017 to July 2018.

Of these, the most common types of incident reported were:

- Three slips/trips/falls meeting SI criteria (27% of total incidents).
- Three recorded as ‘all other categories’ (27% of total incidents).
- Two sub-optimal care of the deteriorating patient meeting SI criteria (18% of total incidents).
- One surgical/invasive procedure incident meeting SI criteria (9% of total incidents).
- One diagnostic incident including delay meeting SI criteria (including failure to act on test results) (9% of total incidents).
- One HCAI/Infection control incident meeting SI criteria (9% of total incidents).

(Source: Strategic Executive Information System (STEIS))

**Safety Thermometer**

The medicine performance dashboard for the trust showed that for August 2018, harm free care was 97.6% which was better than the trust target of 95%.

The Safety Thermometer is used to record the prevalence of patient harms and to provide immediate information and analysis for frontline teams to monitor their performance in delivering harm free care. Measurement at the frontline is intended to focus attention on patient harms and their elimination.

Data collection takes place one day each month – a suggested date for data collection is given but wards can change this. Data must be submitted within ten days of suggested data collection date.

Data from the Patient Safety Thermometer showed that the trust reported 20 new pressure ulcers, one fall with harm and eight new urinary tract infections in patients with a catheter from July 2017 to July 2018 for medical services.
Prevalence rate (number of patients per 100 surveyed) of pressure ulcers at The Rotherham NHS Foundation Trust

1 Total Pressure ulcers (20)

2 Total Falls (1)

3 Total CUTIs (8)

1 Pressure ulcers levels 2, 3 and 4
2 Falls with harm levels 3 to 6
3 Catheter acquired urinary tract infection level 3 only

Source: NHS Digital - Safety Thermometer

Is the service effective?

Evidence-based care and treatment

Staff had access to policies and procedures and other evidence-based guidance via the trust intranet. We reviewed a random selection of five policies including the decontamination policy, the operational escalation policy and the policy for the prevention, control and management of infection. All were within their review date.

Clinical policies had been developed based on national guidance such as the National Institute for Health and Care Excellence (NICE). We found care was provided based on best possible evidence and in line with national guidance, for example, stroke rehabilitation in adults (CG162).

There was a process in place to ensure that clinical practice was in line with the service NICE guidance. This process was monitored and facilitated by the clinical effectiveness team who tracked progress in a NICE database. Where partial or non-compliance was identified, the clinical
effectiveness lead from the affected department developed an action plan with clinicians which was implemented and monitored to specified timelines.

The trust participated in local and national audit and used this to measure and improve effectiveness of care and treatment. We saw that the trust had action plans in place to address poor performance in national and local audit.

**Nutrition and hydration**

Staff identified patients at risk of malnutrition, weight loss or requiring extra assistance at mealtimes. Patients were screened using the Malnutrition Universal Screening Tool (MUST). Food and fluid charts were completed for patients who were vulnerable or required nutritional supplements and support was provided by the dietetic service.

Meal times were protected; however, relatives could stay and assist with feeding if they wished. Patients we spoke with were happy with food choices and said the portion sizes were reasonable.

Specific dietary needs such as a soft diet, pureed or thickened fluids were provided. Patients dietary requirements were clearly written on a white board at the back of the patients’ bed. This also stated if a patient was nil by mouth.

Food menus were on a 14-day cycle to provide variety for patients. Ethnic meals could be provided and the menus were available in different languages on request.

We observed members of nursing staff assisting patients to eat their food. We saw a nurse on Ward A5 ensure that all patients had been served their meal and checked to see if they needed assistance. Patients were sat up or out of bed and food was placed within reach.

Patients all had water jugs and cups within reach. Beakers with two handles and spouts were available for patients who needed them.

We reviewed two prescription charts completed by the dietician. One patient was receiving enteral feeding and one patient was receiving nasogastric tube feeding. Both prescription charts were completed accurately and instructions were documented clearly.

A sign was displayed on wards informing patients they should not hesitate to ask if they needed food or a drink between meals.

**Pain relief**

The service managed pain relief well. Patients we spoke with had no concerns about how their pain was managed.

We observed staff checking patients pain levels and saw them respond when needed. Staff checked with patients that pain relief administered had been effective.

**Patient outcomes**
The trust participated in local and national audit and used this to measure and improve effectiveness of care and treatment. The local audit plan for the medicine CSU included a number of internal and external audits.

A senior nurse ward assurance tool was in use to provide ward managers and matrons with assurance that the ward was meeting standards in a number of areas. For example, staffing, compliance, environment, patient experience, staff experience and the fundamental standards. This tool should be completed by the ward manager weekly and then the following week by the matron to see if the required improvements identified the previous week had been made. Any issues identified should be discussed with staff and themes were fed into the matron harm free care and monthly internal performance meeting. We reviewed a sample of completed assurance tools and found that they were not completed consistently. Some were thorough and clearly identified areas of concern to be shared with staff, others were poorly completed and handwriting was not always eligible. The results were not audited or presented in a report to give senior managers an overview of how wards were performing.

The trust had been identified as an outlier for intestinal obstruction and were working through an action plan to address this.

The endoscopy unit was Joint Advisory Group on Endoscopy (JAG) accredited however the service had been assessed and did not meet all the JAG criteria. The re-accreditation by JAG had been deferred for six months to allow the unit to make improvements.

We saw that the trust had action plans in place to address poor performance in national and local audit. The stroke team had responded to the poor results for speech and language therapy in the SSNAP and this had recently resulted in improvements in this domain.

The overall risk of readmission was lower than expected for both elective and non-elective admissions compared to the England average, although it was higher for elective admissions in general medicine and clinical haematology (see below).

**Risk of readmission**

**Trust level**

From May 2017 to April 2018, patients at the trust had a lower than expected risk of readmission for elective admissions and a lower than expected risk of readmission for non-elective admissions when compared to the England average.

In elective admissions, the trust exceeded the expected risk of readmission in general medicine and clinical haematology.

In non-elective admissions, the trust performed better than the expected risk of readmission in all specialities.

**Elective Admissions – Trust Level**
Note: Ratio of observed to expected emergency readmissions multiplied by 100. A value below 100 is interpreted as a positive finding, as this means there were fewer observed readmissions than expected. A value above 100 is represents the opposite. Top three specialties for specific trust based on count of activity.

**Non-Elective Admissions – Trust Level**

Note: Ratio of observed to expected emergency readmissions multiplied by 100. A value below 100 is interpreted as a positive finding, as this means there were fewer observed readmissions than expected. A value above 100 is represents the opposite. Top three specialties for specific trust based on count of activity.

**Rotherham Hospital**

From May 2017 to April 2018, patients at Rotherham Hospital had a lower than expected risk of readmission for elective admissions and a lower than expected risk of readmission for non-elective admissions when compared to the England average.

In elective admissions, the trust exceeded the expected risk of readmission in general medicine and clinical haematology.

In non-elective admissions, the trust performed better than the expected risk of readmission in all specialities.

**Elective Admissions - Rotherham Hospital**

Note: Ratio of observed to expected emergency readmissions multiplied by 100. A value below 100 is interpreted as a positive finding, as this means there were fewer observed readmissions than expected. A value above 100 is represents the opposite. Top three specialties for specific site based on count of activity.

**Non-Elective Admissions - Rotherham Hospital**
Note: Ratio of observed to expected emergency readmissions multiplied by 100. A value below 100 is interpreted as a positive finding, as this means there were fewer observed readmissions than expected. A value above 100 is represents the opposite. Top three specialties for specific site based on count of activity.

Sentinel Stroke National Audit Programme (SSNAP)

The trust takes part in the quarterly Sentinel Stroke National Audit programme. On a scale of A-E, where A is best, the trust achieved grade B the in latest audit.

Rotherham Hospital

<table>
<thead>
<tr>
<th>Team centred performance</th>
<th>Jan-Mar 16</th>
<th>Apr-Jul 16</th>
<th>Aug-Nov 16</th>
<th>Dec 16 - Mar 17</th>
<th>Apr 17 - Jul 17</th>
<th>Aug 17 - Nov 17</th>
</tr>
</thead>
<tbody>
<tr>
<td>Domain 1: Scanning</td>
<td>A</td>
<td>A</td>
<td>A</td>
<td>A</td>
<td>B↑</td>
<td>A↑</td>
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<tr>
<td>Domain 2: Stroke unit</td>
<td>D↓</td>
<td>C↑</td>
<td>C</td>
<td>D</td>
<td>D</td>
<td>D</td>
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<tr>
<td>Domain 3: Thrombolysis</td>
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<td>Domain 4: Specialist assessments</td>
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<td>Domain 5: Occupational therapy</td>
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<td>Domain 7: Speech and language therapy</td>
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<td>E</td>
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<td>D↑</td>
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<td>Domain 8: Multi-disciplinary team working</td>
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<td>D↓</td>
<td>C↑</td>
<td>C</td>
<td>C</td>
<td>D↓</td>
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<tr>
<td>Domain 9: Standards by discharge</td>
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<td>A</td>
<td>A</td>
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<tr>
<td>Domain 10: Discharge processes</td>
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<td>B↑</td>
<td>C</td>
<td>C</td>
<td>B↑</td>
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<tr>
<td>Team-centred total key indicator level</td>
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<td>C</td>
<td>B↑</td>
<td>C</td>
<td>C</td>
<td>B↑</td>
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Overall Scores

<table>
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<th>Jan-Mar 16</th>
<th>Apr-Jul 16</th>
<th>Aug-Nov 16</th>
<th>Dec 16 - Mar 17</th>
<th>Apr 17 - Jul 17</th>
<th>Aug 17 - Nov 17</th>
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<tbody>
<tr>
<td>SSNAP level</td>
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<td>B↑</td>
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<tr>
<td>Case ascertainment band</td>
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<td>Audit compliance band</td>
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<tr>
<td>Combined total key indicator level</td>
<td>D↓</td>
<td>C↑</td>
<td>B↑</td>
<td>C</td>
<td>C</td>
</tr>
</tbody>
</table>

(Source: Royal College of Physicians London, SSNAP audit)

Lung Cancer Audit

The trust participated in the 2017 Lung Cancer Audit and the proportion of patients seen by a
Cancer Nurse Specialist was 88.1%, which did not meet the audit aspirational standard of 90%. The 2016 figure was 70.1%.

The proportion of patients with histologically confirmed Non-Small Cell Lung Cancer (NSCLC) receiving surgery was 23.0%. The audit indicates that this is good practice. The 2016 figure was not significantly different to the national level.

The proportion of fit patients with advanced (NSCLC) receiving Systemic Anti-Cancer Treatment was 68.8%. This is within the expected range. The 2016 figure was not significantly different to the national level.

The proportion of patients with Small Cell Lung Cancer (SCLC) receiving chemotherapy was 77.5%. This is within the expected range. The 2016 figure was not significantly different to the national level.

The one year relative survival rate for the trust in 2016 is 35.2%. This is within the expected range. The 2016 figure was not significantly different to the national level.

(Source: National Lung Cancer Audit)

National Audit of Inpatient Falls 2017

The crude proportion of patients who had a vision assessment (if applicable) was 0%. This did not meet the national aspirational standard of 100%.

The crude proportion of patients who had a lying and standing blood pressure assessment (if applicable) was 4%. This did not meet the national aspirational standard of 100%.

The crude proportion of patients assessed for the presence or absence of delirium (if applicable) was 33%. This did not meet the national aspirational standard of 100%.

The crude proportion of patients with a call bell in reach (if applicable) was 100%. This met the national aspirational standard of 100%.

(Source: Royal College of Physicians)

Competent staff

At the previous inspection we found that not all staff had received an appraisal with their line manager. We found at this inspection that although most staff we spoke with said they had received an appraisal, compliance rates for were low and did not meet the trust target of 90%. Some staff said that their appraisal had been postponed when there were bed pressures and operational issues within the service. The medicine performance dashboard for August 2018 showed that the overall compliance for the completion of appraisals was 64.7%.

Appraisal rates

From April 2017 to March 2018, 62% of staff within urgent and medicine care at the trust received
an appraisal compared to a trust target of 90%. Due to the way the trust records appraisals, data from April 2018 to August 2018 has not been included, as this does not give a suitably sized dataset for analysis.

<table>
<thead>
<tr>
<th>Staff Group</th>
<th>Appraisals required</th>
<th>Appraisals completed</th>
<th>Percentage completed</th>
<th>Trust Target (90%) met?</th>
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<tbody>
<tr>
<td>Qualified Allied Health Professionals (Qualified AHPs)</td>
<td>32</td>
<td>24</td>
<td>75%</td>
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</tr>
<tr>
<td>NHS infrastructure support</td>
<td>3</td>
<td>2</td>
<td>67%</td>
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<tr>
<td>Support to doctors and nursing staff</td>
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<td>127</td>
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<td>No</td>
</tr>
<tr>
<td>Qualified nursing &amp; health visiting staff (Qualified nurses)</td>
<td>199</td>
<td>118</td>
<td>59%</td>
<td>No</td>
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<tr>
<td>Support to ST&amp;T staff</td>
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<tr>
<td>Qualified Healthcare Scientists</td>
<td>19</td>
<td>8</td>
<td>42%</td>
<td>No</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>462</strong></td>
<td><strong>288</strong></td>
<td><strong>62%</strong></td>
<td><strong>No</strong></td>
</tr>
</tbody>
</table>

(Source: Routine Provider Information Request (RPIR) – Appraisal tab)

Staff we spoke with said they had opportunities to learn develop in their roles. A nurse on the haematology ward had attended a chemotherapy training day and said she felt the trust invested in her development.

We spoke with two nurses who had joined the trust a year ago as newly qualified nurses. Both nurses said they had received a week induction, and had then been for supernumerary on the ward for at least four weeks. They had a six-month preceptorship programme and had received regular supervision. They told us they felt well supported and had received additional training in diabetes care and cannula training.

When we carried out an unannounced inspection in July 2018 we found that only 12% of eligible nursing staff on Ward A1 had completed non-invasive ventilation (NIV) competency training and this was insufficient to safely care for acute NIV patients on the ward. In response to our findings the trust developed an action plan. This involved moving acute NIV patients to the high dependency unit (HDU) until actions could be put in place to ensure they could be safely cared for on Ward A1. The trust ensured that all nursing staff caring for NIV patients on HDU had undertaken the appropriate competency training and assessment. At this inspection we saw that these measures were in place and all patients requiring acute NIV were cared for on HDU.

The trust had introduced a new policy for clinical and practice supervision for registered nurses, midwives and allied health professionals. This policy stated that staff should receive supervision once a year as a minimum and following involvement in a serious incident. Nursing staff we spoke with said they had not received clinical supervision but were confident they could request it if they needed to. The exception to this were the advanced nurse practitioners in the ambulatory care unit who said they had regular supervision.
Junior doctors we spoke with told us they were able to attend lunchtime training and mandatory training sessions. They felt well supported and were able to meet regularly with their clinical supervisor.

Newly qualified physiotherapy staff received an induction which included two weeks teaching and two weeks shadowing. They received regular supervision and were required to achieve competencies as part of their induction and ongoing development. Physiotherapy staff told us they were expanding and developing more competencies for staff.

Speech and language therapists had provided competency based training for physiotherapy staff on the stroke ward to enable them to carry out swallowing assessments and reviews for stroke patients. This was to improve the time taken for stroke patients to receive an assessment.

A bank nurse said she had access to all training relevant to her role. The nurse had worked for the trust previously in a substantive role.

A health care assistant (Band 3) told us she had completed competencies for taking bloods, cannula care, female catheters and taking patient observations. She had received theory training followed by practical training and had these competencies signed off. Clinical skills were reviewed every three years.

The deputy sister on AMU coordinated staff training and supported staff new in their role.

Staff on wards supported student nurses on clinical placements. Students we spoke with said they felt well supported.

**Multidisciplinary working**

Staff spoke positively about multidisciplinary team (MDT) working and said they had good working relationships between professions.

We saw good examples of MDT working. Clinical and non-clinical staff attended daily twice daily safety briefings to share information about patient risk. Wards held multidisciplinary board rounds Monday to Friday. We observed a morning board round on Ward A3 (Gastroenterology) which was attended by the consultant, nurse in charge, doctors, discharge co-ordinator and specialist nurse. Information about each patient was shared and discussed by the team including their condition, test results, tests planned, referrals made, discharge plans, outcomes, psychological needs and interaction with family members. We saw that all present contributed to the meeting and communicated well with other members of the team.

We observed multidisciplinary interventions on the stroke unit and saw evidence of multidisciplinary plans of care and evaluation of patient goals. MDT meetings were held on the unit to discuss patients plan of care and treatment. The MDT was attended by the stroke consultant, junior doctor, physiotherapists, occupational therapists, nursing staff, social care staff and other professionals if required.

Referral pathways were in place for referral to the speech and language therapist, podiatrist and dietitian. Pharmacist and pharmacy technicians supported wards.
Specialist nurses were available to offer support, advice and training to staff in a number of specialist areas. These included tissue viability, stroke, diabetes, and learning disability.

Staff worked across health care disciplines and with other agencies including psychiatric liaison services when required to care for patients. Psychiatric liaison services felt staff referred patients appropriately and would seek advice when they had concerns or when finding a patient’s behaviour difficult to manage.

Seven-day services

To meet the 14 hours of admission to initial consultant review standard set by the NHS there was an acute physician present in AMU Monday to Friday and two general medicine physicians on site during the day at weekends. Consultants were available by telephone during the evening.

The endoscopy unit was open from 8am to 6pm Monday to Friday with some additional sessions provided on Sundays. A 24 hour on call gastrointestinal (GI) bleed rota was in place from Monday to Friday and if endoscopy services were needed out of hours, this would be performed in the operating theatre. From 5pm on Friday until 8am on Monday patients with a GI bleed would be taken to the hospital at Doncaster, which is provided by a different NHS trust.

There was a specialist stroke nurse on duty 24 hours a day, seven days a week to respond to patients with a suspected stroke in the emergency department or on hospital wards. The transient ischaemic attack (TIA) clinic was managed by staff from the acute stroke ward and this was provided seven days a week. During the week the clinic was run by the consultant and a specialist stroke nurse and at weekends the clinic was run by the specialist nurse for patients with low risk TIA’s.

There were on call arrangements to ensure that pharmacy services and diagnostics were available 24 hours a day, seven days a week.

Therapy staff on the stroke ward provided a seven-day service.

The adult psychiatric liaison service was provided between the hours of 7am and 10pm seven days a week and could often attend the ward within an hour. Between 10pm and 7am support was available through the crisis team who could attend within four hours if required.

Health promotion

Diabetes specialist nurses were supporting ‘hypo awareness week’ and were visiting each ward with information to give out to patients, relatives and staff to raise their awareness of hypoglycaemia. This included a quiz with prizes if people answered correctly.

Alcohol screening was carried out on admission. There was an alcohol liaison service on site which offered advice and treatment. If appropriate patients could be referred to the community alcohol services and could refer directly to social prescribing. The service also offered brief advice on smoking cessation.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards
The Mental Capacity Act (MCA) enables people to make their own decisions wherever possible and provides a process and guidance for decision making where people are unable to make decisions for themselves. It applies to individuals over the age of 16. Where someone is judged not to have the capacity to make a specific decision (following a capacity assessment), that decision can be taken for them, but it must be in their best interests.

The MCA allows restraint and restrictions to be used but only if they are in a person's best interest. Extra safeguards are needed if the restrictions and restraint used will deprive a person of their liberty. These are the Deprivation of Liberty Safeguards (DoLs).

At the previous inspection we were not assured that staff were fully aware of the requirements of the MCA regarding documentation.

Improvement of Compliance with the Mental Capacity Act (MCA) was a trust quality priority for 2018/2019. There was an ongoing action plan to achieve this which included quarterly audits following a baseline audit. Results for quarter two and quarter three showed some progress compared to the baseline.

At this inspection we found staff demonstrated an understanding of the relevant consent and decision-making requirements of legislation and guidance, including the Mental Capacity Act 2005 and the Children Acts 1989 and 2004. However, the documentation for mental capacity assessment documentation was brief and did not demonstrate the rationale behind the decision regarding a patient’s capacity or the actions taken to test a patient’s ability to understand, retain, weigh up and communicate the information relating to the decision.

Capacity assessments were broad and covered ‘care and treatment’ as opposed to separate assessments for care and each treatment provided.

Decisions made in a patient’s best interest where a patient was deemed to lack capacity should be recorded in their care records. Out of the 5 records we reviewed we only found one with a record of a best interest meeting. Three records simply recorded ‘care given in patients best interest' with no detail of who made the decision or the options considered.

Applications made under the deprivation of liberty safeguards were seen to be made appropriately. Where a patient had been deemed to lack capacity, an urgent request was applied for initially and an extension requested should the patient remain for more than the seven days. Referrals were processed by the hospital safeguarding team who would request a standard authorisation following an extension of the original application. The lead consultant was responsible for assessing patient’s capacity on a weekly basis. Where a patient regained capacity the deprivation of liberty safeguards application was cancelled. The safeguarding team maintained a log of all referrals to ensure applications were cancelled if a patient was discharged or regained capacity.

We reviewed DoLs application for a patient on Ward A3 and found the paperwork was completed thoroughly. Another DoLS application on the stroke ward was documented correctly and it was noted that after seven days staff needed to contact the safeguarding team to extend it if it was still required.
We observed staff asking patients for their consent prior to providing care and treatment. Patients were asked their consent to share information regarding their care with others involved in their care and this was recorded in the nursing records.

All patients aged 60 years and over received cognitive testing in AMU. We saw a flow chart in the medical clerking proforma which guided staff through an assessment which included an abbreviated mental test if this was indicated by the flow chart.

**Mental Capacity Act and Deprivation of Liberty training completion**

Training in MCA and DoLS was provided as part of the Safeguarding Adults Level 2 training. The trust reported that from April 2017 to May 2018 in medical care services Safeguarding Adults Level 2 training compliance was 71% for qualified nurses and 64% for medical staff in medicine compared to the trust target of 85%. Although this did not meet the trust target it was an improvement on the previous inspection when compliance was 59%.

(Source: Routine Provider Information Request (RPIR) – Training tab)

**Is the service caring?**

**Compassionate care**

Staff cared for patients with compassion. We spoke with 17 patients and three relatives throughout the inspection. Patients and relatives told us that they had been treated kindly and that staff were polite and respectful.

All patients we spoke with were happy with the standard of care they received. They had drinks and call bells located within easy reach. Patients told us they felt safe.

Comments from patients included ‘they have been brilliant’ and ‘I have been well looked after’. Patients also remarked that staff were very busy and there were not enough of them.

We overheard discussions between staff and patients and these were carried out in a compassionate and supportive way. Staff gave reassurance and provided information at a pace appropriate for the patient. We observed patients’ privacy and dignity were maintained when staff delivered care.

We observed two health care assistants coaxing a patient to reposition himself back into chair in an encouraging and caring way.

Staff showed understanding and a non-judgmental attitude when caring for or talking about patients with mental health needs, learning disabilities, autism or dementia.

Staff told us they supported patients who became distressed in an open environment, and would help them maintain their privacy and dignity. For example, staff would take patients to a room away from the open bays to provide patients a space to talk away from the ward.
We saw a doctor patiently explaining test results to a patient on the coronary care unit. The patient was being cared for in a five-bedded bay and the curtains were pulled round. The doctor spoke quietly to ensure privacy and allowed time for the patient to ask questions.

Staff on Ward A1 had raised money to supply a television in each bay which meant that patients on this ward did not have to pay to watch television.

**Friends and Family test performance**

The Friends and Family Test response rate for medicine at the trust was 52%, which was better than the England average of 25% from July 2017 to June 2018.

The average monthly performance for medical wards from July 2017 to June 2018 ranged from 89% to 100% with the lowest average being for Ward A1 at 89%.

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Note - The formatting above is conditional formatting which colours cells on a grading from highest to lowest, to aid in seeing quickly where scores are high or low. Colours do not imply the passing or failing of any national standard.

*(Source: NHS England Friends and Family Test)*

**Emotional support**

Staff provided emotional support to patients to minimise their distress. We saw a member of staff being extremely caring in supporting a patient who had received some bad news about their condition.

Relatives of patients living with dementia were offered information on voluntary organisations, which could provide them with support and advice. Information about several different organisations which could offer support to patients and relatives was displayed on ward notice boards. For example; Parkinson’s UK, The Alzheimer’s Society and Myeloma UK. Macmillan
cancer care support leaflets were made available for patients and relatives on Ward A5 (Haematology).

There was 24 hours access to a psychiatric liaison team. We heard staff discussing patients’ psychological needs at the board round on Ward A3 (Gastroenterology). Psychological support was available to patients on the stroke unit.

Spiritual and pastoral support was available to patients, relatives, carers and staff. There was a multi-faith centre on site with a chapel and a prayer room. Chaplains were available to provide services for different faiths in the chapel or at the patient’s bedside.

**Understanding and involvement of patients and those close to them**

Patients and relatives we spoke with told us they were kept up to date with what was happening and were involved in decisions about their care. Patients said they would know who to approach if they had issues regarding their care, and they felt able to ask questions.

We saw evidence in patient records that patients and their relatives had been involved in making decisions about their care and treatment. Relatives were involved in care planning and discharge arrangements for stroke patients.

We saw that each patient’s name and preferred name were displayed on whiteboard beside the patient’s bed. The name of their nurse and consultant was also written on the board so relatives knew who they needed to speak to for information about their loved one’s care and treatment.

In the endoscopy recovery room, we heard staff explaining to the patient how the procedure had gone and what to expect following this. The member of staff was very reassuring and explained everything clearly and in terms which the patient could easily understand.

Staff advised us that when they were concerned about a patient’s mental health they would discuss a referral to the mental health liaison service with the patient.

**Is the service responsive?**

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

The trust planned and provided services in a way that met the needs of local people.

The trust was working closely with local and regional partners as part of the South Yorkshire and Bassetlaw Integrated Care System (ICS). The ICS had prioritised five areas, three of which covered medical services: gastroenterology, acute stroke services and urgent care. Work was underway to develop shared resilience and sustainability of stroke and gastroenterology services.

There was an ambulatory care unit located within the acute medical unit (AMU) The unit accepted patients with specific conditions who could be seen and discharged the same day. The unit was nurse led with a nurse consultant and advanced nurse practitioners providing clinical care. The unit was open from Monday to Friday, from 8am to 10pm and on Saturdays, from 9am to 3pm.
Patients could be referred directly to the unit by their GP which enabled non-critical patients to be seen quickly and relieved pressure on the emergency department and AMU. The clinical lead for the unit told us that they had achieved an 80% same day discharge rate.

Systems were in place to aid the delivery of care to patients in need of additional support. For example, patients with a learning disability were flagged on the electronic system which allowed the lead nurse for learning disabilities to be involved with their care.

There was a service level agreement in place for both adult and paediatric psychiatric liaison services. There were processes in place to monitor the agreements including regular meetings between representatives of both trusts.

**Average length of stay**

**Trust Level**

From June 2017 to May 2018 the average length of stay for medical elective patients at the trust was 3.1 days, which is lower than the England average of 6.0 days. For medical non-elective patients, the average length of stay was 5.7 days, which is lower than the England average of 6.4 days.

The trust performed notably well in elective – clinical haematology, having an average length of stay over four times shorter than the England average.

**Elective Average Length of Stay – Trust Level**

![Elective Average Length of Stay Chart]

*Note: Top three specialties for specific trust based on count of activity.*

**Non-Elective Average Length of Stay – Trust Level**

![Non-Elective Average Length of Stay Chart]

*Note: Top three specialties for specific trust based on count of activity.*

**Rotherham Hospital**
From June 2017 to May 2018 the average length of stay for medical elective patients at Rotherham General Hospital was 3.1 days, which is lower than England average of 6.0 days. For medical non-elective patients, the average length of stay was 5.7 days, which is lower than England average of 6.4 days.

**Elective Average Length of Stay - Rotherham General Hospital**

![Bar chart showing elective average length of stay.](image)

*Note: Top three specialties for specific site based on count of activity.*

**Non-Elective Average Length of Stay - Rotherham General Hospital**

![Bar chart showing non-elective average length of stay.](image)

*Note: Top three specialties for specific site based on count of activity.*

**Meeting people’s individual needs**

The service took account of patients’ individual needs. Arrangements were in place to meet the individual needs of patients living with dementia or a learning disability. Extra support and supervision was available on medical wards if required.

The trust had a three-year dementia strategy which included continuing to promote the use of ‘forget me not’ signage and the ‘This is me’ documentation to enable the delivery of person centred care. We saw patients on Ward A2 had ‘This is me’ documentation completed so staff knew what their preferences were. There was no dedicated lead nurse for dementia. The dementia lead role had been incorporated into the frailty team for resilience. A physician had been appointed to lead on dementia care and assessments, with protected time within his job plan to achieve this. A dementia, delirium and patient centred care group had been established with multi-disciplinary involvement. The frailty team who were based in AMU were aware of patients being admitted to the hospital and could offer dementia advice and support. Each medical ward had a dementia champion.

A forget-me-not passport scheme was in place to allow relatives of patients with dementia free parking and unrestricted visiting at the hospital.
The day room on Ward A2 (elderly care) had been adapted to look like a lounge at home with a television and fireplace. The ward had a sensory wall and windows which had been decorated to show scenic views. Games, puzzles and comforting dolls were available for patients.

The purple butterfly suite was available for patients receiving end of life care. The suite was separated into two areas, one area for the patient and another with a pull-out bed for relatives to stay overnight. Bathroom facilities and a small kitchen area were also included.

Volunteers on Ward A3 took a library trolley around to patients on the ward three times a week. Any donations or money raised from book sales was used to support the purple butterfly room.

The trust had a strategy for people with a learning disability and/or autism. All patients with a learning disability were flagged on the electronic patient administration system. The lead nurse in learning disabilities was involved with the care pathway of patients with a learning disability. They supported environmental adjustments and could help staff to source alternative methods of communication if required. The hospital used a traffic light assessment which provided staff with a person-centred view of how to care for that person. Traffic light magnets were used to highlight this to staff.

Staff could access telephone translation services or a face to face interpreter. They could also book a face to face British Sign Language interpreter. Posters were displayed in over 10 different languages which gave patients information on how to get more information in their own language should they need it. We saw ‘tell us what you think’ posters and leaflets were available in several languages.

To meet the needs of patients with sensory loss, patient information was available in different formats such as braille. This could be requested via the patient experience team. The trust website had the facility to enable patients to increase the font size of the text, convert the text into different languages, read the page content aloud and download patient information leaflets as audio files.

Staff demonstrated an understanding of the needs of patients presenting with mental health needs. However, staff told us that the lack of specific assessment tools, risk assessments and training meant the quality of care a patient received relied on the experience of the staff member and their ability to identify specific risks and take appropriate actions to mitigate these. There were standards in place for mixed sex accommodation and staff knew when to report a potential breach. The trust declared no mixed sex breaches in medical care from June 2017 to June 2018.

We saw that there was clear signage on toilet and bathroom doors to distinguish between male and female facilities. The signs were interchangeable and planned to ensure patients dignity was maintained. The exception to this was the coronary care unit which had eight beds (one five bedded bay and three side rooms). The unit had only one bathroom. This was on risk register and staff told us there were plans to create new bathroom facilities in a store room but staff didn’t know how far the plans had progressed. We saw that staff went out of their way to ensure patients dignity was maintained.

Access and flow
There were no escalation wards or beds open at the time of our visit.

The trust had clear arrangements for ensuring medical outliers were seen daily by a relevant consultant or specialist registrar. Medical patients outlaying on a non-medical ward were allocated to the designated consultant covering a specific area. There were a small number of medical patients outlaying on non-medical wards at the time of our visit. We found these patients had been regularly reviewed by appropriate medical staff. At our last inspection there was concern that a high number of medical outliers on Ward B11 (Gynaecology). We visited this ward and found no medical outliers. Staff told us they hadn’t had any for a long time and the ward was running much better as a result.

A frailty team was based in the acute medical unit (AMU). The team’s role was to facilitate the timely and safe discharge of elderly patients and prevent unnecessary admission. The frailty team had started as a pilot project and had proved to be successful in shortening the average patient length of stay. A decision had been made to make the team permanent.

The integrated discharge team facilitated the discharge of patients with complex needs who required co-ordinated care and support to return home. Wards had discharge co-ordinators who linked in with this team to assist with the timely discharge of patients home. Each patient’s progress and discharge plan was discussed daily at ward board rounds. We saw a colour coded system being used to identify whether a patient was medically fit (red), had been reviewed by therapy staff (amber) or had all therapy recommendations in place (green).

Patients ready for discharge could wait in the discharge lounge for transport or for their take home medications to be prepared. Staff told us there were sometimes delays in patients receiving their medication and some patients came back to collect it later. Pharmacy staff told us that patients sometimes went home without all their medication from AMU because they didn’t want to stay and wait for them. One patient on the coronary care unit was told he could go home at 8am but was still waiting for his take home medication at 3pm.

Staff in the cardiac catheter laboratory told us they could respond to an inpatient referral in one to two days and the waiting list for outpatients was approximately three to four weeks.

The endoscopy unit were trialling a new system for patients to go directly from outpatients to the unit to have their pre-operative assessment the same day. This meant that patients would need to make one less visit to the hospital as the next appointment would be for the procedure. An additional nurse was on duty to carry out the assessments. There were no breaches in the two week and six week waits for endoscopy services.

Thrombolysis for stroke patients was carried out in the emergency department between the hours of 8am and 8pm. Specialist stroke nurses assessed the patients for suitability for thrombolysis then the final decision was made by the consultant. From 8pm to 8am Monday to Friday and 5pm to 9am at weekends, thrombolysis was covered by the telemedicine regional rota and was carried out in a dedicated room on the stroke unit during these times.

The adult psychiatric liaison service was provided between the hours of 7am and 10pm seven days a week and could often attend the ward within an hour. Between 10pm and 7am support was available through the crisis team who could attend within four hours if required.
Overall the trust’s referral to treatment time (RTT) for admitted pathways for medicine was about the same as the England average. Four specialities were above and three were below.

**Referral to treatment (percentage within 18 weeks) - admitted performance**

From July 2017 to June 2018 the trust’s referral to treatment time (RTT) for admitted pathways for medicine was about the same as the England average.

(Source: NHS England)

**Referral to treatment (percentage within 18 weeks) – by specialty**

Four specialties were above the England average for admitted RTT (percentage within 18 weeks).

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Four specialties were below the England average for admitted RTT (percentage within 18 weeks).

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<tr>
<td>Rheumatology</td>
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(Source: NHS England)

**Patient moving wards per admission**

This information was not provided because the trust does not record moves made for a clinical or non-clinical reason.

(Source: Routine Provider Information Request (RPIR) – Ward moves tab)
Patient moving wards at night

Data provided by the trust for the 12 month period from June 2017 to May 2018 showed there were 633 patient moving wards at night across medical wards and 4255 in the acute medical unit (AMU).

(Source: Routine Provider Information Request (RPIR) – Moves at night tab)

Learning from complaints and concerns

The service treated concerns and complaints seriously, investigated them and learned lessons from the results, which were shared with staff.

Wards displayed information from their friends and family feedback. This included compliments and themes around concerns and what action was being taken to address these.

Posters with information for patients on how to complain were displayed on ward notice boards.

We saw that complaints and compliments were discussed at clinical service unit (CSU) governance meetings.

Following investigation of the complaint, an action plan was completed and learning was shared with staff. Ward managers were involved in meeting with patients and their families to try and resolve complaints.

Summary of complaints

From June 2017 to May 2018 there were 57 complaints about medical care. The trust took an average of 47 days to investigate and close complaints, this is not in line with their complaints policy, which states complaints should be dealt with within 30 days if not of a complex nature.

(Source: Routine Provider Information Request (RPIR) – Complaints tab)

In the six months prior to inspection, the service had received 33 complaints, of which 30 were answered within the agreed timescales. The largest proportion of complaints were made around patient care, with 24 complaints.

The trust advised that extensions to the 30-day deadline could be granted when the nature of the complaint was complex. This meant some complaints could be resolved within the agreed extension time frame. However, we did not receive any data which highlighted how many of the 57 complaints had been granted an extension and, if so, whether they had been resolved within the agreed timescale.

Number of compliments made to the trust

From June 2017 to May 2018 there were 1,149 compliments within medicine.

(Source: Routine Provider Information Request (RPIR) – Compliments tab)
Is the service well-led?

Leadership

Medical care (including older peoples care) was provided within a clinical service unit (CSU) under the Division of Integrated Medicine. The division was also responsible for providing emergency care and community care and was led by an interim director of clinical services, a general manager and a head of nursing. An associate general manager led the CSU for medical care.

We saw effective ward managers. Wards were well organised, tidy and appeared calm. Staff spoke positively about their ward managers and matrons said they were well supported. Matrons were visible on wards and we observed them helping with patient care when staff were under pressure.

Staff we spoke with were aware of how to whistle-blow if they had concerns. However, not all staff were aware of the role of the freedom to speak up guardian. Training compliance with raising concerns and whistleblowing were low in both nursing and medical staff at 65% and 23% respectively.

Staff told us they regularly saw the divisional leaders, particularly the head of nursing who was approachable.

However, we found examples of when the divisional leadership team had not listened and taken the concerns of staff seriously. Staff had concerns about the safe care of patients on non-invasive ventilation (NIV) on the respiratory ward and had raised this with managers. No immediate action had been taken. Following our unannounced visit on July we raised the same concerns and managers did take action to ensure that patients were safe. Staff on the stroke unit told us they had raised concerns about the ward environment to the divisional leadership team but had not received any feedback on whether action was being taken.

Vision and strategy

The Division of Integrated Medicine had a clear vision and strategy which was linked to those of the trust. The service was committed to delivering an acute care transformation programme which included the reconfiguration of the acute assessment unit, the ambulatory care pathway and the frailty pathway. Within the programme there were three project workstreams underway;

Project 1: Supporting patient flow
Project 2: Reconfiguration of the acute bed base
Project 3: Reconfiguration of the TRFT Community Bed Base

This programme was driven by the Hospital Services Review, as part of the South Yorkshire & Bassetlaw Integrated Care System and aimed to deliver services that were clinically led and financially sustainable.

Managers told us this included bed modelling and the relocation of medical wards together within the hospital. Part of this plan was the relocation of the stroke unit.
Culture

We found staff morale to be generally good. Staff supported each other well and there was good team work. We observed good rapport between staff of different professions and teams we spoke with were proud of the services they provided to patients.

However, the morale of staff on the stroke unit was not as good. Some staff we spoke with on the stroke unit said that although they felt supported by the ward manager and matron, they felt forgotten by the leadership team and did not feel they were always listened to.

We found staff to be friendly, helpful and enthusiastic. Most staff said they felt invested in and that the trust valued and appreciated them.

Most staff told us that there was an open culture and they felt able to raise concerns with their line manager, however, some staff told us that they had raised concerns but nothing had happened.

Therapy staff knew the trust values of ambitious, caring, together and were introducing the values into their appraisals.

Governance

There were clear lines of reporting in the Division of Integrated Medicine however new arrangements had been introduced in July 2018 and were still being embedded.

Each medical speciality had a monthly quality governance and effectiveness meeting which fed into the CSU governance meeting which in turn fed into the divisional business, governance and transformation meeting. The divisional meeting reported into the trust clinical governance committee.

We reviewed the minutes of the CSU governance meetings for July and August 2018 which included key headings for patient safety, patient experience, clinical effectiveness, risks and items to escalate to the divisional business, governance and transformation meetings.

The speciality meetings were attended by the clinical lead, ward managers, matron, specialist nurses, consultants, support services and the operational and performance manager. Items discussed included risks, patient safety, patients experience and clinical effectiveness. Themes and trends were identified and lessons learnt. Matters to escalate were agreed at the end of each meeting.

Management of risk, issues and performance

Performance was measured and monitored on a monthly medicine performance dashboard against a number of key performance indicators. Indicators included harm free care, medication error rates, average length of stay, dementia assessment rates, delayed transfer of care and appraisal and mandatory training completion rates. The report clearly showed if performance was meeting or failing in meeting the target and showed the trend and direction of performance for each indicator.
Individual wards received information regarding their performance against key indicators on a ward dashboard. The trust was changing the process for producing quality dashboard information to a live system. Previously each division was sent a monthly summary of quality metrics for each ward. A panel was held to review each ward monthly and identify areas needing improvement. This process stopped earlier in the year in preparation for the changeover to a live system which had taken longer than anticipated to become fully functional. Oversight of quality performance continued to be gained through monthly performance meetings.

Staff we spoke with knew how to escalate a risk and were aware of the highest risks for their speciality area. We saw each ward had identified and displayed their top three risks on ward notice boards.

Divisional managers were clear on their top three risks which were nurse staffing levels, medical staffing levels and failure to achieve the four-hour standard in the emergency department.

Risk registers were developed at speciality level in medical care and were escalated from speciality level to the divisional risk register. We reviewed the divisional risk register and found it contained 178 risks. Risks we identified on the inspection were included on the register, however, there was no evidence to show that all risks were regularly reviewed and updated. Risks on the divisional register scored between two (for the lowest risk) and 20 (for the highest). There did not appear to be criteria for risks to be accepted onto the divisional risk register. Some risks had been on the register for a number of years and had not been reviewed.

We saw in the minutes of the divisional business, transformation and governance meeting that risks scoring 12 and above were discussed and reviewed.

**Information management**

Information management systems were used effectively in patient care and for audit purposes to monitor and improve quality. Managers used information to manage the performance of the department against local and national indicators.

Staff were aware of their responsibilities in relation to data protection and making sure that confidential information was managed securely. Staff were required to complete information governance training as part of their mandatory training. Compliance with this training was 84% for nursing staff and 86% for medical staff working in medical care services compared to the trust target of 95%.

Staff could access a number of IT systems to record and view information such as test and x-ray results and patient records. The trust used an IT interface called SEPIA which enabled staff to view shared records of patients including care they were receiving from community services. This aided integrated working and improved communication between staff in the hospital and those working in community services.

Ward managers could access information on the electronic staff record which helped them manage their teams. This included information on staff sickness, mandatory training and appraisals.
Engagement
Staff received ‘shining star’ awards from managers in recognition of good work. A nurse working on the acute medical unit (AMU) had received an award from the ward manager for maintaining good morale.

Senior managers told us they wanted projects to be clinically led and would get staff involved in the early stages, however, we found examples of clinical staff not being involved in plans for service changes. For example, the ward sister for the respiratory unit had not been involved in a recently submitted business case to improve the service provision for NIV patients.

Patient engagement was part of the trust strategy. Patient representatives were invited to be part of working groups and forums. There was a stroke association representative on the stroke working group. We saw a notice encouraging patients to join the patient forum for haematology services.

Patients were encouraged to give feedback through the friends and family test and through the patient experience team. We saw posters displayed encouraging patients to share their compliments and complaints which were in six different languages.

Patient feedback was displayed on notice boards at the entrance to wards. Thank you cards and letters from patients and relatives were also displayed. We also saw ‘what we are proud of’ information displayed on wards.

Learning, continuous improvement and innovation
The trust had held an annual innovation week in 2017 and was planning another event for 2018. The event gave colleagues the opportunity to hear about innovative and transformative work that was taking place across the trust to improve patient care. Staff were rewarded for good practice and innovation by the trust at the ‘Proud’ award evening.

The trust also held annual ‘Day to Celebrate’ events which gives colleagues the opportunity to showcase their ideas to improve patient care, efficiency and effectiveness.

Following a successful tender, the cardiology department had been awarded the contract to become the second regional implantation centre. This involved bid submission alongside several other local providers to commence treatment of bradycardia, heart failure and arrhythmia using implantable cardioverter-defibrillators (ICD). This service commenced in March 2018.

The trust had received been shortlisted for the Health Service Journal awards for the Rotherham dietetic led nutritional prescribing project and the Occupational therapies single point of access project.
Facts and data about this service

The trust has 24 maternity beds with a delivery suite and antenatal and postnatal care provided on Wharncliffe ward. The ward is laid out with four-bedded bays and some individual rooms. Delivery suite has 15 rooms, including four rooms set aside for midwifery led care and a bereavement suite. There is a triage area with three curtained cubicles close to reception. The maternity service provides antenatal, intrapartum and postnatal care to the mothers and families who are resident in the Rotherham Clinical Commissioning Group (CCG) area. It also provides antenatal and postnatal care to mothers who live locally but choose to deliver elsewhere. Further to this some mothers will choose to give birth in Rotherham, but are residents of neighbouring CCGs and have their community midwifery care across the border.

The maternity service provides early booking for new pregnancies to ensure that a timely assessment and response is provided within the first weeks to newly pregnant women, and the right pathway is selected with them for their ongoing care. Women are given all the information required on their care options, including the venue of care and their place of birth choices. The multi-disciplinary team across the unit work with women and families throughout their pregnancies, for the provision of safe and effective maternity care, focussing also upon maternal wellbeing, lifestyle and wider public health issues.

There is provision for antenatal education on preparation for labour, birth and infant feeding. The unit has a strong focus on the promotion of normality in childbirth with good clinical outcomes, against a profile of some significant clinical risk factors and patient dependency within the community. In the post-natal period there is ongoing support for women’s physical or mental health needs with a smooth transition to the 0 to 19 service within the Rotherham area at the conclusion of community midwifery care.

(Source: Trust Provider Information Request)

From April 2017 to March 2018 there were 2,595 deliveries at the trust.

A comparison from the number of deliveries at the trust and the national totals during this period is shown below.
Number of babies delivered at The Rotherham NHS Foundation Trust – Comparison with other trusts in England

A profile of all deliveries and gestation periods from January 2017 to December 2017 can be seen in the tables below.

<table>
<thead>
<tr>
<th>Profile of all deliveries (January 2017 to December 2017)</th>
<th>THE ROTHERHAM NHS FOUNDATION TRUST</th>
<th>England</th>
</tr>
</thead>
<tbody>
<tr>
<td>Deliveries (n)</td>
<td>Deliveries (%)</td>
<td>Deliveries (%)</td>
</tr>
<tr>
<td>Single or multiple births</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Single</td>
<td>2,287</td>
<td>99.0%</td>
</tr>
<tr>
<td>Multiple</td>
<td>24</td>
<td>1.0%</td>
</tr>
<tr>
<td>Mother's age</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Under 20</td>
<td>123</td>
<td>5.3%</td>
</tr>
<tr>
<td>20-34</td>
<td>1,881</td>
<td>81.4%</td>
</tr>
<tr>
<td>35-39</td>
<td>255</td>
<td>11.0%</td>
</tr>
<tr>
<td>40+</td>
<td>52</td>
<td>2.3%</td>
</tr>
<tr>
<td>Total number of deliveries</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Total</td>
<td>2,311</td>
<td>592,194</td>
</tr>
</tbody>
</table>

(Source: Hospital Episodes Statistics (HES) – Provided by CQC Outliers team)

The number of deliveries at the trust by quarter for the last two years can be seen in the graph below.
Number of deliveries at The Rotherham NHS Foundation Trust by quarter

SOURCE: Hospital Episode Statistics - HES Deliveries (April 2017 - March 2018)

Is the service safe?
By safe, we mean people are protected from abuse* and avoidable harm.

*Abuse can be physical, sexual, mental or psychological, financial, neglect, institutional or discriminatory abuse.

Mandatory Training

Mandatory training completion rates
The trust set a target of 85% for completion of mandatory training.

Trust level
A breakdown of compliance for mandatory training courses from April 2017 to May 2018 at trust level for qualified nursing staff in maternity is shown below:

<table>
<thead>
<tr>
<th>Training Course</th>
<th>Number of eligible staff</th>
<th>Number of staff trained</th>
<th>Percentage Completed</th>
<th>Trust target (85%) met?</th>
</tr>
</thead>
<tbody>
<tr>
<td>Infection Prevention (Level 1)</td>
<td>168</td>
<td>168</td>
<td>100%</td>
<td>Yes</td>
</tr>
<tr>
<td>Dementia Awareness (inc Privacy &amp; Dignity standards)</td>
<td>168</td>
<td>166</td>
<td>99%</td>
<td>Yes</td>
</tr>
<tr>
<td>Infection Prevention (Level 2)</td>
<td>166</td>
<td>149</td>
<td>90%</td>
<td>Yes</td>
</tr>
<tr>
<td>Hand Hygiene</td>
<td>168</td>
<td>150</td>
<td>89%</td>
<td>Yes</td>
</tr>
<tr>
<td>Information Governance</td>
<td>168</td>
<td>150</td>
<td>89%</td>
<td>No*</td>
</tr>
</tbody>
</table>
The trust target for Information Governance training compliance is 95%

Nursing staff exceeded the target completion rate for six out of 11 mandatory training modules.

The service provided up to date mandatory training information for medical staff in maternity immediately after our inspection. This showed compliance for 16 out of 19 mandatory training courses did not meet the trust target. Several modules showed very poor compliance with two modules at only 9%.

The service had systems and processes in place to ensure that staff could access mandatory training and staff we spoke with confirmed they had enough time to complete mandatory training.

All mandatory training compliance for medical and midwifery staff was managed by a clinical education lead midwife. Staff we spoke with assured us all staff including midwives, health care assistants, managers and medical staff, were rostered to attend all elements of mandatory training. Courses were held monthly with e-learning modules and classroom based sessions. Those who did not attend received a reminder, copied to their manager.

The clinical education lead midwife showed us the system for collating staff training information and we saw for all essential and mandatory training at the time of our inspection, midwives were 98% compliant, consultants were 85%, specialty trainees and middle grade doctors 88%, and junior doctors 95% compliant.

All maternity staff, including community midwives and doctors, completed skills training and emergency drills including birthing pool evacuation and obstetric emergencies. However, staff told us it had been two years since the last pool evacuation drill.

**Safeguarding**

**Safeguarding training completion rates**

The trust set a target of 85% for completion of safeguarding training.

**Trust level**

A breakdown of compliance for safeguarding training courses from April 2017 to May 2018 at trust level for qualified nursing staff in maternity is shown below:

<table>
<thead>
<tr>
<th>Training Course</th>
<th>Number of eligible staff</th>
<th>Number of staff trained</th>
<th>Percentage Completed</th>
<th>Trust target (85%) met?</th>
</tr>
</thead>
<tbody>
<tr>
<td>Safeguarding Adults (Level 2)</td>
<td>161</td>
<td>150</td>
<td>93%</td>
<td>Yes</td>
</tr>
</tbody>
</table>
The service provided up to date safeguarding training information for medical staff in maternity immediately after our inspection. This showed medical staff compliance for safeguarding adults level two was at 50% and safeguarding children level three was 36%.

Midwives completed online training for level three safeguarding and told us they also completed safeguarding supervision sessions. Staff told us that for complex cases they would contact the trust safeguarding lead who provided support regarding any women identified with safeguarding issues. Staff told us they took part in quarterly safeguarding supervision sessions and shared learning following any safeguarding concerns, regional and national events through handovers, staff notices and emails. Supervision was recorded electronically for all caseload holding midwives.

The trust had policies, systems and processes in place to protect children and adults from neglect or abuse. Staff we spoke with had undertaken safeguarding training so that safeguarding was everyone’s business. Staff we spoke with understood their responsibilities in identifying and reporting any safeguarding concerns. We saw several examples of case reviews and appropriate safeguarding referrals.

Staff were able to give us examples of safeguarding referrals made including domestic abuse and child protection. Staff were aware and made appropriate referrals when they suspected or when women reported female genital mutilation (FGM).

Midwives told us they undertook FGM and child sexual exploitation (CSE) training as part of their mandatory training. Staff told us they were aware of women who had presented with this and that any case would be shared with the safeguarding midwife, complex abuse team, community teams, GP, and health visitors. We found staff made contributions to multi agency work once CSE had been identified and staff from the complex abuse team had attended midwifery team meetings. However, staff told us community midwives did not undertake their own CSE assessments and not all midwives we asked were aware assessments could or should be completed for any woman under 18. Therefore, there was limited identification of new cases unless risks were obvious or disclosures were made. This limited the opportunity for young people in Rotherham to be protected from exploitation until they were already at risk of significant harm.

There was a clear referral pathway via the community midwives if there were any identified safeguarding issues with expectant mothers, for example mothers who may have had children removed previously, those living with drug and alcohol abuse, and domestic violence. We looked in detail at three cases with safeguarding issues and found that risks had been assessed and recorded. Staff told us mothers were involved in any decisions about their care and staff would ensure any plans of action would be made clear.

Staff set a red flag alert in the electronic patient record in maternity and used a “green book” within patient paper records to ensure all staff were aware of safeguarding issues for a mother. We saw green books used in patient records to identify any patient with a reported safeguarding concern and to keep a comprehensive record of all aspects of care relating to the concern. We saw evidence to show the team identified babies at risk at birth due to social issues, discharge plans to ensure safety and continuity of care in the community. Staff told us an alert would also show on any electronic record.
Once the mother was discharged home, staff would alert community staff such as GPs and health visitors of risks. The midwives referred women into the local authority safeguarding team and received feedback when required from the social workers.

The trust had a specialist community midwife who was responsible for 15 hours per week for vulnerable women such as young parents, women suffering domestic abuse, women involved in abuse of drugs or alcohol, and women living with learning disabilities. At our previous inspection there had been two full time substance misuse midwives, a teenage pregnancy midwife and a link midwife for domestic abuse. Staff told us that up to 60% of women were vulnerable in one way or another. Since our last inspection, there had been a reduction in specialist midwives, and the service had been remodelled to meet the needs of vulnerable women. Staff told us they ensured vulnerable women were involved in development of birth plans to meet their needs. Staff worked closely with the perinatal mental health team. Staff worked with doctors and nurses in specialist clinics such as for diabetes.

Staff we spoke with were aware of the trust’s abduction policy and confirmed it had been formally tested with an unannounced drill on delivery suite. However, there was no record of when this had occurred, which staff had been involved, or any lessons learned and shared.

**Cleanliness, infection control and hygiene**

We found that the environment was visibly clean and that systems and processes were in place to control infection and promote hygiene. We saw the results of monthly cleaning audits displayed in ward areas. Compliance was consistently measured at 100%.

We found cleaning rotas and checklists for all patient areas including delivery rooms. Midwives told us they were each responsible for cleaning the pool immediately after use. Domestic held cleaning rotas for public areas. Staff complied with the Health and Safety Executive guidance by running the hot water in the birthing pool for 10 minutes daily to reduce the risk of legionella. Staff told us flushing records were held in the delivery suite. Flushing was completed in line with trust guidelines for labour and birth in water in a hospital or community setting.

Hand washing facilities and antibacterial gel dispensers were available at the entrance of the wards and on corridors. There was clear signage encouraging visitors and staff to wash their hands. We observed staff using personal protective equipment when required, and they adhered to ‘bare below the elbow’ guidance.

Women we spoke with said they had observed all disciplines of staff washing their hands and using hand gel.

All rooms on delivery suite were single rooms and 12 out of 14 rooms had ensuite facilities. Two rooms shared a bathroom, equipped with a large bath and a toilet, across the main corridor. Single rooms were available on the antenatal and postnatal ward if a patient needed to be isolated. However, the triage area adjacent to delivery suite was a large room with three curtained couches and women used the visitors’ toilet facilities. Staff told us the triage area was under review and they hoped to be able to incorporate it into the main delivery suite in the near future.
We observed equipment stored in the corridor and asked staff if it was clean or waiting to be cleaned. Staff told us it should be clean and during our visit we noted it had been properly cleaned and had attached dated assurance stickers showing it was ready for use. Staff explained that the room previously used for storage of equipment had been changed into a delivery room so storage for equipment was not so readily available. We noted there was sufficient space for easy access to all areas and equipment did not block fire exits.

The infection control team carried out regular hand hygiene audits and we saw all wards displayed the results. All the wards we visited had achieved 100% compliance throughout 2018.

We saw clinical waste and domestic waste was appropriately segregated and disposed of correctly in accordance with trust policy. Separate utility areas were designated for clean and dirty use. Separate bins for clinical and domestic waste were evident throughout all wards visited.

We saw posters offering women flu vaccinations.

Women were screened for Meticillin resistant staphylococcus aureus (MRSA) before undergoing elective caesarean sections as part of the pre-operative assessment.

Environment and equipment

We found the wards were accessible using a buzzer system, with good signage. All main entrances to the delivery suite and antenatal/postnatal ward were locked and admission was only possible via a telecom system. Staff gained entry and could only exit via a swipe card system and any unaccompanied women or visitors were required to use the buzzer to exit the department. We observed all staff and visitors were compliant with ward security. Staff challenged all visitors.

Staff we spoke with reported having enough equipment that was ready and safe to be used. We saw that audit results displayed on a wall in the delivery unit showed that daily checks of resus trolleys, portable O2 suction equipment, and resuscitaires were all at 100% compliance for August 18.

Fridges and a freezer used for the storage of breast milk were monitored and audited for temperature checks and contents. We saw all breast milk was appropriately stored and individually labelled.

Cardiotocography (CTG) equipment was available to enable staff to monitor the fetal heart rate in labour. The trust had a medical devices and equipment policy which set out how checks on equipment were done, how faults or damage were reported and what monitoring was in place.

We noted there was sufficient space for easy access to all areas, and although some equipment was stored in corridors, it did not impede access or block fire exits.

Planned preventative maintenance was managed between estates and team leaders. Repairs needed earlier could be requested through the estates department. All the equipment we saw had visible evidence of electrical testing indicating safety checks although some of these were beyond
their review dates. For example, labels showed equipment in one kitchen had not been checked for over two years.

The Trust provided results of the most recent patient-led assessment of the care environment (PLACE) review of Wharncliffe Ward, the antenatal and postnatal ward, undertaken on 2 May 2018. The assessment identified 2 areas of failure –

1. One or more fans were found on the ward to have dust upon them.
2. There was not a patient’s day room on the ward. However, they found there were alternatives available:
   o After 6pm and at weekends, the day unit seating area and television are available to parents on the ward. This is utilised quite regularly.
   o There is also a private infant feeding room that any mother can use
   o There is a further small sitting room which can be used.

All other assessed areas under this review were passed by the inspection team. We saw no recorded complaints or concerns from women or families regarding the environment.

The delivery suite was situated on the second floor and could be accessed via a lift or stairs.

The delivery suite had 14 single labour, delivery, recovery and postnatal (LDRP) rooms and there was another room set aside for bereaved women and their families. Twelve delivery rooms had en-suite facilities and a wet room, and two rooms shared a bathroom across the corridor. Delivery rooms close to the nurses’ station were used for women with higher risk scores and other rooms were used for women at lower risk. Four rooms had been set aside for midwifery led care. However, staff told us this had been a recent development and they were not yet in full use.

A birthing pool was available on the delivery suite and a sling was stored in the room to be used for an emergency evacuation. Staff ran emergency pool evacuation simulation as part of their mandatory training.

There was an antenatal and postnatal ward with a mix of four-bedded bays and some single rooms. Staff told us the bays could be used depending on the needs of women admitted, but most often one bay was kept for antenatal women.

There were two theatres located just off the delivery suite, this enabled quick and easy access. One theatre was a dedicated obstetric theatre in regular use for elective and emergency use and the second theatre was allocated for day surgery and theatres provided it as a second obstetric theatre for elective caesarean section lists. During normal weekday working hours theatre staff provided scrub nurses but at night and outside normal working hours midwives undertook this role and delivery suite HCA’s acted as theatre runners. A midwife was allocated to attend elective caesarean sections to take over care of the baby. Theatres were cleaned and fully stocked every day by theatre teams.

Resuscitation trolleys were located on the main corridors in each of the areas we visited. We checked the resuscitation trolleys in all the clinical areas. These were managed and stocked by theatres and staff told us they were always fully stocked and ready for use but they had no responsibility for checking them.
There were eight portable resuscitaires for use on delivery suite. Seven of these were stored in the corridor outside labour, delivery, recovery and postnatal (LDRP) rooms and one was stored in the obstetric theatre. Staff told us a resuscitaire would be moved into any room where a woman was in established labour and if necessary, a resuscitaire would be shared between two adjacent rooms. We asked if staff were assured there were sufficient resuscitaires and medical and midwifery staff told us there had never been an incident where a resuscitaire could not be accessed immediately.

Oxygen was piped directly into delivery rooms and also securely stored in cylinders for use as required. We checked cylinder use by dates and all were in date.

Community staff explained they carried weighing scales to monitor weight of mums and babies to ensure nutrition was taking place. Equipment carried by community midwives was calibrated and checked following a protocol to ensure correct measurements were obtained and the equipment was safe to be used.

Staff had quick and easy access to the special care baby unit (SCBU), located very close to the delivery suite, and if a baby was in need of urgent or special care they could be available immediately. We observed special care staff attending in response to urgent requests on delivery suite during our inspection.

**Medicines**

We checked the storage of medicines on the wards we visited. We found that medicines were stored securely in appropriately locked rooms and stocks were in date. Pharmacy staff checked storage and stocks of medicines weekly.

We checked the storage and administration of controlled drugs, which require specific controls, in all clinical areas. We found controlled drugs were appropriately stored with access restricted to authorised staff. Records showed the administration of controlled drugs were subject to a second check. We observed staff carrying out a controlled drugs audit. After administration, the stock balance was confirmed to be correct and the balance recorded. We checked records between July and September 2018 and found there were some omissions from three dates in July but remaining records had been completed appropriately. Intravenous fluids were securely stored in all the clinical areas we visited.

We found records for epidural infusions within intrapartum records but wasted epidural fluids were not recorded so staff were not aware of how much fluid was left over and if it had been disposed of correctly.

Medicines that required refrigeration were stored appropriately in fridges. The drugs fridges were locked and there was a method in place to record daily fridge temperatures. All fridge minimum and maximum temperatures were checked and recorded daily. There were no gaps in recording. Staff we spoke with understood their responsibilities for raising concerns if the fridge temperature went out of range. There were clear instructions displayed showing actions to be taken if fridge temperatures were outside of the safe range.
We checked ten prescription charts and found these to be comprehensive and completed to a high standard. Women received medicines promptly and any allergies were clearly recorded.

All midwives were practising under patient group directives (PGDs). PGDs provide a legal framework that allows some registered health professionals to supply and/or administer specified medicine(s) to a predefined group of women without them having to see a doctor. Records showed PDGs were in date and included exemptions.

Pre-made emergency medicines boxes were stored in the locked fridge on delivery suite. These were checked daily with completed checklists and each box contained an algorithm for care. There was also a documentation template for correct management of medicines. However, we found a post-partum haemorrhage (PPH) documentation sheet was out of date and the accompanying drug interaction sheet was dated 2014.

Drugs for home births were ordered from pharmacy and included Syntocinon, Ergometrin, vitamin K and occasionally Lidocaine. Community midwives stored their homebirth emergency equipment boxes and Entonox within the medicine room and would take this with them to home births. Community midwives did not carry or transport medical gases at any other times. The box contained equipment such as blood sample bottles, suture materials and scissors but no drugs. We spoke with a community midwife who told us boxes were checked monthly if unused and once used they were cleaned and restocked and sealed by the midwife who had used them.

**Records**

We reviewed seven sets of records and found them all to be legible, detailed, signed, and safely stored. Records showed each woman had a named midwife responsible for their care. Individualised care plans for pregnancy and labour were documented and venous thromboembolism (VTE) risk assessments were completed.

We found labour and birth notes were partially completed contemporaneously then taken away by the midwife to be completed in full following the birth.

Patient records were a mix of electronic and paper patient notes (for instance patient held notes were paper based). Antenatal records were stored on an electronic database. Paper records were stored securely away from patient areas and maternity used an electronic record from admission. Records could be viewed by community midwives and data could be shared with other community services.

Women carried their own national hand-held records throughout their pregnancy. These included a trust booking proforma before nine weeks gestation where possible, and were shared with community midwives and GPs. Results from antenatal tests were documented in these records and on Systm1. All staff could access test results using the trust electronic system.

Information relating to discharge was communicated using the situation, background, action and result (SBAR) tool to ensure timely communication on discharge from the maternity unit. Information was sent electronically to women’s GPs and health visitors. Community midwives could access the information electronically. Staff said any woman with complex needs had a list of contacts to forward information to and the system enabled this in a timely and efficient manner.
Staff we spoke with told us, and we observed, senior midwives undertook a monthly spot check record audit of records. Any learning points, trends or good practice were disseminated to clinical areas.

We looked at five cardiotocograph (CTG) readings and reviewed the patient records. We saw the ‘fresh eyes’ approach was used every two hours to review CTG’s by a different member of staff. This ensured an independent view was obtained of readings taken over every period of two hours. Records were legible and correctly interpreted and staff told us CTG audits were completed, although we did not see any results of these.

Assessing and responding to patient risk

Within the maternity service staff used the modified early obstetric warning score (MEOWS) to assess the health and wellbeing of women. These assessment tools enabled staff to identify if a patient’s clinical condition was changing. Women on the delivery suite and antenatal/postnatal ward were assessed using the MEOWS score. We reviewed three sets of records and found there was sufficient and regular information recorded for staff to assess women’s conditions and staff understood escalation protocols and interventions.

Nursery nurses employed on the postnatal ward used the national early warning score (NEWS) to undertake baby observations.

Staff used the national sepsis tool to ensure early recognition and action regarding postnatal infection and a skin bundle to prevent pressure damage for women who were required to stay in one position for a prolonged length of time.

Staff used the World Health Organisation (WHO) safety checklist, modified for maternity, for all interventional procedures and staff told us the checklist would be started in the delivery room from the time of decision to proceed. We saw completed checklists and reviewed records of a woman who had been to theatre. All WHO checklists had been completed correctly. Staff carried out audits of WHO checklist completion as part of their Datix meeting reviews. The maternity service had recently introduced an electronic WHO checklist for use in delivery suite and theatre. Audit regarding its completion was underway.

We observed an MDT handover, midwife handovers and medical staff communications and saw staff at all levels and grades took part fully in handovers of patient care from one shift to the next. We saw handovers were attended by the full multidisciplinary team (MDT) and we spoke with staff from paediatrics and anaesthetics who were fully engaged and involved in the handovers. Staff gave updates on labouring women, transfers to and from other wards or theatre and details of women requiring additional care. We saw staff used a situation, background, action and result (SBAR) framework to transfer patients between teams. This appeared to work well. However, staff did not attend from the antenatal and postnatal ward, although staff told us delivery suite midwives gave individual handover on transfer of women to the postnatal ward.

We saw evidence the unit used the ‘fresh eyes’ approach, a system that required two members of staff to review fetal heart tracings. This indicated a proactive approach in the management of obstetric risk as it reduced the risk of misinterpretation of the heart tracings. We also saw a second
midwife attended a birth wherever possible. We observed the consultant on call made an effort to attend every labouring woman and the delivery of any woman with complex needs.

The service promoted normal birth as much as possible while ensuring women received informed choice and safe pathways of care, which were safe, risk assessed and personalised. Midwives completed risk assessments at booking to identify women with any medical, obstetric, psychological or lifestyle risk factors. This determined if an individual was high or low risk. High risk women were referred to consultant led antenatal clinics. Midwives we spoke with told us risk assessments were repeated at each antenatal visit. We saw evidence of this in records we reviewed. Women referred by their GP or the emergency department attended the delivery suite for assessment.

Delivery suite had three rooms identified for high risk patients and three midwives had been trained to provide high dependency unit (HDU) care. Staff told us they were experienced in the use of the severe pre-eclampsia toxaemia (PET) protocol and an outreach team from the main HDU were available if necessary.

We observed clinical information was discussed formally between all levels of medical staff and recorded on the office patient information board.

Consultant obstetricians and anaesthetists were available out of hours for an emergency caesarean section and if a patient’s condition gave rise for concern. There was a lead anaesthetist for delivery suite every day and we saw anaesthetists would stay on the ward to look after any seriously unwell woman. National guidance recommends obstetricians perform category 2 caesarean section in most situations within 75 minutes of making the decision. We asked the trust to provide audit information on time taken.

There were arrangements in place with the local ambulance service to attend babies born before arrival of a midwife at home. Community midwives told us they informed the ambulance service before attending any home birth in case an emergency arose.

**Nurse and midwifery staffing**

**Planned vs actual**

The trust has reported their staffing numbers below for the period March 2018 and June 2018.

<table>
<thead>
<tr>
<th>Staffing Group</th>
<th>Planned staff - WTE - Jun 18</th>
<th>Actual staff - WTE - Jun 2018</th>
<th>Fill Rate - Jun 18</th>
<th>Planned staff - WTE - Mar 18</th>
<th>Actual staff - WTE - Mar 18</th>
<th>Fill Rate - Mar 18</th>
</tr>
</thead>
<tbody>
<tr>
<td>Qualified nursing &amp; health visiting staff (Qualified nurses)</td>
<td>22.5</td>
<td>21.0</td>
<td>93%</td>
<td>21.5</td>
<td>21.8</td>
<td>101%</td>
</tr>
<tr>
<td>Qualified nursing midwifery staff (Qualified nurses)</td>
<td>93.0</td>
<td>93.3</td>
<td>100%</td>
<td>94.0</td>
<td>96.4</td>
<td>103%</td>
</tr>
<tr>
<td>Grand Total</td>
<td><strong>115.5</strong></td>
<td><strong>114.0</strong></td>
<td><strong>98%</strong></td>
<td><strong>115.5</strong></td>
<td><strong>118.2</strong></td>
<td><strong>102%</strong></td>
</tr>
</tbody>
</table>

(Source: Routine Provider Information Request (RPIR) – Total staffing tab)
Staffing levels were recorded and displayed on noticeboards in ward areas. Most shifts were calculated to require seven midwives. However, there were regularly only six on day and night shifts. Lead midwives and managers were supposed to be supernumerary on day shift but staff told us they regularly worked to make up the numbers. At night the team regularly worked one midwife short. Staff told us they found this very difficult to manage but they were used to this and staff from the community teams were required to work additional night shifts. These were planned to be no longer than 4 hours but staff told us they were often required to stay for a full night. Staff told us community midwives were called upon too often and this regularly occurred when they had already worked their own full shift or were expected on duty the following morning.

Community midwives told us on call midwives for home births were used several times a week to make up staff numbers at night for delivery suite. This was in addition to working day shifts and limited the opportunity for a timely response for multi-agency safeguarding requests, increasing risks to women from midwives being burnt out and potentially missing increasing concerns that would need an enhanced approach. We discussed this with matrons and senior managers who all told us midwifery staffing was under review but the department was fully staffed following recent successful recruitment. However, several new staff were recently qualified and would be required to complete their preceptorship and therefore be supernumerary until they had completed all of their competencies and rotation to other departments including the ward and antenatal clinics. Senior staff told us they were planning to address staffing on delivery suite through Birthrate Plus to manage and balance risk.

All midwifery staff we spoke with told us the department was continuously busy and staff felt there were insufficient staff to provide safe care for their women. Senior staff told us staffing levels were based on risk and the needs of women admitted to delivery suite. However, staff told us midwife staffing levels were static and the department did not risk assess daily. Staff had raised this issue at our previous inspection and told us at this inspection it had not been addressed in the meantime and we found there had been no progress since our last inspection.

However, senior staff told us staffing data was pulled from e-roster records overnight to monitor staff movement between areas within maternity. There was also a daily audit of admissions and readmissions to enable staff to quickly visualise activity in each area. These appeared to be short term measures to manage staffing on a day to day basis and there was no evidence of long-term audit to capture this data and act upon staffing, quality and safety.

There were two HCAs on each shift, one on the delivery suite, and the other in triage.

Maternity dashboard data showed midwives provided one to one care for 78% of women in established labour. However, senior midwives told us this figure was lower than the actual rate because the service did not remove data for women who had an elective caesarean section and therefore no labour. They estimated the actual rate was 100% and planned to record this more accurately in future.

**Vacancy rates**

From July 2017 to June 2018, the trust reported a vacancy rate of -0.6% in maternity; this indicates maternity may be slightly overstuffed.
However, staff told us in September 2018 the service had a 6% vacancy rate for midwives and these posts had been recruited to. The majority of new starters would be newly qualified midwives who would be required to work as supernumerary and complete their preceptorship before being counted in numbers for qualified staff.

Turnover rates

From July 2017 to June 2018, the trust reported a turnover rate of 8.4% in maternity; the trust has not specified a trust target.

Sickness rates

From July 2017 to June 2018, the trust reported a sickness rate of 5.7% in maternity; slightly higher than the trust target of 4%.

Bank and agency staff usage

The service did not use agency staff but had its own bank staff of existing staff who worked flexibly and those who only worked bank shifts. The trust provided information to show all bank staff had undergone recruitment checks.

From July 2017 to June 2018, the trust reported a bank shift fill rate of 12.73% for qualified staff and 12.38% unqualified staff on delivery suite. The bank shift fill rate for Wharncliffe ward was 6.95% for qualified staff and 8.59% unqualified staff.

Midwife to birth ratio

From April 2017 to March 2018 the trust had a ratio of one midwife to every 21.39 births. This was better than the England average of one midwife to every 25.68 births.

Medical staffing

Planned vs actual

The trust reported their staffing numbers below for the period September 2018 and August 2018. These figures included medical staff at all grades. The trust employed 10 full time substantive consultants and one long term locum consultant and the remaining staff included trust grades and specialty trainees.
### Medical Staffing

<table>
<thead>
<tr>
<th>Staffing Group</th>
<th>Planned staff - WTE</th>
<th>Actual staff - WTE</th>
<th>Vacancies - WTE</th>
</tr>
</thead>
<tbody>
<tr>
<td>Medical &amp; Dental staff - Hospital</td>
<td>28</td>
<td>26.1</td>
<td>1.9</td>
</tr>
</tbody>
</table>

Medical staff provided a total of 62.5 consultant hours for delivery suite every week.

**Vacancy rates**

From September 2017 to August 2018, the trust reported medical staff vacancies of 1.9 WTE in maternity; this relates to 26 staff in post out of an establishment of 28.

**Turnover rates**

From September 2017 to August 2018, the trust reported a turnover rate of 0% in maternity; the trust has not specified a target turnover rate.

**Sickness rates**

From July 2017 to June 2018, the trust reported a sickness rate of 6.2% in maternity; worse than the trust target of 4%.

**Locum and agency staff usage**

Staff told us consultants posts were filled with 10 substantive posts and one long-term locum. Further locums were used to fill gaps in the specialty trainee and trust grade doctor rotas.

**Staffing skill mix**

In May 2018, the proportion of consultant staff reported to be working at the trust was lower than the England average and the proportion of junior (foundation year 1-2) staff was lower.

**Staffing skill mix for the 24 whole time equivalent staff working in maternity at The Rotherham NHS Foundation Trust.**

<table>
<thead>
<tr>
<th></th>
<th>This Trust</th>
<th>England average</th>
</tr>
</thead>
<tbody>
<tr>
<td>Consultant</td>
<td>37%</td>
<td>41%</td>
</tr>
<tr>
<td>Middle career^</td>
<td>5%</td>
<td>9%</td>
</tr>
<tr>
<td>Registrar group~</td>
<td>57%</td>
<td>44%</td>
</tr>
<tr>
<td>Junior*</td>
<td>0%</td>
<td>6%</td>
</tr>
</tbody>
</table>
Incidents

The trust had a clear policy for the reporting of incidents, near misses and adverse events. Staff were encouraged to report incidents using the trust electronic reporting system. The staff we spoke with described the process of incident reporting and understood their responsibilities to report safety incidents and community staff showed us the system on their laptop. Staff told us they received feedback regarding any incident they reported through the electronic reporting system.

Staff discussed an example of learning from an incident regarding long acting and fast acting Nifedipine when the wrong medicine had been administered. These medicines had been separated in storage to ensure a clear difference to staff.

Between April 2018 and October 2018 there were 527 incidents specifically categorised as obstetrics and reported to the National Reporting and Learning System (NRLS). Of these, 381 were reported as no harm; 40 moderate and 98 low harm. We saw comments recorded by staff regarding lessons to be learned and actions identified for follow up. There had been 8 deaths reported, all of which were baby deaths, the majority of which occurred before 20 weeks gestation. There was evidence of late reporting and NRLS data showed 203 incidents were not reported until after 61 days following the incident.

Staff we spoke with said feedback from incidents was shared in a number of ways including; staff huddles including community midwife safety huddles, a weekly Datix review meeting, case reviews, and face to face feedback. The governance midwife relayed feedback and updates to staff.

The service held monthly perinatal mortality and morbidity meetings where serious incidents and case reviews were discussed. These were attended by obstetric and neonatal staff. An annual perinatal mortality and morbidity event had been planned but had to be postponed because a low number of attendees was expected.
The duty of candour is a regulatory duty that relates to openness and transparency and requires providers of health and social care services to notify patients (or other relevant persons) of certain ‘notifiable safety incidents’ and provide reasonable support to that person. Staff we spoke with understood and could describe duty of candour requirements and understood the importance of being open and honest with women. It was evident in the serious incident investigations we reviewed that the duty of candour had been applied.

There were escalation processes to activate plans during internal critical incidents such as shortfalls in staffing levels or bed shortages. However, some staff told us they felt escalation plans did not allow community staff sufficient time off between shifts and there was no additional staffing resource, especially at night.

**Never Events**

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.

From August 2017 to July 2018, the trust reported zero incidents which were classified as never events for maternity.

(Source: Strategic Executive Information System (STEIS))

A never event declared before this data collection, in May 2017, was a retained swab. We saw evidence on inspection and from information provided by the trust to show actions taken and lessons learned and shared to prevent such an event occurring again. Practices and policies regarding swab counts had been changed and swab counts were always checked and signed by two staff.

In accordance with the Serious Incident Framework 2015, the trust reported serious incidents (SIs) in maternity which met the reporting criteria set by NHS England from August 2017 to July 2018.

Of these, the most common types of incident reported were:

- Two maternity/Obstetric incident meeting SI criteria: mother and baby (this include foetus, neonate and infant) (50% of total incidents).
- Two maternity/Obstetric incident meeting SI criteria: baby only (this include foetus, neonate and infant) (50% of total incidents).
Safety Thermometer

The Maternity Safety Thermometer is used to record the prevalence of patient harms and to provide immediate information and analysis for frontline teams to monitor their performance in delivering harm free care.

Measurement at the frontline is intended to focus attention on patient harms and their elimination. Data collection takes place one day each month – a suggested date for data collection is given but the service can change this. Data must be submitted within 10 days of suggested data collection date.

Maternity Patient Safety Thermometer scores provided by the Trust for the past 12 months: September 2017 to August 2018 are included in the following table:

<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Proportion of women</td>
<td>87.23</td>
<td>77.50</td>
<td>84.62</td>
<td>72.22</td>
<td>83.33</td>
<td>94.29</td>
<td>90.63</td>
<td>80.85</td>
<td>77.42</td>
<td>82.35</td>
<td>76.19</td>
<td>83.33</td>
</tr>
</tbody>
</table>

Is the service effective?

Evidence-based care and treatment

The trust had systems and processes in place to ensure that care was given by the service according to published national guidance such as that issued by National Institute for Health and Care Excellence (NICE) and Royal College of Obstetricians and Gynaecologists (RCOG). All staff we spoke with could access on the trust's intranet, guidelines, policies and procedures relevant to their role. Maternity guidelines, policies and procedures we viewed were reviewed on time and information within them was up to date and correct.

The service had an annual audit programme. Doctors and midwives were involved in the audit programme. For instance, we saw audits on venous thromboembolism (VTE) risk assessment on admission and perinatal domestic abuse screening. Actions from audits were discussed and monitored at governance meetings and staff gave presentations at education meetings.

Nutrition and hydration
We found the service met the needs of women having babies, babies and visitors, and carers or relatives. However, some women on the postnatal ward told us they had to ask for a drink and there were no kitchen facilities for women. There was a water cooler on delivery suite but inspectors had to ask for cups to be provided. Staff told us there was a supply of cups and labouring women were provided with water in their room.

There was specialist midwife for infant feeding who worked with community and hospital based midwives and led on the implementation and training associated with implementing United Nations Children’s Fund (UNICEF) Baby Friendly Initiative standards. This had recently been awarded. There were breastfeeding peer supporters employed by the trust and women told us staff supported them with breast feeding. All women had access to breast pumps if they wished to use them.

Breastfeeding initiation rates for deliveries that took place in the hospital for August 2018 was 68%. Staff told us and the maternity dashboard showed the service aimed for a rate of 66%.

Women had access to donor breast milk on SCBU which could be ordered by staff. A water fountain was situated in the corridor on delivery suite.

Women told us they had a choice of meals and these took account of their individual preferences, including religious and cultural requirements. Most women we spoke with said there was a good choice of meals available.

**Pain relief**

To help women manage their pain we saw that the service could offer a range of options, both medical and non-medical. However, women and staff told us the service was not always able to offer pain relief in a timely way.

Women received information of the pain relief options available to them, this included Entonox (nitrous oxide and oxygen) and pharmacological methods such as Pethidine and epidural.

For those women who wanted medical pain relief there was 24/7 anaesthetic cover available to the service for epidurals. Between September 2017 and August 2018 16% of women used epidural as a method of pain relief.

Community staff told us any required pain relief for a home birth would be prescribed by the GP and midwives would bring a supply of Entonox with them.

The delivery suite had one birthing pool and had produced a business case for funding for a second pool. In addition, there were birth balls available.

The service promoted complementary therapies such as aromatherapy and staff told us there were 14 midwives trained to use aromatherapy during delivery and 22 more staff had requested training.

**Patient outcomes**
The service had systems and processes in place to monitor patient outcomes, such as case reviews, use of a maternity dashboard, maternity safety thermometers, and taking part in a programme of national and local audits, the results from all of which were used to improve the experience of women who used the service.

**National Neonatal Audit Programme**

In the 2017 National Neonatal Audit trust performance in the two measures relevant to maternity services was as follows:

- **Are all mothers who deliver babies from 24 to 34 weeks gestation inclusive given any dose of antenatal steroids?**

  There were 52 eligible cases identified for inclusion, 84.7% of mothers were given a complete or incomplete course of antenatal steroids.

  This was within the expected range when compared to the national aggregate where 86.1% of mothers were given at least one dose of antenatal steroids.

  The hospital did not meet the audit’s recommended standard of 85% for this measure.

- **Are mothers who deliver babies below 30 weeks gestation given magnesium sulphate in the 24 hours prior to delivery?**

  There were 8 eligible cases identified for inclusion, 25% of mothers were given magnesium sulphate in the 24 hours prior to delivery.

  This was lower than the national aggregate of 43.5%, and put the hospital in the middle 50% of all units.

  *(Source: National Neonatal Audit Programme, Royal College of Paediatrics and Child Health)*

**Standardised Caesarean section rates and modes of delivery**

From January 2017 to December 2017 the total number of caesarean sections was as expected. The standardised caesarean section rate for elective sections was as expected and rates for emergency sections as expected.

<table>
<thead>
<tr>
<th>Type of caesarean</th>
<th>England</th>
<th>THE ROTHERHAM NHS FOUNDATION TRUST</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Caesarean rate</td>
<td>Caesareans (n)</td>
</tr>
<tr>
<td>Elective caesareans</td>
<td>12.4%</td>
<td>233</td>
</tr>
<tr>
<td>Emergency caesareans</td>
<td>15.7%</td>
<td>367</td>
</tr>
<tr>
<td>Total caesareans</td>
<td>28.1%</td>
<td>600</td>
</tr>
</tbody>
</table>
In relation to other modes of delivery from January 2017 to December 2017 the table below shows the proportions of deliveries recorded by method in comparison to the England average:

<table>
<thead>
<tr>
<th>Delivery method</th>
<th>THE ROTHERHAM NHS FOUNDATION TRUST</th>
<th>England</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Deliveries (n)</td>
<td>Deliveries (%)</td>
</tr>
<tr>
<td>Total caesarean sections(^1)</td>
<td>600</td>
<td>26.0%</td>
</tr>
<tr>
<td>Instrumental deliveries(^2)</td>
<td>255</td>
<td>11.0%</td>
</tr>
<tr>
<td>Non-interventional deliveries(^3)</td>
<td>1,456</td>
<td>63.0%</td>
</tr>
<tr>
<td>Total deliveries</td>
<td>2,311</td>
<td>100%</td>
</tr>
</tbody>
</table>

(Source: Hospital Episodes Statistics (HES) – provided by CQC Outliers team)

The maternity dashboard displayed at the trust for August 2018 showed the service reported:
- a total caesarean section rate of 21%. This was better than the regional average of 27% and the England average of 28%.
- an elective caesarean section rate of 9.3% which was better than the England average of 12.4%.
- an emergency caesarean section rate of 11.7% which was better than the England average of 15.6%.

The maternity dashboard for August 2018 showed the service reported an induction of labour rate of 41% (averaging at 32% over 12 months). Staff told us they believed the current national guidance rate of less than 25% was unachievable due to other factors such as comorbidities and best practice guidance regarding the reduction of emergency caesarean sections.

The maternity dashboard for August 2018 showed the service reported the number of 3\(^{rd}\) and 4\(^{th}\) degree vaginal tears was 4 in a month which was better than the trust target of less than 8 per month. It was not clear how trust targets were set but staff used a red, amber, and green flag system to show how results compared to targets.

The maternity dashboard for August 2018 showed the service reported 5 post-partum haemorrhages of 1500mls. The trust target was less than 4 per month. The service did not report separately for a post-partum haemorrhage of 2000mls or more.

Maternity active outlier alerts

As of September 2018 the trust reported no active maternity outliers.

(Source: Hospital Evidence Statistics (HES) – provided by CQC Outliers team)

Maternal, Newborn and Infant Clinical Outcome Review Programme (MBRRACE UK Audit)

The trust took part in the 2017 MBRRACE audit and their stabilised and risk-adjusted extended perinatal mortality rate (per 1,000 births) was 4.27.
This is up to 10% lower than the average for the comparator group rate of 4.73. 

(Source: MBRRACE UK)

**Competent staff**

**Appraisal rates**

From April 2017 to March 2018, 52% of staff within urgent and maternity care at the trust received an appraisal compared to a trust target of 90%.

<table>
<thead>
<tr>
<th>Staff Group</th>
<th>Appraisals required</th>
<th>Appraisals completed</th>
<th>Percentage completed</th>
<th>Trust Target (90%) met?</th>
</tr>
</thead>
<tbody>
<tr>
<td>Support to doctors and nursing staff</td>
<td>61</td>
<td>40</td>
<td>66%</td>
<td>No</td>
</tr>
<tr>
<td>Qualified nursing midwifery staff (Qualified nurses)</td>
<td>111</td>
<td>54</td>
<td>49%</td>
<td>No</td>
</tr>
<tr>
<td>Qualified nursing &amp; health visiting staff (Qualified nurses)</td>
<td>23</td>
<td>8</td>
<td>35%</td>
<td>No</td>
</tr>
<tr>
<td>NHS infrastructure support</td>
<td>4</td>
<td>1</td>
<td>25%</td>
<td>No</td>
</tr>
<tr>
<td>Other Qualified Scientific, Therapeutic &amp; Technical staff (Other qualified ST&amp;T)</td>
<td>1</td>
<td>0</td>
<td>0%</td>
<td>No</td>
</tr>
<tr>
<td><strong>Grand Total</strong></td>
<td><strong>200</strong></td>
<td><strong>103</strong></td>
<td><strong>52%</strong></td>
<td><strong>No</strong></td>
</tr>
</tbody>
</table>

None of the staff groups met the trust target for completion of appraisals. However, staff we spoke with told us they had completed an appraisal or personal development review or had a date booked for one before the year end.

The service ensured that staff were competent in their roles by sharing information by email or at team meetings or in a newsletter, and by offering staff additional training, including support for the new professional midwife advocate role. Three staff had completed training for this role with more staff identified to attend courses in future. Staff told us places on the course were limited so there was a shortage of midwife advocates and nobody undertaking the role for community midwives.

Junior doctors attended medical obstetric and gynaecology meetings and we saw an example of a presentation and discussion given by a neonatal specialty trainee on recent guidance and incidents around identification of small for gestational age (SGA) babies within the service.

Student midwives and newly qualified midwives worked through a preceptorship package. Staff told us all newly qualified staff were allocated a preceptor and staff feedback showed they found the preceptorship package provided a clear plan. All staff, including specialist midwives and community midwives worked for a period on Delivery Suite to ensure up to date skills and competence in all areas. We spoke with some staff who were completing skills updates or rotation on delivery suite. These staff were supernumerary but told us they were kept very busy.
We spoke with one band 6 midwife who was undertaking a development role and working to band 7 responsibilities with support from an experienced band 7 midwife. However, there was no structure to this. For example, no clear targets to meet or development courses planned. Senior staff we spoke with were aware of the need for succession planning in preparation for some staff nearing retirement age.

The service previously had a number of midwives occupying specialist roles, such as for vulnerable women, diabetes, safeguarding and governance. However, the vulnerable women specialist midwife had only 15 hours per week to deal with women of all vulnerabilities including teenagers, drug and alcohol abuse. Some staff told us they felt this was not sufficient time to meet the needs of staff caring for the full range of vulnerable women.

Staff received training within their department which included simulation training using SimMom, a simulation dummy. This training was multi-disciplinary and attended by all staff. Skills and emergency drill simulations were attended by all staff on mandatory training days and invitations were extended to other departments. A consultant from A&E had commended the maternity team for their attitude and the way they worked together and embraced the concept of simulation training. Staff also offered training sessions in other departments where pregnant women may present and need to be treated differently from other patients.

Junior doctors we spoke with told us they felt well supported and felt able to approach senior colleagues if advice was needed. However, the most recent specialty trainee survey results showed some GP trainees were dissatisfied with the level of clinical supervision they received.

**Multidisciplinary working**

We saw different teams and health professionals working together with staff at the service to ensure effective services were delivered to women.

Midwives told us they felt confident to discuss care with medical staff and obstetricians told us they valued midwives’ skills very highly.

MDT handover took place 3 times a day. We observed and staff told us handover between shifts was open, with structured, and encouraged detailed communication between doctors and midwives. Staff advised us that handovers would cover patients physical, psychosocial and emotional care needs as standard.

Anaesthetists were made aware of any high-risk women at the MDT handover.

Staff told us maternity and special care staff were two separate teams but worked together well and special care staff came immediately if called.

We saw that healthcare assistants were a highly valued part of the team although they were not always free to attend meetings.

A number of clinics that the service ran drew on specialist consultants or other health professionals from outside the service.
Specialist midwives worked closely with GPs, social workers, health visitors, and support workers, to ensure that vulnerable women and those with long term conditions received effective care. Staff told us they had very good links with the perinatal mental health team who could provide assessment and treatment as necessary.

Paediatricians and neonatal specialty trainees attended medical education meetings and completed skills and drills alongside obstetricians and midwives in a whole team approach to emergency situations.

**Seven-day services**

There was a specific obstetric theatre available at all times and a second theatre available next door in the day surgery unit on most days. Staff told us they had never experienced a problem with accessing a theatre in an emergency. The theatre team was always available although out of hours midwives would scrub and HCAs acted as runners. Anaesthetic cover was available 24 hours a day, with a consultant anaesthetist dedicated to delivery suite every week day, an additional on call anaesthetist and specialty trainee available. We asked about delays for women receiving an epidural and were told staffing problems on delivery suite often meant they were unable to meet women’s wishes in a timely manner. However, there had been no reports of any woman waiting over 30 minutes for an anaesthetist to provide an epidural.

There was medical staff presence on the delivery suite 24 hours a day. Senior staff told us the medical team provided 68% to 70% consultant presence. Consultants were present on delivery suite from 8am to 8.30pm every day. Consultants worked a 1:8 on call rota for nights and weekends. Specialty trainees and trust grade doctors provided additional cover at all times.

Maternity triage was provided in an area adjacent to delivery suite from 7am to 7pm every day and outside of these times women attending for advice or with specific needs attended delivery suite. The antenatal ward was available seven days a week and undertook routine day assessments of pregnant women including blood pressure profiles and pre-operation checks.

Ultrasound scans were available at antenatal clinic with sonographers Monday to Friday 9am to 5pm. However, we were told there was no longer a full time scanning consultant so ultrasound was sometimes not available in clinics. The consultants on delivery suite undertook ultrasound scans so any urgent case could be scanned there and staff told us they could access ultrasound scanning service at weekends. Women told us the service could not offer scans from 36 weeks and some women chose to receive care at a nearby trust where scans were not restricted.

Community midwives provided seven-day cover. They provided antenatal clinics in community settings and postnatal visits took place in the home. They had implemented a postnatal weekend clinic to help mothers attend a clinic to suit their needs and to reduce travelling time for midwives, thus enabling more women and babies to be seen.

The service had recently introduced two New Infant Physical Examinations NIPE clinics per week to enable women and their babies to go home and return for the NIPE checks at one of the clinics. Community staff also offered a NIPE clinic. This reduced travelling time for midwives so more newborn baby checks could be carried out.
Antenatal booking clinics had been introduced in the evenings and at weekends to enable working women to attend at more suitable times and to reduce a backlog of booking requests over the previous months. Staff told us clinics regularly ran very late and on one occasion women waited for four hours to see a doctor. However, the trust told us they did not record waiting times within clinics. Managers told us they were hoping to formally recruit a locum obstetrician with scanning skills to help reduce some clinic waiting times although staff were unsure this would be sufficient to reduce all long waits.

**Health promotion**

Staff explained that Rotherham was an area that suffered severe socio-economic deprivation and up to 60% of women using the service were at moderate or high risk during pregnancy. Staff told us there were many vulnerable women and there were high smoking levels at booking, a very high BMI rate, and substance misuse and homelessness were a regular feature amongst the population. Staff raised concerns that the service was providing care for a steady increase in the proportion of vulnerable women but the specialist midwife posts for these groups had been reduced.

The maternity dashboard for August 2018 showed the service reported the rate of women smoking at booking appointment was 19%. This was slightly worse than the trust target of less than 18%. Staff told us women were encouraged to stop smoking.

**Consent, Mental Capacity Act and Deprivation of Liberty safeguards**

**Mental Capacity Act and Deprivation of Liberty training completion**

Staff knew the importance of gaining consent to treatment and had received training in consent, mental capacity and deprivation of liberty safeguards as part of their mandatory training and online modules.

The trust reported that from April 2017 to May 2018 Training on Consent, Mental Capacity Act (MCA) and Deprivation of Liberty Safeguards (DoLS) was completed by 93% of midwifery staff and 100% of medical staff in maternity compared to the trust target of 85%. This was included within the Trust Safeguarding Adults level 2 training package.

Our discussions with staff and review of patient records showed that consent was written where any medical procedure was carried out, such as a caesarean section, with verbal consent for everyday tasks, such as taking blood pressure. We reviewed three records of women undergoing a medical procedure and noted that consent was properly evidenced in writing in all records. Staff told us women were given relevant background information for procedures involving written consent, for example in a caesarean section preparation clinic. This promoted good understanding and ensured consent was informed consent.

Midwives we spoke with could not describe what was meant by Gillick competence or Fraser guidelines (tests used to assess a young person’s ability to give consent). However, staff were able to explain clearly how they would speak to a young woman or someone with a learning disability and explain all elements of their care in a way in which they could understand. Staff informed us this was part of their mental capacity training.

Staff could not provide us with evidence of audit around consent.
Is the service caring?

Compassionate care

Friends and family test performance (antenatal), The Rotherham NHS Foundation Trust

From June 2017 to June 2018 the trust’s maternity Friends and Family Test (antenatal) performance (% recommended) was generally similar to the England average.

Friends and family test performance (birth), The Rotherham NHS Foundation Trust

From June 2017 to June 2018 the trust’s maternity Friends and Family Test (birth) performance (% recommended) was generally slightly better than the England average.

Friends and family test performance (postnatal ward), The Rotherham NHS Foundation Trust

From June 2017 to June 2018 the trust’s maternity Friends and Family Test (postnatal ward) performance (% recommended) was generally slightly better than the England average.

Friends and family test performance (postnatal community), The Rotherham NHS Foundation Trust
From June 2017 to June 2018 the trust’s maternity Friends and Family Test (postnatal community) performance (% recommended) was generally similar to the England average.

(Source: NHS England Friends and Family Test)

Wharncliffe ward staff told us they used an iPad to collect Friends and Family feedback while women were waiting to be discharged. We did not see this being used and were told that a Friends and Family feedback leaflet was included within the discharge information given to women.

CQC Survey of women’s experiences of maternity services 2017

The trust performed similar other trusts for 15 out of 16 questions in the CQC maternity survey 2017, performing worse than other trusts in the area of use of the call button to summon help.

<table>
<thead>
<tr>
<th>Area</th>
<th>Question</th>
<th>Score</th>
<th>RAG</th>
</tr>
</thead>
<tbody>
<tr>
<td>Labour and birth</td>
<td>At the very start of your labour, did you feel that you were given appropriate advice and support when you contacted a midwife or the hospital?</td>
<td>8.74</td>
<td>About the same</td>
</tr>
<tr>
<td></td>
<td>During your labour, were you able to move around and choose the position that made you most comfortable?</td>
<td>7.26</td>
<td>About the same</td>
</tr>
<tr>
<td></td>
<td>If your partner or someone else close to you was involved in your care during labour and birth, were they able to be involved as much as they wanted?</td>
<td>9.42</td>
<td>About the same</td>
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<tr>
<td></td>
<td>Did you have skin to skin contact (baby naked, directly on your chest or tummy) with your baby shortly after the birth?</td>
<td>8.66</td>
<td>About the same</td>
</tr>
<tr>
<td>Staff during labour and birth</td>
<td>Did the staff treating and examining you introduce themselves?</td>
<td>9.01</td>
<td>About the same</td>
</tr>
<tr>
<td></td>
<td>Were you and/or your partner or a companion left alone by midwives or doctors at a time when it worried you?</td>
<td>6.86</td>
<td>About the same</td>
</tr>
<tr>
<td></td>
<td>If you raised a concern during labour and birth, did you feel that it was taken seriously?</td>
<td>6.58</td>
<td>Worst performing trusts</td>
</tr>
<tr>
<td></td>
<td>Thinking about your care during labour and birth, were you spoken to in a way you could understand?</td>
<td>9.27</td>
<td>About the same</td>
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<tr>
<td></td>
<td>If you used the call button how long did it usually take before you got the help you needed?</td>
<td>7.64</td>
<td>Worst performing trusts</td>
</tr>
<tr>
<td></td>
<td>Thinking about your care during labour and birth, were you involved enough in decisions about your care?</td>
<td>8.61</td>
<td>About the same</td>
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<tr>
<td></td>
<td>Thinking about your care during labour and birth, were you treated with respect and dignity?</td>
<td>9.01</td>
<td>About the same</td>
</tr>
<tr>
<td></td>
<td>Did you have confidence and trust in the staff caring for you during your labour and birth?</td>
<td>8.40</td>
<td>About the same</td>
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</table>
Care in hospital after the birth

<table>
<thead>
<tr>
<th>Question</th>
<th>Rating</th>
<th>Response</th>
</tr>
</thead>
<tbody>
<tr>
<td>Looking back, do you feel that the length of your stay in hospital after the birth was appropriate?</td>
<td>6.46</td>
<td>About the same</td>
</tr>
<tr>
<td>Thinking about the care you received in hospital after the birth of your baby, were you given the information or explanations you needed?</td>
<td>7.64</td>
<td>About the same</td>
</tr>
<tr>
<td>Thinking about your stay in hospital, how clean was the hospital room or ward you were in?</td>
<td>8.39</td>
<td>About the same</td>
</tr>
<tr>
<td>Thinking about the care you received in hospital after the birth of your baby, were you treated with kindness and understanding?</td>
<td>8.11</td>
<td>About the same</td>
</tr>
<tr>
<td>Thinking about your stay in hospital, how clean were the toilets and bathrooms you used?</td>
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</table>

(Source: CQC Survey of Women’s Experiences of Maternity Services 2017)

We spoke with five women, three partners, and three relatives, all of whom spoke positively about their experience. Women told us they felt well cared for on delivery suite and that the midwives made them feel safe. Women told us staff were always available if they needed them and staff introduced themselves. Women we spoke with told us staff were very caring. One woman noted “care was friendly, reassuring and professional”. Women noted they had experienced good communication prior to coming into the delivery unit. One woman told us she “didn’t feel rushed”. Families told us community midwives were “just fantastic” and “caring, helpful and supportive”. However, one family commented they were left alone for what they felt was a long time following the birth of their baby while the midwife completed their paperwork.

Community staff told us they met regularly with Forging Families women’s groups who were very proactive locally and had completed and presented a survey of women who had received maternity care at Rotherham. The most recent results showed:
- 94% of women were positive about their care in pregnancy
- 90% positive about care in labour
- 86% positive about care in the first few weeks following birth.

Partners were involved with the care and women told us they had continuity of care in the community. We saw continuity of carer throughout antenatal and postnatal records.

We observed staff reacted promptly to telephones and call bells in all areas we inspected.

Women told us they could contact the maternity unit or their community midwife if they had any concerns. We observed good interaction between midwives, women, and their partners or relatives attending for triage.

We saw many thank you cards on the delivery unit that were positive in their praise of the quality of care that staff gave. Statements included “Thank you for making the experience as straightforward as possible. I felt constantly supported. You kept my best interests at heart” and “To midwives, thank you for your fabulous care and attention” and “Thank you for helping me have a perfect labour”.

We were told by a patient her wishes for privacy and dignity had been listened to. She explained that she had requested in her birth notes not to have students present at the birth and this had been listened to.
There were no set visiting times on the delivery unit and visitors could have access 7 days a week. The number of visitors was limited to two per person due to the need for space to carry out clinical investigations.

Visitors to the Wharncliffe antenatal and post-natal ward could attend between 12.30pm and 3.30pm and 6.30pm to 8pm, 7 days a week. The ward manager told us there was open visiting for partners, and sibling children were able to attend outside of these hours in special circumstances.

The Wharncliffe ward had five transitional care beds for babies needing additional observations including light therapy. Staff told us mothers would receive care for their babies on the ward rather than babies being transported to the special care baby unit to reduce separation between mother and baby. However, staff told us babies requiring antibiotics had to be taken by staff to be treated in SCBU. Parents were given the option to accompany their baby if they wished.

Staff showed understanding and a non-judgmental attitude when caring for or talking about patients with mental health needs, learning disabilities, autism or dementia.

However, women on the postnatal ward gave some negative comments about attitude of staff, lack of communication and understanding. Some women felt there was a lack of compassion postnatally and felt rushed to leave. Senior staff were aware of new data from the 2018 CQC Maternity Survey that showed women in postnatal care at the trust had reported similar experiences.

Some women we spoke with told us they felt safe and cared for on delivery suite but their care on the postnatal ward had been very different at the weekend; doctors had given them conflicting information and there was a lack of communication between teams, women did not feel listened to, Staff told us they used more locum doctors at weekends.

Three women told us they had suffered delays for information and at discharge.

**Emotional support**

Staff valued and cared for families’ emotional needs in all departments we inspected.

The delivery suite had a bereavement suite (Handsel Suite), available for women and families to use following a stillbirth or death of an infant. The room was well appointed and included a cold cot where a baby’s body would be preserved to enable the family to spend time in privacy.

Staff told us the trust chaplain worked closely with the maternity services to support bereavement needs and that the unit also had a part time bereavement midwife. Staff could link with the trust bereavement team for additional support. The service organised an annual memorial service for families who had suffered losses.

We saw that the bereavement suite was situated at the end of a corridor and slightly separate from the other delivery rooms. However, patients and families had to walk through the whole delivery unit to reach it. Staff confirmed that there was no alternative access.

Perinatal mental health risk assessments took place at the booking appointment, throughout pregnancy and during the post-natal period. Women with a suspected mental health illness were
cared for in partnership with the perinatal mental health team for further assessment and treatment. This assessment also included mental and emotional health and social needs of partners. The process informed planning to meet the needs of the unborn baby.

The Afterthoughts telephone service was available in the unit. This provided patients with a means to give verbal feedback on their experiences to management and ask questions about their clinical care, especially following a complex birth. The Afterthought information card formed part of the discharge information pack. Staff told us that patients would be able to seek emotional support through a debrief from a senior midwife, ask questions and receive answers.

Staff told us where they had concerns about a new mother’s mental health they would follow the perinatal mental health plans in place. If they were new concerns they would discuss these with the new mother and request support from the lead consultant. Staff advised if they were concerned they would complete the Edinburgh postnatal assessment with the patient to identify any deterioration in the woman’s mood.

**Understanding and involvement of patients and those close to them**

Women we spoke with said they felt involved in decisions about their care and had been provided with all the relevant information to help them make an informed choice about where to have their baby.

In the patient records we reviewed we saw evidence of discussions of the risks and benefits of different birthing locations and discussions about birthing preferences.

Community midwives told us and we saw completed birth plans to support women of all needs including those with complex and difficult birth choices.

**Is the service responsive?**

**Service delivery to meet the needs of local people**

**Bed Occupancy**

From February 2017 to June 2018 the bed occupancy levels for maternity were generally higher than the England average, with the trust having approximately 83% occupancy in Quarter one of 2018/19 compared to the England average of 58%.

A higher bed occupancy rate means the unit provided care for more women at the same time and would require more staff to provide safe care.

The chart below shows the occupancy levels compared to the England average over the period.

<table>
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<tr>
<th>England Average</th>
<th>This Trust</th>
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Women were offered booking and midwife contacts at home, in a GP surgery, or in clinic. This provided women with choice on where they were seen.

Regarding elective caesarean sections, the hospital main theatres were used on Tuesdays and Thursdays. For the rest of the week staff told us that they were carried out on the delivery suite.

We saw that many patient information leaflets on the delivery unit were out of date. When a sample was checked three out of the five were out of date (revisions due in 2016 and 2017). These included information booklets about postnatal information for women and choices for birth after caesarean section. Inspectors noted that some guidance was out of date within these and we asked staff to check the information contained within all information booklets to ensure guidance referred to the most up to date clinical advice and evidence. We also noted some information sheets were of very poor quality, having been photocopied many times and some diagrams were too faint to be seen clearly. Staff reported during our inspection these had been removed and replaced with good quality sheets.

The local population of Rotherham has demographically high levels of obesity. Maternity services at the trust offered a gestational diabetic clinic which is MDT led with nurses, midwives, sonographers, obstetricians, specialist nurses and medical staff. The service also provided an anaesthetist specialist clinic to further reduce patient risks.

The local population also had high numbers of smokers. Staff told us the service had a smoking cessation midwife and there were specific midwifery training courses that included smoking cessation. They told us there were also trained maternity support workers doing dedicated smoking cessation work as their sole role.

The service offered baby scanning on Saturdays and Sundays. The staff we spoke with told us that scans were reported within 24 hours. However, the trust did not offer scanning to term, a
service where foetal birth defects were monitored more frequently through the course of pregnancy.

Staff told us the service did not currently meet the National Guideline Alliance guidelines commissioned by the Royal College of Gynaecologists with respect to smoking outcomes. We saw that this risk was on the department’s risk register and that the business case for more scanning availability was to be reviewed at the end of October.

Breast feeding support was led by breast feeding specialist midwives. Two support workers offered support in the community six days a week and breast feeding peer supporters worked on the postnatal ward. Staff told us health care assistants and midwives had been trained to support this service.

The trust no longer provided routine physiotherapy for all women on the postnatal ward. However, there was physiotherapy support for those who had suffered perineal tears. Midwives had completed training to help women with pelvic floor exercises.

Tissue viability nurses supported maternity services Monday to Friday.

Women in the area had the option to receive low risk or high risk care at Rotherham, Doncaster or Barnsley. The service had booked 30 women for home births and 11 women delivered at home. In some cases, risks identified meant a woman would deliver in hospital but on two occasions women were unable to have a home delivery because community midwives were covering delivery suite leaving only one midwife on call. Staff told us that home births were not being encouraged due to the shortage of community midwifery staff.

The service had two community hubs at Maltby and Aston. The hubs each provided a base for five midwives who could make referrals to the Green Oaks antenatal clinic at the trust. The hubs offered glucose screening tolerance tests meaning that women did not have to travel to the hospital.

Mental health specific post-natal and ante natal clinics were held in the community hubs. These were led by a consultant obstetrician with a special interest in mental health.

A vulnerabilities midwife worked in the community and liaised with general practitioners. This role was supported by a crisis team made up of social workers and mental health practitioners.

The maternity service offered CT scans for families after bereavement. However, post mortems were not accommodated on site but in Sheffield.

There were no facilities for partners to have showers on the Wharncliffe ward due to mixed sex protocols. Charitable funds were being assessed to support the provision of reclining chairs so that partners would be more comfortable.

Staff we spoke with on the Wharncliffe ward told us nursery workers were not available 24 hours a day. Managers told us there was nursery nurse cover for six nights a week and one vacancy to be filled. Staff told us this currently left them understaffed during holidays and sickness.
The service recorded babies born before arrival and if the ambulance service were called to a woman in labour there was an agreement in place to bring her direct to hospital.

The community staff worked out of local GP surgeries or two local hub offices and community midwife teams were organised around geographical areas to ensure women had a responsive local service. The service aimed to provide two further hub bases for community midwives in the near future.

Women were encouraged to formulate birth plans at about 34 weeks to suit their needs and wishes and all decision making was supported by midwife and consultant risk assessments. Women had the option to deliver at home, on the delivery suite with consultant led care, and there was new provision for maternity led care with four rooms set aside on delivery suite.

The trust website had a dedicated section about maternity services.

Meeting people’s individual needs

The service treated women as individuals and strove to develop care plans that responded to their individual needs having taken into account any risk factors. The delivery unit had one birthing pool. We saw an activity chart on the wall showing that between January to December 2017 there were 53 uses of the pool with an average monthly use of 4.4. Within this time period there were 31 deliveries via the pool with a monthly average of 2.6. For the most recent time period from January to September 2018 there were 46 uses with a monthly average of 5.1. Within this time period there were 26 deliveries with a monthly average of 2.8. Therefore, the demand on the pool had increased. We were told that a business case had been started for a second birth pool.

We noted that a water and births policy kept next to the pool was out of date and needed to be revised. However, staff immediately produced an up to date version from the intranet and replaced the old copy. We saw that telemetry was available by the pool to accommodate higher risk women.

The unit had a bereavement facility called the Handsel Suite. This unit contained a cold cot used to provide families with time with babies that had died. The facility also contained a small kitchen, toilet, pull out bed and sofas. We checked the Handsel Suite daily check record book and noted that in September there had been 3 days when it had not received the daily check regarding equipment and facilities. Staff told us they would remind staff to ensure the bereavement suite was checked every day. We were told that charitable funds had been used to resource a second cold cot.

There had been a reduction in specialist midwives, although staff told us the service had been remodelled to meet the needs of vulnerable women. We were told that the full time bereavement midwife band 7 had recently left the service and had been replaced by two band 6 midwives, each dedicating 15 hours a week to the bereavement service. Consultants offered on call bereavement services and we were told that other band 7 midwives had completed bereavement training so there was always a member of the team available for bereavement advice and support.

Midwives had implemented the use of Acupins (small acupuncture devices worn on the wrist) for women suffering from hyperemesis gravidarum (serious and prolonged nausea and sickness in
pregnancy). Staff told us these devices contained no medicines and reduced or stopped nausea for many pregnant women.

Aromatherapy was available for women on the delivery suite. Staff confirmed that 14 midwives could provide the service and 22 more midwives were being trained.

Balloon inductions were provided by the unit. This was recognised positively by staff as a mechanism that gave women a more relaxing atmosphere and non-pharmaceutical method in which to be induced as they attended the unit briefly and then went home. Two midwives were trained in balloon inductions.

On the delivery unit, partners were able to stay on the ward 24 hours a day and each delivery room had a chair beside the bed for sleeping. Delivery suite provided breakfast for partners.

We saw that a drinks fountain was available on the delivery unit. However, when we checked, no cups were available.

Staff told us that visitors to the delivery unit would be offered breakfast and sandwiches.

The maternity service used a telephone translation service. Staff told us that if a patient required an interpreter staff would access the service and the patient would be free to talk with the interpreter via a speaker phone. We noted that screening and discharge information leaflets were available in alternative languages on the post natal ward. Staff told us that upon discharge, women could download the Bounty app on their mobile phones which would allow them to set which language they want patient information to be displayed.

Women told us that community birth plans had given them the chance to personalise their care plans and that a choice of hospitals were provided for their care. Choices of the type of birth were also given, including water births.

One parent we spoke with told us privacy was easily maintained by the use of the bay curtains and that in general the service was excellent. However, they also mentioned the chairs in the delivery unit were uncomfortable. Staff told us they had accessed charitable funds to order some reclining chairs and two were already available.

The Wharncliffe ward had four side rooms that could accommodate women having twins as they included double cots, a pull-out bed for partners and generally more space.

Staff told us they had supported women who became distressed in an open environment, and would help them maintain their privacy and dignity. For example, staff would utilise the interview room to provide women a space to talk away from the ward or a side room if necessary.

The trust has a learning disability nurse who supported maternity services and worked Monday to Friday. Women living with learning disabilities were also supported in the community by health visitors and community learning disability nurses.

We asked about communication aids for helping women with special needs or learning difficulties understand about their care. Staff told us they did not have access to any specific communication aids such as picture boards and would rely on women or their partner or carer to bring these in.
However, staff could contact the learning disability lead nurse who could support with any specific communication difficulties and had access to interpretation services for women who used sign language.

Women we spoke with told us they felt the service had listened to them and involved them in their care. Midwives told us they listened to partners about their needs and wishes. There were opportunities for women to discuss any wishes or plans that were outside recommendations and guidance. Women’s wishes were supported whenever it was safe and possible to do so. All midwives, with the support of a specialist midwife, were responsible for planning the care of and supporting vulnerable women such as those with addictions that could harm the baby. They also provided a source of expertise for all staff access. Careful assessment supported staff in shaping the care plan to respond to the needs of the woman and their baby. This included referral to the perinatal mental health team where necessary.

Access and flow

The bed capacity on the delivery suite was increased by reducing the need for women undergoing induction of labour to stay on the unit with the adoption of balloon inductions. Women attended the antenatal ward for an hour and then went home to progress induction rather than staying on the ward.

Delivery suite reception was staffed between 8am and 6pm. Staff told us that a ward clerk was usually present at night between 9pm and 6am or 7am. If there was no ward clerk out of hours, delivery suite staff would greet women and visitors.

Mental health specific postnatal and antenatal clinics were held in community hubs on Thursdays, led by a consultant obstetrician with special interest in mental health.

Several staff we spoke with noted that discharge delays on the post-natal ward were a concern. Women told us they were disappointed their discharges had been delayed and this theme was noted among negative responses to the Maternity Survey. Staff recorded in the minutes of the most recent governance meeting that this needed to be addressed.

Staff told us the lack of formal ward rounds in the post natal unit meant that women could often be waiting several hours before being discharged. Staff told us junior doctors could be called to emergencies leaving complex cases waiting to be discharged. Both of these issues contributed to delays. Women and partners also told us they felt there was a lack of communication between teams and they had expected to be given information about delays.

An additional reason for delayed discharges was women experienced long waits for take home medicines before being discharged. We heard from staff that pharmacists came to support the ward but this was not on a routine basis and health care assistants were used to transfer kardex information to the pharmacy department and also going to collect medicines and bring them back to the unit.

We heard that New Infant Physical Examinations (NIPE) clinics had recently started at the post-natal unit to reduce admissions. Four hospital midwives and five community midwives had completed NIPE training. This meant that these checks, which needed to be done within 72 hours
of birth, could be done in a clinic or the community rather than keeping women in hospital and taking up beds on the unit.

Women could self-refer into the service and community midwives conducted the booking appointments at GP surgeries or appropriate venues throughout the local area. The maternity matron informed us that there had been a backlog of processing referrals onto the Green Oaks antenatal clinic. This was due to administrative staffing absences. We met with senior staff who told us staffing shortages had been addressed and the backlog managed with provision of extra evening and weekend clinics.

Community staff could access electronic discharge summaries. This supported community staff in ensuring they visited the mother and baby within 24 hours of discharge.

The service had not closed to women in labour in the last year (September 2017 to August 2018). Women attended the ward and clinics as needed for growth scans, amniotic fluid index (AFI) scans (to measure the amount of fluid was present around the baby before birth), and doppler scans (to measure the flow of blood to the baby through the umbilical cord).

Women could attend the department with concerns or issues with their pregnancy. They could self-refer, or through their GP, or the emergency department. One midwife and one HCA worked within triage. Depending on capacity on the ward other midwives could support triage. Staff told us they tried to triage women within 30 minutes. However, they did not document triage waiting times.

Learning from complaints and concerns

Summary of complaints

From June 2017 to May 2018 there were 14 complaints about maternity. The trust took an average of 43 days to investigate and close complaints. This is not in line with their complaints policy, which states complaints should be resolved within 30 days unless complex. Patient care complaints made up 50% of the complaints made.

(Source: Routine Provider Information Request (RPIR) – Complaints tab)

In the six months prior to inspection, the service had received 3 complaints and all were answered within the agreed timescales.

The trust advised that extensions to the 30-day deadline could be granted when the nature of the complaint was complex. This meant some complaints could be resolved within the agreed extension time frame. However, we did not receive any data which highlighted how many of the 14 complaints had been granted an extension and, if so, whether they had been resolved within the agreed timescale.

Number of compliments made to the trust

From June 2017 to May 2018 there were 22 compliments within maternity.

(Source: Routine Provider Information Request (RPIR) – Compliments tab)
We did not see information on the wards regarding how to make a complaint but staff told us there were booklets available that described using the yourexperience@rothgen.nhs.uk address to email complaints and concerns directly to the trust.

Staff told us they would always aim to resolve any concern raised informally and at the point it was raised.

We saw the complaints policy was relevant and up to date.

We saw complaints were managed via the trust’s Your Experience team using the Datix system, who set deadlines by which to respond to the complaint or concern via email. We were told that complaints were reviewed at weekly maternity leadership meetings attended by the head of midwifery, governance lead midwife, deputy head of midwifery and a consultant obstetrician and gynaecologists.

We were told that during complaints investigations patient notes were reviewed at governance meetings and any concerns would be shared with ward managers who would meet with front line staff to share learning.

We were told themes from complaints involved poor staff communication with women, having access to a water tower as the Wharncliffe ward got very hot in the summer and also that the Green Oaks clinic was over booked especially in relation to diabetic clinics.

Staff we spoke with noted that written complaint responses would be initially quality assured by the head of midwifery and then by the deputy chief nurse. The chief executive would sign all letters.

The Afterthoughts service provided women with a means to informally ask questions and challenge the quality of care offered by the maternity services. A matron managed this service and completed case note reviews and offered face to face meetings. Staff told us themes from this feedback included communication before emergency theatre. Staff gave an example of how a complaint had been managed and how they used the afterthoughts service to talk to a woman about a concern she had raised. They described how learning points from this service were disseminated to staff as part of team meetings and verbal shift handovers, and lessons learned were also printed out for staff. We saw the patient Afterthoughts information card included information on how to access the service in several different languages.

**Is the service well-led?**

**Leadership**

Several staff we talked to described the leadership of the service as being “fragmented”. The recent departure of the head of midwifery (HOM) and their preceding long-term absence had caused concern and frustration and a lack of strategic level organisation within the unit. The department had recruited a new HOM, and there was a longstanding deputy HOM. There was interim project support for Better Births with an Associate Head of Midwifery. Staff told us they were now feeling more positive about leadership within the service.
The service sat within the family health division. The clinical lead and divisional clinical director had both been in post for several years. The medical director and their deputy managed and led the medical team of consultants, middle grade doctors, including locums and junior doctors.

Members of the local leadership team met regularly with the director of nursing or the medical director and through them they had ready and open access to the board. One of the non-executive directors (NED) was the department’s representative on the trust board. The team also networked with medical staff and midwives in local trusts and regional network groups in order to benchmark its service against their services and share good practice and learning.

The senior leadership team were approachable and available and this was confirmed by staff we spoke with who also said they felt supported and listened to. The team met regularly in different forums to discuss issues of quality, finance and governance.

The leadership team were supported by a matron, clinical leads, lead midwives for community, out patients, delivery suite, and governance.

Staff said they felt supported by their line managers who worked as role models and part of the team. However, we saw line managers who should have been supernumerary, working clinically as part of the delivery suite team due to high acuity of patients and a shortage of qualified staff. This meant managers could not complete their non-clinical responsibilities or be available to other staff during those shifts.

Staff were offered opportunities to develop and step up into a more senior role. However, these roles were informal and it was not clear how staff were supported to take on new responsibilities.

**Vision and strategy**

Senior leaders we spoke with told us, and we saw, there was a documented maternity strategy for the service to ensure maternity services in the local region meet the needs of local people. The senior leadership team confirmed its aim was to deliver Better Births within agreed timeframes.

Formal arrangements would be confirmed once the Integrated Care System (ICS) trust responsibilities were confirmed. Staff were planning to adopt a continuity of caring model across the whole geographical area covered by the Trust. Managers said this would be a community based model. Staff told us they thought this could work well but because community teams already felt stretched due to high caseloads (1:96) and extra shifts in delivery suite, some staff were anxious about future plans.

Leaders we spoke with told us they felt involved in plans for the future of the service. However, junior staff felt less informed and involved.

**Culture**

All staff we spoke with told us provided patient focussed care to women throughout their pregnancy journey.

Staff felt supported within their own teams. However, we observed there were no handovers, safety huddles or effective communication involving the whole team. Teams such as the ward and
delivery suite appeared to work in isolation and this became apparent through patient comments about lack of communication and information available to them. It was not clear how information such as the maternity dashboard and maternity safety thermometer data was shared with all staff, although senior midwives and managers did understand and act on results.

Staff told us they were confident about raising concerns and we did not come across any complaints or concerns about bullying or harassment. However, we were told some staff felt badly treated during and following investigations into serious incidents. However, some staff told us previous managers had been inconsistent in their approach to managing investigations involving staff in serious incidents and following appropriate HR processes. This had led to some uncertainty amongst staff about what to expect.

Some staff told us they felt it was difficult to progress professionally within the department and explained that funding was lacking. However, other staff told us there were good progression pathways within the department and good opportunities and funding available for external training courses.

We saw notices displayed in the delivery suite office but there was no obvious display of learning activities or continuous professional development (CPD) events.

We saw that staff were open and honest and we saw examples where the duty of candour had been used.

**Governance**

The service had a clear governance framework with staff assigned specific roles that ensured quality performance and risks were known about and managed.

Staff told us about, and we observed, a weekly Datix group where medical and midwifery staff met to discuss individual incidents and cases. The outcome of these meetings was discussed at leadership meetings and governance meetings. Lessons to be learned were shared with staff verbally at handovers and more formally through emails, posters and the intranet.

Governance was the responsibility of the local leadership team which met regularly at monthly governance meetings to review a range of issues such as performance, risk, and quality measurement.

The service had a governance lead midwife whose role was to work full time on reviewing risks posed to the service, oversee rapid reviews and root cause analyses into serious incidents, and distribute learning.

**Management of risk, issues and performance**

The service’s risk register supported the local leadership team in tracking risks and ensuring that staff were taking actions to reduce or extinguish the risk. We reviewed the service’s risk register and saw that each risk was given a unique identifier, a risk rate, a status, brief details, and the review date. Each risk had an action plan and staff identified were responsible to manage the plan to completion.
The main recorded risks included ventilation systems, the patient experience maternity survey 2017 results and on-call community midwife support for peaks of activity on night duty. An extreme risk was identified regarding midwives carrying out a scrub role in theatres for which they were not trained.

The condition of scanning probes had been escalated to the medical imaging risk register but not the maternity risk register. Staff had said these were not reliable or accurate for checking fetal measurements and the trust would have to develop a business case for them to be replaced.

The maternity dashboard was regularly updated and displayed in the main office in delivery suite. Staff knew the measures achieved but some staff told us they felt unable to make any difference and accepted some results as inevitable such as the rate for women smoking at the time of booking.

The service had recently had a maternity clinically led visit from the Royal College of Obstetricians and Gynaecologists (RCOG) and the results and action plan were displayed in the staff office. Positive feedback included the positive morale and resilience of the team who work well together and two negative points were discharge delays from the postnatal ward and staff felt very busy.

The service had a lone worker policy for community midwives and we observed this in practice when staff made a security call to the office to state all was well.

**Information management**

A new electronic record system had been implemented with some initial teething problems. Staff told us early issues had been resolved and staff now received good quality, timely information. We saw some good examples of MDT records obtained from the system to share information about high risk women.

**Engagement**

Regular staff meetings, huddles and handovers ensured staff were informed and involved in day to day activities. Staff took part in audit production and presentation. Staff described how the service used email to share lessons or pass on important messages. Team leaders had regular meetings and passed on information to staff at handovers.

Staff sought feedback and opinions of those who used the service. Friends and family cards which were distributed with discharge packs.

We did not find any examples of changes made following feedback from women who used the service. Results from the maternity survey in 2017 had raised some cause for concern regarding discharge delays but no action had been taken to change this.

Staff described feeling engaged by the service in its aims to provide good quality care for women.

We saw a post box in delivery suite for staff comments and suggestions but found this was not used regularly and some staff were unaware of it.
Staff had organised a closed Facebook group to encourage staff to take part in social event and fundraising.

Community staff told us they worked with the Rotherham Organisation for Downs Syndrome (RODS) and signposted staff and families to this network.

Staff told us they took part in fundraising initiatives and had raised funds towards a new cold cot for the bereavement suite.

**Learning, continuous improvement and innovation**

Some midwives we spoke with had no clear understanding of how information and data from dashboards could be used to drive improvement and we saw no evidence of staff engagement in quality improvement strategies.

There were no clear pathways or encouragement seen for fostering innovation or improvements to the service across different levels within the teams. However, there had been some clinical improvements made.

Staff had implemented balloon catheter inductions which were commenced on the ward and then the woman would go home until labour began. This method did not use any medicines and had shown a range of benefits including improved access and flow due to the release of beds that would otherwise have been taken by women awaiting the onset of labour. Staff noted this method reduced the use of inductions using medicines. Staff told us initial findings showed better clinical outcomes at delivery including a reduced emergency caesarean section rate, reduced fetal distress, and reduced pain, all due to a better experience and restful environment for the woman in the early stages of labour.

At our last inspection we reported the gynaecology team had implemented the use of Acupins (small acupuncture devices worn on the wrist) to reduce nausea following surgery. The obstetrics team had developed the use of Acupins further by using them for women suffering from hyperemesis gravidarum (serious and prolonged nausea and sickness in pregnancy). Two community midwives had been trained to apply Acupins and women had reported reduction or full elimination of symptoms with their use. Staff reported a reduction in antenatal admissions for hyperemesis. Senior managers told us this was the first reported use of Acupins in an NHS setting specifically for the treatment of hyperemesis. Staff had presented a paper and it had been published in a national journal.
Services for children and young people

Facts and data about this service

There is a 10 bedded children’s assessment unit (CAU) where children are referred to from General Practitioners, Emergency Department, Midwives and from other professional agencies. Children who require to stay longer than 24 hours will be transferred to the children's ward which has 12 in-patient beds. There is also a High Dependency area that is commissioned for one critical care level one bed. Children and young people are admitted up to the age of 16 on the children's ward and CAU, young people aged between 16 and 18 are offered a choice of being cared for on either the children's ward or an adult ward wherever possible based on clinical need.

Children cared for on children's ward or CAU are cared for under many specialties including paediatrics, general and specialist surgery, orthopaedics, maxillofacial and ENT. Elective day case surgery cases are cared for on the children's ward.

Special Care Baby Unit is a 14-bedded unit that is commissioned for two intensive care cots, two high dependency cots and 10 special care cots. Admissions come to the unit via labour ward, emergency department, midwives, repatriation and babies born in other units that need ongoing care. The unit works closely with the Embrace transport team and the local Neonatal Network.

(Source: Routine Trust Provider Information Request (RPIR) – Sites tab)

The trust had 1,302 spells from June 2017 to May 2018.

Emergency spells accounted for 97% (1,269 spells), 2% (20 spells) were day case spells, and the remaining 1% (13 spells) were elective.

Percentage of spells in children’s services by type of appointment and site, from June 2017 to May 2018, The Rotherham NHS Foundation Trust

![Percentage of spells in children’s services by type of appointment and site](image)

Total number of children’s spells by Site, The Rotherham NHS Foundation Trust.

<table>
<thead>
<tr>
<th>Site name</th>
<th>Total spells</th>
</tr>
</thead>
<tbody>
<tr>
<td>Rotherham General Hospital</td>
<td>1,302</td>
</tr>
<tr>
<td>England total</td>
<td>1,122,195</td>
</tr>
</tbody>
</table>
Is the service safe?

By safe, we mean people are protected from abuse* and avoidable harm.

*Abuse can be physical, sexual, mental or psychological, financial, neglect, institutional or discriminatory abuse.

Mandatory Training

The trust set a target of 85% for completion of mandatory training.

Trust level

A breakdown of compliance for mandatory training courses from April 2017 to May 2018 at trust level for qualified nursing staff in children’s services is shown below:

<table>
<thead>
<tr>
<th>Training Course</th>
<th>Number of eligible staff</th>
<th>Number of staff trained</th>
<th>Percentage Completed</th>
<th>Trust target (85%) met?</th>
</tr>
</thead>
<tbody>
<tr>
<td>Dementia Awareness (inc Privacy &amp; Dignity standards)</td>
<td>63</td>
<td>63</td>
<td>100%</td>
<td>Yes</td>
</tr>
<tr>
<td>Equality and Diversity</td>
<td>63</td>
<td>63</td>
<td>100%</td>
<td>Yes</td>
</tr>
<tr>
<td>Infection Prevention (Level 1)</td>
<td>63</td>
<td>60</td>
<td>95%</td>
<td>Yes</td>
</tr>
<tr>
<td>Information Governance</td>
<td>63</td>
<td>60</td>
<td>95%</td>
<td>Yes*</td>
</tr>
<tr>
<td>Preventing Radicalisation (Levels 1 and 2)</td>
<td>63</td>
<td>57</td>
<td>90%</td>
<td>Yes</td>
</tr>
<tr>
<td>Fire Safety</td>
<td>63</td>
<td>57</td>
<td>90%</td>
<td>Yes</td>
</tr>
<tr>
<td>Hand Hygiene</td>
<td>63</td>
<td>56</td>
<td>89%</td>
<td>Yes</td>
</tr>
<tr>
<td>Infection Prevention (Level 2)</td>
<td>63</td>
<td>50</td>
<td>79%</td>
<td>No</td>
</tr>
<tr>
<td>Conflict Resolution</td>
<td>63</td>
<td>49</td>
<td>78%</td>
<td>No</td>
</tr>
<tr>
<td>Raising concerns and whistleblowing</td>
<td>63</td>
<td>49</td>
<td>78%</td>
<td>No</td>
</tr>
<tr>
<td>Health, Safety and Welfare</td>
<td>63</td>
<td>47</td>
<td>75%</td>
<td>No</td>
</tr>
</tbody>
</table>

* The trust target for Information Governance training compliance was 95%.

The trust’s target was met for seven of the 11 mandatory training modules for which qualified nursing staff were eligible. In relation to the remaining four modules, compliance ranged from 75% to 79%.

A breakdown of compliance for mandatory training courses from April 2017 to May 2018 at trust level for medical staff in children’s services is shown below:

<table>
<thead>
<tr>
<th>Training Course</th>
<th>Number of eligible staff</th>
<th>Number of staff trained</th>
<th>Percentage Completed</th>
<th>Trust target (85%) met?</th>
</tr>
</thead>
</table>
Medical staff were compliant for five of the 11 mandatory training modules. They were below the trust target of 85% for the remaining six modules.

The children’s ward and department managers maintained an oversight of the staff’s mandatory training. Staff told us they were up to date with their mandatory training, some training was face to face, however most of their training was online.

We saw up to date training matrixs in the areas we inspected. Staff were either compliant, or on course to meet the trusts training compliance targets by April 2019. For example, in the children’s outpatient department, the training matrix showed that staff had reached the trust target of 85% in all mandatory courses to date.

**Safeguarding**

The trust set a target of 85% for completion of safeguarding training.

**Trust level**

A breakdown of compliance for safeguarding training courses from April 2017 to May 2018 at trust level for qualified nursing staff in children’s services is shown below:

<table>
<thead>
<tr>
<th>Training Course</th>
<th>Number of eligible staff</th>
<th>Number of staff trained</th>
<th>Percentage Completed</th>
<th>Trust target (85%) met?</th>
</tr>
</thead>
<tbody>
<tr>
<td>Safeguarding Children (Level 3)</td>
<td>63</td>
<td>61</td>
<td>97%</td>
<td>Yes</td>
</tr>
<tr>
<td>Safeguarding Adults (Level 2)</td>
<td>62</td>
<td>58</td>
<td>94%</td>
<td>Yes</td>
</tr>
</tbody>
</table>

A breakdown of compliance for safeguarding training courses from April 2017 to May 2018 at trust level for medical staff in children’s services is shown below:

* The trust target for Information Governance training compliance is 95%

(Source: Routine Provider Information Request (RPIR) – Training tab)
<table>
<thead>
<tr>
<th>Training Course</th>
<th>Number of eligible staff</th>
<th>Number of staff trained</th>
<th>Percentage Completed</th>
<th>Trust target (85%) met?</th>
</tr>
</thead>
<tbody>
<tr>
<td>Safeguarding Adults (Level 2)</td>
<td>11</td>
<td>10</td>
<td>91%</td>
<td>Yes</td>
</tr>
<tr>
<td>Safeguarding Children (Level 3)</td>
<td>17</td>
<td>9</td>
<td>53%</td>
<td>No</td>
</tr>
</tbody>
</table>

(Source: Routine Provider Information Request (RPIR) – Training tab)

Staff we spoke with understood their responsibilities with regards to safeguarding children and young people. We saw safeguarding concerns were flagged on the electronic patient record.

Staff knew how to report concerns and could tell us the process they would follow, including contacting the Multi-Agency Safeguarding Hub (MASH).

The governance lead and ward manager had received training to deliver safeguarding supervision. Staff had access to group safeguarding supervision, and these were held each week.

Nursing staff had completed safeguarding level three training however, the training was via e-learning. We were not assured all staff attended multi-disciplinary, and inter-agency training delivered internally and externally. Therefore, we were not assured the training was in line with that recommended by the Royal College of Paediatrics and Child Health (RCPCH) intercollegiate document (2014).

Female genital mutilation (FGM) and child sexual exploitation (CSE) were included in the safeguarding training. All staff had Prevent training on induction. Prevent is part of the Government counter terrorism strategy.

We asked the service leads about the low training compliance for medical staff. They told us they thought it could be how the safeguarding training of trainees was recorded.

Medical and nursing staff routinely discussed safeguarding concerns. During the inspection we attended a safety huddle on the children’s ward and Special Care Baby Unit (SCBU). We heard discussions about safeguarding cases and action taken to keep people safe.

Cleanliness, infection control and hygiene

All areas we inspected were uncluttered and visibly clean. Equipment cleaning labels provide assurance that re-usable patient equipment was clean and ready for use.

The children’s ward and departments had infection control link staff, for example, in the children’s outpatient department this role was carried out by a health care assistant (HCA). The HCA attended trust infection control meetings, verbally shared the feedback with staff and attached the minutes of the meetings to the staff noticeboard for all staff to read.

Infection prevention and control (IPC) was part of the trust’s mandatory training programme, together with hand hygiene training. The compliance target was 85% for both courses. From April 2017 to May 2018, qualified nursing staff had achieved 79% compliance for level one IPC training and 95% for level two training. Whilst medical staff over the same monitoring period, achieved 100% compliance for both levels. The nursing staff achieved 89% compliance for hand hygiene training and the medical staff 94%. Both were better than the trust target of 85%.
There were antibacterial hand gel dispensers located at the entrance and exit of each ward, in each bed bay and clinical areas, together with hand wash basins. We observed staff and visitors using them appropriately.

We saw that staff used personal protective equipment where appropriate. Such as gloves, aprons and face masks, and these were readily available in clinical areas. We also observed staff adhering to the ‘bare below the elbow’ policy and national good hygiene practice.

A (bare below the elbow, microbial decontamination, and peripheral cannula,) hand hygiene audit for medical and nursing staff was completed monthly from April to August inclusive. The results for the children’s outpatient’s department, children’s assessment unit, and children’s ward, was 100% compliance. The same audit took place for SCBU between April to June and they also scored 100% compliance.

In the CAU the bare below the elbow monthly audit results from April to August inclusive, showed 100% compliance for medical and nursing staff.

In the bathroom on the children’s ward we saw records to indicate that the estates department had carried out monthly showerhead cleaning.

Completed cleaning schedules were seen for example, in the sensory room (an interactive environment which helps reduce agitation and anxiety), children’s ward, and in areas where there were toys. In the outpatient department we saw information for parents and carers about the cleaning of the toys and it informed them they could ask to see the cleaning record if they wished.

There were felt noticeboards in the children’s assessment unit and in the corridor to the SCBU. The felt boards were a potential low-level infection control risk, as the board could not be cleaned. This was brought to the attention of the trust at the inspection in 2016 and was on the current risk register. Plans were in place to replace the felt boards with laminated ones, which could be appropriately cleaned.

At the inspection in 2016, we found the children’s outpatient clinic consulting rooms were carpeted. At this inspection we found the floor coverings had been replaced with appropriate, cleanable floor covering.

Single rooms were available for the isolation of patients, if needed.

In the CQC Children and Young People’s Survey 2016 the trust scored 8.81 out of ten for the question ‘How clean do you think the hospital room or ward was that your child was in?’ This was about the same as other trusts.

(Source: CQC Children and Young People’s Survey 2016, RCPCH)

Environment and equipment
The environment across all areas where children and young people accessed care and treatment was child and young person-friendly.
At the last inspection, we found pull cords in the bathrooms on the children’s ward which were a ligature risk. At this inspection we did not see any ligature risks. Curtain rails were collapsible and toilet doors opened both ways for ease of access.

Parents and patients on the wards and in the departments told us they felt safe. Access to the children’s ward, assessment unit and neonatal unit was secure with entry intercoms for parents and visitors. Visitors could not exit the units unless a staff member opened the door. We also saw on the children’s assessment unit, a poster to remind staff not to open the door to anyone without verifying who they wished to see.

The paediatric dental unit and the paediatric outpatient department did not have secure entry; however, the reception desks were situated at the entrance to the units. There had been a recent incident in the paediatric outpatient department where an aggressive adult had entered the department. This was on the risk register and the trust planned to install a security intercom and door alarm system. In the interim, the security team were asked to patrol the area.

Although there were play specialists in children’s services and they did supervise children’s play, parents and carers were reminded to supervise their children when using the playrooms. These included the playrooms in the children’s outpatient department, children’s assessment unit, children’s ward, and an outside play area. Information was displayed to remind parents/carers to supervise their children.

In all areas we found the floor displays, posters and noticeboards were decorated to be child friendly.

There was adequate equipment in the wards and departments to meet patients’ needs and staff confirmed this. The utility and stock rooms we inspected were clean and organised. At the inspection in 2016 we found one of the emergency call alarms in the sensory room was not in place. At this inspection, we found appropriate emergency call alarms in place.

The portable, electrical equipment across children’s services, had up to date electrical tested labels. The resuscitation trolleys were sealed. The checking of the equipment on these trolleys were carried out by the theatre staff.

**Assessing and responding to patient risk**

The children’s ward and assessment unit used a paediatric early warning score to help identify when a child’s condition was deteriorating. This tool included guidance on what action to take depending on the score. Audit data for the month of August 2018, showed a compliance level of between 80% and 100% for eight out of 10 completed recordings, an action plan was provided with timelines. At the time of our inspection we reviewed three PEWS charts and saw they were appropriately completed.

There were guidelines for staff to follow for medical conditions, such as asthma and sepsis. We also saw an up to date standard operating procedure (SoP) for the paediatric early warning score (PEWS) and situation background assessment recommendation (SBAR) escalation policy. The SBAR was used to improve communication about a patient’s condition between health care professionals. The tool was used to ensure that the person receiving the information knows everything they need to know about the patient.
The trust had a sepsis group which was attended by the Clinical Governance lead for family health.

We saw an in date, Sepsis standard operating procedure. Staff had access to sepsis guidelines, followed the sepsis six pathway and could tell us the process they would follow for a child with suspected sepsis. Staff also completed Paediatric Sepsis 6 recognition documentation. However, they were not completing a sepsis toolkit or plan of care and staff had not had any specific training on paediatric sepsis. This had been recognised by the ward manager; the documentation was now in print and there were plans to introduce training sessions for staff. Following the inspection, we received information from the trust which stated new sepsis charts were being implemented. The information also stated that the paediatric team were liaising with the audit department to devise an audit tool, in line with national recommendations.

The children’s ward had a two-bedded high dependency unit. These beds were used for children requiring more support, such as those with exacerbation of asthma, diabetes, sepsis and those requiring high flow oxygen. All staff had been trained in the use of high flow oxygen and there were five staff members who had completed a high dependency course.

The regional transport service was used for advice and support and for the transfer of critically ill children. Staff told us the service provided excellent support, and delivered teaching sessions on a regular basis.

Safety huddles were held on the children’s ward every day. Medical and nursing staff attended the huddles and any child who staff felt was deteriorating or at risk of deterioration were discussed.

Staff attended regular simulation days and held ‘stop the shift’ scenarios.

There was not a member of staff on every shift on the children’s ward and assessment unit who was trained in advanced paediatric life support (APLS); this is not in line with current guidance.

Staff used a safer supportive risk assessment tool, when risk assessing any child or young person admitted with mental health needs. There was a child and adolescent mental health service (CAMHS) liaison nurse who contacted the ward every morning. (The liaison team held study days and drop in sessions, which were attended by staff.) We were informed that If a patient need 1:1 care the staff could arrange a bank nurse; the nurse would have the competencies and skills to care for the child/ young adult.

The seven care records we reviewed included a completed paediatric skin integrity tool, a body map, and an assessment of the child’s nutritional status (to be completed as applicable).

In the CQC Children and Young People’s Survey 2016 the trust scored 8.36 out of ten for the question ‘Were the different members of staff caring for and treating your child aware of their medical history?’ This was better than other trusts.

(Source: CQC Children and Young People’s Survey 2016, RCPCH)
Nurse staffing

The trust has reported their staffing numbers below for the period March 2018 and June 2018.

<table>
<thead>
<tr>
<th>Staffing Group</th>
<th>Planned staff - WTE - Jun 18</th>
<th>Actual staff - WTE - June 2018</th>
<th>Fill Rate - Jun 18</th>
<th>Planned staff - WTE - Mar 18</th>
<th>Actual staff - WTE - Mar 18</th>
<th>Fill Rate - Mar 18</th>
</tr>
</thead>
<tbody>
<tr>
<td>Qualified nursing &amp; health visiting staff (Qualified nurses)</td>
<td>58.9</td>
<td>61.0</td>
<td>103%</td>
<td>54.6</td>
<td>59.5</td>
<td>109%</td>
</tr>
</tbody>
</table>

(Source: Routine Provider Information Request (RPIR) - Total staffing tab)

The children’s ward and assessment unit used the paediatric acuity and nurse dependency assessment (PANDA) tool to work out staffing requirements. However, the ward manager told us they did not feel this was a useful tool for general paediatric wards. They had started to use a safer staffing care tool and were planning to continue using this electronically rather than the PANDA tool.

Nurse staffing for the children’s ward and the assessment unit was from the same rota. The planned staffing on a shift was five trained staff and two healthcare assistants. Three trained staff and a healthcare assistant were allocated to work on the children’s ward and two trained staff and a healthcare assistant were allocated to work on the assessment unit.

The Royal College of Nursing (RCN) guidance (2013) recommends staff to patient ratios of 1:4 for over two-year olds and 1:3 for under two-year olds. The ward manager told us they worked on a ratio of 1:4, but looked at dependencies and altered staffing as needed. They told us they did not have any staffing concerns and they would use bank staff if needed. The deputy ward sister also told us they did not have concerns and that the ward staffing levels were safe.

During our inspection, we saw there were 12 patients on the ward and three trained nurses. One nurse was caring for a high dependency patient and this left the other two nurses looking after five and six patients each. The ward manager told us that the dependencies of the patients was low and that the child nursed in high dependency was due to be transferred back to the ward area. They also told us that as the dependency of that person had reduced, they were able to look after other patients.

A band six nurse was available on every shift. The nurse in charge of the shift was not supernumerary as recommended by the RCN.

On the Special Care Baby Unit (SCBU) seventeen out of thirty qualified nursing staff, including the unit sister (57%), were qualified in speciality (QIS). A further nurse was in training and once qualified, the figure would increase to 60% of staff QIS. However, this did not meet the national neonatal guidance of 70% of staff QIS.

The British Association of Perinatal Medicine (BAPM) standards state that day to day management of care on the neonatal unit should be undertaken by a senior nurse who has no clinical commitment during the shift. However, the neonatal unit did not have a supernumerary coordinator on a shift.
The BAPM standards recommend a staff to patient ratios of 1:1 for intensive care, 1:2 for high dependency care and 1:4 for special care.

We saw the neonatal review action plan dated 2018, which had been approved at the children and young people’s service governance committee, author, ward manager and lead consultant.

The plan showed nurse staffing none compliance with the BAPM standards for shift co-ordinator and QIS. The identified progress showed two staff were to commence training in critical care of the newborn in September 2018, and a further three staff to commence training in May and September 2019. The ward manager was the identified lead person; there was a completion date of September 2018 with daily and six-monthly monitoring in place. The traffic light system on the action plan showed amber to denote the training had commenced and green to denote the monitoring of the management and safe staffing of the SCBU was complete.

During the inspection we spoke with the senior sister in SCBU, who was also the clinical educator. They provided mentorship for student nurses and training on equipment for staff.

The SCBU ward sister was ‘acting up’ to cover sickness leave and therefore not supernumerary. Staff told us they worked with the medical staff as a team, and although the unit was busy it was safe.

We inspected the registered nurse and care staffing levels, and fill rate for June and July 2018. In June 2018, we saw the fill rate for registered nurses was 107.5% and 112% for care staff. In July 2018, the fill rate for registered nurses was 98.4% and care staff 103.2%. On night duty the fill rates for both months for the registered nurses was 100%.

The paediatric dental unit did not have any children’s nurses working in the department and there were no paediatric nurses working in the main theatre recovery area. However, if they needed support, arrangements were in place for them to contact the ward.

Staff in the theatre recovery area told us that children and young people requiring surgery had a paediatric anaesthetist. The recovery staff also confirmed that they received training in the care and recovery of children.

Vacancy rates

From July 2017 to June 2018, the trust reported a vacancy rate of 6.3% in children’s services, the trust has not specified a target vacancy rate.

(Source: Routine Provider Information Request (RPIR) - Vacancy tab)

Turnover rates

From July 2017 to June 2018, the trust reported a turnover rate of 0% in children’s services.

(Source: Routine Provider Information Request (RPIR) – Turnover tab)

Sickness rates

Between July 2017 to June 2018, the trust reported a sickness rate of 2.9% in children’s services,
lower than the trusts target rate of 4%.

(Source: Routine Provider Information Request (RPIR) – Sickness tab)

**Bank and agency staff usage**

From June 2017 to May 2018, the trust reported a bank and agency usage rate of percentage in children, young people and families.

A breakdown of locum and agency usage and unfilled shifts is shown below:

<table>
<thead>
<tr>
<th>Bank and agency</th>
<th>Number of shifts</th>
<th>% of total shifts</th>
</tr>
</thead>
<tbody>
<tr>
<td>Bank</td>
<td>370</td>
<td>9.4%</td>
</tr>
<tr>
<td>Agency</td>
<td>0</td>
<td>0.0%</td>
</tr>
<tr>
<td>Not filled</td>
<td>36</td>
<td>0.9%</td>
</tr>
</tbody>
</table>

(Source: Routine Provider Information Request (RPIR) - Nursing bank agency tab)

**Medical staffing**

The trust has reported their staffing numbers below for the period March 2018 and June 2018.

<table>
<thead>
<tr>
<th>Staffing Group</th>
<th>Planned staff - WTE - Jun 18</th>
<th>Actual staff - WTE - Jun 2018</th>
<th>Fill Rate - Jun 18</th>
<th>Planned staff - WTE - Mar 18</th>
<th>Actual staff - WTE - Mar 18</th>
<th>Fill Rate - Mar 18</th>
</tr>
</thead>
<tbody>
<tr>
<td>Medical &amp; Dental staff - Hospital</td>
<td>15.3</td>
<td>12.6</td>
<td>83%</td>
<td>15.3</td>
<td>11.3</td>
<td>74%</td>
</tr>
</tbody>
</table>

(Source: Routine Provider Information Request (RPIR) – Total staffing tab)

**Vacancy rates**

From July 2017 to June 2018, the trust reported a vacancy rate of 0% in children’s services, this shows an overstaffing which is not borne out by the staffing fill rates.

(Source: Routine Provider Information Request (RPIR) – Vacancy tab)

**Turnover rates**

From July 2017 to June 2018, the trust reported a turnover rate of 62.6% in children’s services.

(Source: Routine Provider Information Request (RPIR) – Turnover tab)

**Sickness rates**

From July 2017 to June 2018, the trust reported a sickness rate of 0.2% in children’s services, lower than the trust target rate of 4%.

(Source: Routine Provider Information Request (RPIR) - Sickness)
Staffing skill mix

In May 2018, the proportion of consultant staff reported to be working at the trust was higher than the England average and the proportion of junior (foundation year 1-2) staff was the same.

Staffing skill mix for the 17-whole time equivalent staff working in children’s services at The Rotherham NHS Foundation Trust

<table>
<thead>
<tr>
<th></th>
<th>This Trust</th>
<th>England average</th>
</tr>
</thead>
<tbody>
<tr>
<td>Consultant</td>
<td>62%</td>
<td>43%</td>
</tr>
<tr>
<td>Middle career</td>
<td>6%</td>
<td>7%</td>
</tr>
<tr>
<td>Registrar Group</td>
<td>26%</td>
<td>44%</td>
</tr>
<tr>
<td>Junior</td>
<td>6%</td>
<td>6%</td>
</tr>
</tbody>
</table>

^ Middle Career = At least 3 years at SHO or a higher grade within their chosen speciality
~ Registrar Group = Specialist Registrar (StR) 1-6
* Junior = Foundation Year 1-2

(Source: NHS Digital Workforce Statistics)

There had been an increase in the number of consultants since our last inspection. There were eight consultants in post and a business case had been approved for another one. There were lead consultants for specific areas, such as diabetes, epilepsy and governance. There had recently been recruitment of a cardiology paediatrician. At our last inspection, there was no clinical lead in post. At this inspection, there was a clinical lead in post for the women’s and children’s service.

Service leads told us that up until August 2018 there had been gaps in the tier two rota which had been filled by locums. At the time of the inspection there was a full tier two rota.

We reviewed the minutes from the July 2018, Health Education England (HEE), Monitoring the Learning Environment (MLE) meeting. The minutes noted that from a General Medical Council, National Trainee Scheme review, the group of paediatric trainees were unhappy due to having to fill rota gaps and not able to attend teaching.

The trainee placements changed over on the first of August 2018 with a new intake. The registrar told us they had an eight-person staff rota and currently there were no gaps in the rota. They also told us that trainees viewed the placement as an attractive rotation as it was not as busy as other placements and they had more time to care and do things properly.

There had been approval to recruit two overseas doctors and the service leads told us they were exploring the use of doctors from the medical trainee initiative (MTI). The MTI is a scheme that provides junior doctors from around the world with the opportunity to work and train in the UK, while giving trusts a high quality, longer term alternative to using locums to fill gaps in rotas.
There were two paediatric advanced nurse practitioners who supported the tier one rota.

We saw evidence that every child admitted with an acute medical problem was seen within 14 hours of admission by a consultant paediatrician, in line with the Royal College of Paediatrics and Child Health (RCPCH) standards (2014). Consultant led handovers took place twice a day.

British Association of Perinatal Medicine (BAPM) standards recommend that a local neonatal unit should have a tier one rota that does not cover paediatrics in addition to the neonatal unit. At Rotherham Hospital the tier one doctors covered paediatrics and neonates. The service leads told us that as they were a small unit, it was not feasible to have two separate rotas.

**Records**

We reviewed seven sets of care records. We saw the notes were multidisciplinary with separate sections for nursing and medical assessments.

The records were legible and staff completed them accurately. The information included patient observations and risk assessments, including non-accidental injury, nutritional status (where appropriate), and diagnosis and management care plans.

There was also evidence of input and discussion with the family, the patient, the practitioner’s initials were documented and where appropriate the patient consent was recorded.

In October 2017, an inpatient documentation audit was carried out in the children service and 20 patient’s records, out of 203, were audited. The results showed the records were signed, dated and the time was recorded (95%), and handwriting entries were legible (96%). The conclusion was that there was good performance on signing dating and timing of the records. The recommendation for improvement was to remind junior and middle grade doctors about documentation at their induction.

**Medicines**

There was a dedicated pharmacy service for the children’s services. The pharmacist visited the children’s ward between Monday and Friday. The ward had a stock of take home medications for patients needing to be discharged out of hours; an on-call pharmacist was available. The pharmacist also provided training to staff and undertook audits.

The trust had a policy for the administration and storage of medicines. Medicines were securely stored and the medicines we reviewed were within the use-by date. Storage cupboards and medicines refrigerators were locked.

There were processes in place to record all medicines dispensed by nurses under patient group directives (PGDs). PGDs are written instructions to help supply or administer medicines to patients, usually in planned circumstances.

Staff were able to describe their learning from incidents, this included information to remind staff of the correct procedure to follow in the administration of medicines. We saw signage fastened to the medicines trolley. This reminded staff of the procedure to follow to ensure, the correct medication,
route, and dosage, was given to the right patient at the right time. The procedure showed two qualified staff checked the medication. During the inspection we saw staff following the procedure.

We reviewed nine prescription charts. Overall, staff completed the charts accurately and the staff records were legible. Staff recorded the date and their signature, allergies were documented, and antibiotics were prescribed as per guidelines. Staff also recorded the weight of the child.

An up to date list of staff signatures, initials and printed names were maintained. This was good practice and ensured that if there were any discrepancies, as to who had signed a treatment sheet or patient record, it could be followed up.

In the CQC Children and Young People’s Survey 2016 the trust scored 9.51 out of ten for the question ‘Were you given enough information about how your child should use the medicine(s) (e.g. when to take it, or whether it should be taken with food)?’ This was about the same as other trusts. (Source: CQC Children and Young People’s Survey 2016, RCPCH)

We saw that medicines refrigerator temperature checks had been completed in the children’s outpatient department. Minimum and maximum temperatures were recorded.

The medicines refrigerator in the high dependency room on the children’s ward, had not had daily checks recorded on 21 days between July and September 2018. On two occasions the maximum temperature had exceeded the recommended temperature and on eight occasions the minimum temperature had fallen below the recommended temperature. There was no record of any action being taken on these occasions. On one date when the maximum temperature had exceeded the recommended temperature and the minimum temperature had fallen below the recommended temperature, there was a record of action taken. However, the record stated the temperature recording should be reported, but the information did not indicate whether it had been reported.

**Incidents**

The trust had a policy for reporting incidents, near misses and adverse events. Staff told us they were encouraged to report incidents and were aware of the process to do so.

Staff reported incident on the trust’s electronic incident reporting system. Medical and nursing staff felt confident reporting incidents and near misses.

Learning from incidents was variable. Some staff told us they did not always receive feedback from incidents. Whilst other staff told us the procedure changed and they now received feedback, where appropriate. For example, a nurse on the assessment unit told us about an incident that had occurred on the neonatal unit and the learning from the incident was sent to staff through a memorandum.

The ward manager told us they identified that learning from incidents was an area for improvement. Staff told us they did receive emails and information about learning but they did not always read them. To address this, the managers planned to have a monthly learning event, where learning from incidents and complaints would be shared with staff.

We saw an in-date duty of candour (DoC) policy which was accessible to staff on the computerised system. The duty of candour is a regulatory duty that relates to openness and
transparency. It requires providers of health and social care services to notify patients (or other relevant persons) of certain ‘notifiable safety incidents’ and provide reasonable support to that person.

The ward manager was aware of the duty of candour, however the understanding of staff on the ward and departments was variable.

Never Events

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.

From August 2017 to July 2018, the trust reported no incidents classified as never events for children’s services.

(Source: Strategic Executive Information System (STEIS))

Breakdown of serious incidents reported to STEIS

In accordance with the Serious Incident Framework 2015, the trust reported no serious incidents (SIs) in children’s services which met the reporting criteria set by NHS England from August 2017 to July 2018.

(Source: Strategic Executive Information System (STEIS))

Safety Thermometer

The Safety Thermometer is used to record the prevalence of patient harms and to provide immediate information and analysis for frontline teams to monitor their performance in delivering harm free care. Measurement at the frontline is intended to focus attention on patient harms and their elimination.

Data collection takes place one day each month – a suggested date for data collection is given but wards can change this. Data must be submitted within 10 days of suggested data collection date.

Data from the Patient Safety Thermometer showed that the trust reported no new pressure ulcers, no falls with harm and no new urinary tract infections in patients with a catheter from July 2017 to July 2018 for children’s services.

(Source: NHS Digital)

Is the service effective?

Evidence-based care and treatment

At our last inspection there were a significant amount of out of date policies and guidelines. At this inspection we found the policies and guidelines were in date. For example, the management of
neonatal sepsis on the SCBU (review date 2020). Service leads told us they now had a database for policies and guidelines to ensure they were in date, and old versions archived.

Medical and nursing staff adhered to guidelines, and policies and procedures were based on national guidance such as, the Royal College of Paediatrics and Child Health (RCPCH), the National Institute for Health and Care Excellence (NICE), and other professional guidelines such as the British Association of Perinatal Medicine. Policies and guidelines were available on the trust intranet (‘Hub’) and staff knew how to access them.

The neonatal unit had Bliss baby charter and Baby Friendly Initiative (BFI) accreditation. BLISS accreditation recognises those units that offer high quality family centred care. BFI is a global programme introduced to improve practice for infant feeding in healthcare settings.

Children’s services participated in national audits such as diabetes in children and young people, and the neonatal audit programme. We also saw evidence of local audit activity to assess compliance with quality standards, and the clinical audit action plan with dates when follow up actions would be addressed. For example, one of the actions was to identify a breast-feeding champion on the neonatal unit and delegate the role of promoting breastfeeding.

**Nutrition and hydration**

Children and young people were offered a choice of meals that were age appropriate and supported individual dietary needs. We spoke with three parents on the children’s ward about the provision of food and drink their child received. All three parents gave positive feedback about the quality and variety of the food and the availability of drinks.

Staff told us they made dietetic referrals for children or young people requiring nutritional support, or supplements. The staff reported the dietitians were very responsive, and used a nutritional screening tool. They told us the dieticians visited patients with weight loss and those needing a specialised diet. For example, they advised on the calories to be given to a child with a fractured jaw and who had difficulty in eating. We were also informed that the dietician followed up the patients when they were discharged from the ward, in a dietician outpatient clinic.

We saw staff monitored and recorded the fluid intake and output of patients where appropriate, and some parent/carers record the information for their child.

We observed food being offered to a breastfeeding mother, and staff told us that any leftover food was offered to parents; especially on a weekend when the café was closed. Parents and careers who were resident on SCBU had access to kitchen facilities to make their own food and drinks.

Parents who wished to bottle feed were encouraged to bring their feeding bottles from home and shown how to sterilize the equipment.

On SCBU we noted in the room where the baby feeding bottles were sterilized, that the sterilizing products were stored in an unlocked cupboard. Under the Control of Substances Hazardous to Health Regulations (COSHH) these products must be stored in a locked cupboard. This was brought to the attention of staff and immediately addressed.
**Pain relief**

Child friendly pain assessment tools were used and pain scores were documented on the paediatric early warning score (PEWS) charts.

Children and young people had access to a range of pain relief if needed, including oral analgesia and patient-controlled analgesics. We saw evidence of a pain scoring system and completed pain assessments in the care records we reviewed.

Other non-pharmacological methods were also used by staff across the service. The children’s ward had a dedicated play specialist who told us they used age appropriate play and activities as a means of helping to prepare children for procedures.

Staff in the neonatal unit did not use a specific pain assessment tool and instead used oral sucrose analgesia, administered pre-procedure, for new-born infants undergoing painful procedures. The use of sucrose as an analgesia is common practice across the UK and the rest of the world. Staff recognised that sucrose, ‘non-nutritive’ sucking, breastfeeding and physical comfort all had a role to play in providing relief from the pain associated with certain procedures. The unit had also introduced the use of breast milk as a means of comforting babies.

**Patient outcomes**

Children’s services participated in national clinical audits to monitor and improve patient outcomes.

**Paediatric diabetes audit 2015/16**

HbA1c levels are an indicator of how well an individual’s blood glucose levels are controlled over time.

The data below shows that in the 2015/16 diabetes audit the trust performed similar to the England average.

The proportion of patients receiving all key care processes annually was 29.2% which was within the expected range, compared to a national aggregate of 35.5%. The previous year’s score was 11.1%.

The average HbA1c value (adjusted by case-mix) at the trust was 65.7% which was within the expected range, compared to a national aggregate of 68.3%, the previous year’s score was classified as ‘better than expected’.

(Source: National Paediatric Diabetes Audit 2015/16)

**Emergency readmission rates within two days of discharge**

The data shows that from February 2017 to January 2018 there was a higher percentage of patients aged 1-17 years old readmitted following an elective admission compared to the England average.

<table>
<thead>
<tr>
<th>Treatment Specialty</th>
<th>Total Readmissions</th>
<th>Under 1 Age Group Readmissions</th>
</tr>
</thead>
<tbody>
<tr>
<td>General</td>
<td>50</td>
<td>10</td>
</tr>
<tr>
<td>Surgery</td>
<td>30</td>
<td>5</td>
</tr>
<tr>
<td>Emergency</td>
<td>20</td>
<td>4</td>
</tr>
</tbody>
</table>

There were emergency readmissions after elective admission among patients in the under 1 age group from February 2015 to January 2016. However, no treatment specialty reported six or more readmissions.
readmissions.

Emergency readmissions within two days of discharge following elective admission among the 1-17 age group, by treatment specialty (February 2017 to January 2018)

<table>
<thead>
<tr>
<th>Specialty</th>
<th>The Rotherham Foundation NHS Trust</th>
<th>England</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Readmission rate</td>
<td>Discharges (n)</td>
</tr>
<tr>
<td>ENT</td>
<td>1.9%</td>
<td>320</td>
</tr>
</tbody>
</table>

The tables below show the percentage of patients (by age group) who were readmitted following an emergency admission. The tables show the three specialties with the highest volume of readmissions and only those specialties where six or more readmissions recorded are shown in the table.

The data shows that from February 2017 to January 2018 there was a lower percentage of under-ones readmitted following an emergency admission compared to the England average, and a lower percentage of patients aged 1-17 years old readmitted following an emergency admission compared to the England average.

Emergency readmissions within two days of discharge following emergency admission among the under 1 age group, by treatment specialty (February 2017 to January 2018)

<table>
<thead>
<tr>
<th>Specialty</th>
<th>The Rotherham Foundation NHS Trust</th>
<th>England</th>
</tr>
</thead>
<tbody>
<tr>
<td>Paediatrics</td>
<td>Readmission rate</td>
<td>Discharges (n)</td>
</tr>
<tr>
<td>Paediatrics</td>
<td>1.2%</td>
<td>601</td>
</tr>
</tbody>
</table>

Emergency readmissions within two days of discharge following emergency admission among the 1-17 age group, by treatment specialty (February 2017 to January 2018)

<table>
<thead>
<tr>
<th>Specialty</th>
<th>The Rotherham Foundation NHS Trust</th>
<th>England</th>
</tr>
</thead>
<tbody>
<tr>
<td>Paediatrics</td>
<td>Readmission rate</td>
<td>Discharges (n)</td>
</tr>
<tr>
<td>Paediatrics</td>
<td>1.4%</td>
<td>1,020</td>
</tr>
</tbody>
</table>

(Source: Hospital Episode Statistics, provided by CQC Outliers team)

Rate of multiple emergency admissions within 12 months among children and young people for asthma, epilepsy and diabetes

From March 2017 to February 2018 the trust sample size was too small to allow for comparison against the England average for the multiple readmission rates.

Rate of multiple (two or more) emergency admissions within 12 months among children and young people for asthma, epilepsy and diabetes (March 2017 to February 2018)

<table>
<thead>
<tr>
<th>Long term condition</th>
<th>The Rotherham Foundation NHS Trust</th>
<th>England</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Multiple admission rate</td>
<td>At least one admission (n)</td>
</tr>
<tr>
<td>Asthma Under 1</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>1 to 17</td>
<td>*</td>
<td>65</td>
</tr>
<tr>
<td>Diabetes Under 1</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>1 to 17</td>
<td>*</td>
<td>21</td>
</tr>
<tr>
<td>Epilepsy</td>
<td></td>
<td></td>
</tr>
<tr>
<td>----------</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Under 1</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>1 to 17</td>
<td>*</td>
<td>17</td>
</tr>
</tbody>
</table>

Note - For reasons of confidentiality, numbers below 6 and their associated proportions have been removed and replaced with "*".

(Source: Hospital Episode Statistics, provided by CQC Outliers team)

National Neonatal Audit Programme

In the 2017 National Neonatal Audit the trust performance in the four measures relevant to children and young people’s services was as follows:

Do all babies <32 weeks gestation have a temperature taken within an hour of admission that is 36.5°C-37.5°C?

There were 21 eligible cases identified for inclusion, 66.4% of babies who had their temperature measured within an hour of admission had a temperature measurement between 36.5°C and 37.5°C.

This was within the expected range when compared to the national aggregate where 61.0% of babies who had their temperature measured within an hour of admission had a temperature measurement between 36.5°C and 37.5°C.

The hospital did not meet the audit’s recommended standard of 90% for this measure.

Is there a documented consultation with parents by a senior member of the neonatal team within 24 hours of admission?

There were 168 eligible cases identified for inclusion, 98% of these cases had a first consultation with parents by a senior member of the neonatal team within 24 hours of admission.

This was better than expected when compared to the national aggregate where 90.5% of cases had the first consultation within 24 hours of admission.

The hospital did not meet the audit’s recommended standard of 100% for this measure.

Do all babies < 1501g or a gestational age of < 32 week at birth receive appropriate screening for retinopathy of prematurity (ROP)

There were 33 eligible cases identified for inclusion, 96.3% of babies with a weight of < 1501g or a gestational age of < 32 week at birth received the appropriate ROP screening.

This was within the expected range when compared to the national aggregate where 94.2% of cases received the appropriate ROP screening.

The hospital did not meet the audit’s recommended standard of 100% for this measure.

Do all babies with a gestation at birth <30 weeks receive a documented follow-up at two years gestationally corrected age?

There were 16 eligible cases identified for inclusion, 75% of babies with a gestation at birth of <30 weeks received a documented follow-up at two years gestationally corrected age.
This was within the expected range when compared to the national aggregate where 61.2% of babies with a gestation at birth of <30 weeks received a documented follow-up at two years gestationally corrected age.

The hospital did not meet the audit’s recommended standard of 100% for this measure.

(Source: National Neonatal Audit Programme, Royal College of Paediatrics and Child Health)

Competent staff

Appraisal rates

From April 2017 to March 2018, 50% of staff within services for children and young people care at the trust received an appraisal compared to a trust target of 90%.

<table>
<thead>
<tr>
<th>Staff Group</th>
<th>Appraisals required - 04/17-03/18</th>
<th>Appraisals completed - 04/17-03/18</th>
<th>Percentage completed</th>
<th>Trust Target (90%) met?</th>
</tr>
</thead>
<tbody>
<tr>
<td>Support to doctors and nursing staff</td>
<td>19</td>
<td>10</td>
<td>53%</td>
<td>No</td>
</tr>
<tr>
<td>Qualified nursing &amp; health visiting staff</td>
<td>62</td>
<td>32</td>
<td>52%</td>
<td>No</td>
</tr>
<tr>
<td>(Qualified nurses)</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Support to ST&amp;T staff</td>
<td>3</td>
<td>0</td>
<td>0%</td>
<td>No</td>
</tr>
<tr>
<td>Grand Total</td>
<td>84</td>
<td>42</td>
<td>50%</td>
<td>No</td>
</tr>
</tbody>
</table>

(Source: Trust Provider Information Request – Appraisal tab)

The outpatient manager, and ward manager for the children’s ward and assessment unit told us all their staff were up to date with their appraisals. We inspected the appraisal documentation in the paediatric outpatient department and saw 100% of staff had received an appraisal. In the SCBU 91% of staff had an appraisal (31 out of 34 staff). The staff who had not received an appraisal had recently returned from either sickness, or maternity leave. These figures exceeded the trust target of 90%.

Staff told us they had attended study days for mental health conditions. These were run by the child and adolescent mental health service (CAMHS) liaison nurse and included training such as, eating disorders. Staff had also attended a transgender study day.

There was not always a member of staff on duty, who had completed the advanced paediatric life support (APLS) course. The ward manager told us there were six staff members, APLS trained and there was a plan in place to ensure all band six nurses attended the course.

Information provided by the trust in October 2018, showed all the theatre recovery staff, and day surgery nurses had attend a Paediatric Life Support course. The information stated that the course was more advanced than the hospital Paediatric resuscitation course and the attendance of the staff had been recorded on the master data base.

Staff attended training provided by the critical care network educator, who ran two training days a year. The training included topics such as, the paediatric early warning score and sepsis.
The ward manager told us that a practice educator role had been created, and the role would cover the children’s ward, assessment unit and ED.

Staff told us new staff were supernumerary for a minimum of a month. In the outpatient’s department all nursing staff were trained in phlebotomy and new starters or staff returning to work repeated the training to update their skills.

There were two paediatric advanced nurse practitioners and a further one was in training.

There were specialist nurses in post for specific conditions, such as diabetes and asthma, and a vacancy for an epilepsy nurse specialist. The specialist nurses held training days for staff to attend for the care of children with specific conditions.

The neonatal service had recently set up an outreach team.

Student nurses spoke positively about their placements and described a good support network to help develop their nursing knowledge; all students had a mentor.

**Multidisciplinary working**

The neonatal unit held a multidisciplinary ward round every Monday and included staff such as, a consultant paediatrician, doctors, nursing staff, and a dietitian.

Play staff worked on the children’s ward, assessment unit and in the outpatient department. However, they did not routinely go with the children to theatre or other departments in the hospital.

There was good liaison with the child and adolescent mental health service (CAMHS). The CAHMS team telephoned the ward each day to check if there were any patients they should see. Staff told us that on occasions the out of hours support for this service was a little difficult. This was because the on-call staff were not locally based and in some instances had to travel a distance when visiting the ward.

Transition to adult services was patient centred. This helped ensure they were cared for where best met their emotional and physical needs.

Our observation of practice, review of records and discussion with staff confirmed effective multidisciplinary team (MDT) working practices were in place. Medical and nursing staff worked closely together and with other allied healthcare professionals such as dieticians, health visitors and GPs.

Staff spoke positively about the relationship with the tertiary care centre at Sheffield. They gave examples of liaising and arranging the transfer of children from one hospital to the other.

Medical and nursing staff told us relationships with each other was good.

**CQC Children and Young People’s Survey 2016 – Q23**

In the CQC Children and Young People’s Survey 2016 the trust scored 9.01 out of ten for the question ‘Did the members of staff caring for your child work well together?’ This was about the
same as other trusts.

(Source: CQC Children and Young People’s Survey 2016, RCPCH)

Seven-day services

Consultant ward rounds took place seven days a week on the children's ward and assessment unit. On the neonatal unit the consultant ward rounds took place on a Monday and a Wednesday.

Consultants and doctors were available out-of-hours; there were no reported concerns about accessing out-of-hours support.

Staff could access the Embrace network and the local tertiary hospital services to discuss and agree treatment and plans of care for sick children at weekends and out of hours. The Embrace service is a highly specialist, round-the-clock transport service for critically ill infants and children in Yorkshire and the Humber who require care in another hospital in the region or further afield.

The children’s outpatient clinic was open from 8:30am to 5pm Monday to Friday and the children’s assessment unit was open seven days a week.

Staff did not raise concerns over accessing diagnostic services such as the x-ray department, and laboratory services during the weekend and out of hours.

Health Promotion

Health promotion information was available in all areas we visited. There were display boards and patient information leaflets to educate children, young people and families about health matters, such as safer sleep, eczema, asthma and dental care.

On SCBU we saw information with advice about: Screening for Retinopathy of Prematurity (RoP), the NHS Screening Programs, meningitis, and measles. We also saw information about baby feeding.

There were specialist nurses in post for specific conditions, such as diabetes and asthma, and they provided support and advice to patients, parents/carers and staff.

Consent, Mental Capacity Act and Deprivation of Liberty safeguards

Staff we spoke with understood Gillick competency and Fraser guidelines. The 'Gillick Test' helps clinicians to identify children aged under 16 who have the legal capacity to consent to medical examination and treatment. Fraser guidelines relate specifically to contraception and sexual health.

One of the dental consultants explained the consent process and how they asked children and young people to sign their own consent form, (along with parental signature). This was to empower them to take responsibility of their own treatment and health.

The mental capacity act (MCA) training was included in the trusts safeguarding training. Staff we spoke with had limited knowledge of the MCA and were unsure of what action they would take if they felt a parent didn’t have the capacity to consent.
Other CQC Survey Data

CQC Children and Young People’s Survey 2016 Data

The trust performed about the same as other trusts for all four questions relating to effectiveness in the CQC Children and Young People’s Survey 2016. Question 54 was recorded as ‘No score’.

CQC Children’s Survey questions, effective domain, The Rotherham NHS Foundation Trust

<table>
<thead>
<tr>
<th>Question Number</th>
<th>Question</th>
<th>Age Group</th>
<th>Trust score</th>
<th>RAG</th>
</tr>
</thead>
<tbody>
<tr>
<td>21</td>
<td>Did you feel that staff looking after your child knew how to care for their individual or special needs?</td>
<td>0-15 adults</td>
<td>8.30</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>9</td>
<td>Did staff play with your child at all while they were in hospital?</td>
<td>0-7 adults</td>
<td>8.07</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>19</td>
<td>Did different staff give you conflicting information?</td>
<td>0-7 adults</td>
<td>7.45</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>33</td>
<td>During any operations or procedures, did staff play with your child or do anything to distract them?</td>
<td>0-15 adults</td>
<td>8.40</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>54</td>
<td>Did hospital staff play with you or do any activities with you while you were in hospital?</td>
<td>8-11 CYP</td>
<td>No Score</td>
<td>No Score</td>
</tr>
</tbody>
</table>

(Source: CQC Children and Young People’s Survey 2016, RCPCH)

Is the service caring?

Compassionate care

Throughout our inspection, we observed medical and nursing staff delivering compassionate and sensitive care that met the needs of children, young people, and their families.

Staff introduced themselves by name, explained what they were doing and offered reassurance and support to children, young people and families.

We observed members of staff who had a positive and friendly approach. We observed indirect care being given by non-clinical staff such as receptionists, domestic staff, housekeepers and kitchen staff serving children their food. They actively listened, personalised conversations and gave caring responses.

Feedback from families in the SCBU was positive. They said the staff were amazing, nothing was too much trouble, staff helped with any questions and always put their mind at rest.

Patients we spoke with said that staff answered the nurse call alarms quickly, and we observed this in practice during the inspection.
We observed patient’s privacy and dignity being respected, as curtains were drawn around patient’s beds when staff delivered care and treatment.

The staff on the children’s assessment unit respected the religious needs of patients and staff. They gave an example of how the clinic time of the rapid access clinic had been changed to accommodate prayer time.

**CQC Children and Young People’s Survey 2016**

The trust performed about the same as other trusts for all nine questions relating to compassionate care in the CQC Children and Young People’s Survey 2016.

**CQC Children and Young People’s Survey 2016 questions, compassionate care, The Rotherham NHS Foundation Trust**

<table>
<thead>
<tr>
<th>Question Number</th>
<th>Question</th>
<th>Age group</th>
<th>Trust score</th>
<th>RAG</th>
</tr>
</thead>
<tbody>
<tr>
<td>10</td>
<td>Did new members of staff treating your child introduce themselves?</td>
<td>0-7 adults</td>
<td>8.82</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>14</td>
<td>Did you have confidence and trust in the members of staff treating your child?</td>
<td>0-15 adults</td>
<td>8.83</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>22</td>
<td>Were members of staff available when your child needed attention?</td>
<td>0-15 adults</td>
<td>8.13</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>42</td>
<td>Do you feel that the people looking after your child were friendly?</td>
<td>0-7 adults</td>
<td>9.25</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>43</td>
<td>Do you feel that your child was well looked after by the hospital staff?</td>
<td>0-7 adults</td>
<td>9.07</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>44</td>
<td>Do you feel that you (the parent/carer) were well looked after by hospital staff?</td>
<td>0-15 adults</td>
<td>8.40</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>58</td>
<td>Was it quiet enough for you to sleep when needed in the hospital?</td>
<td>8-15 CYP</td>
<td>No Score</td>
<td>No Score</td>
</tr>
<tr>
<td>64</td>
<td>If you had any worries, did a member of staff talk with you about them?</td>
<td>8-15 CYP</td>
<td>8.76</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>74</td>
<td>Do you feel that the people looking after you were friendly?</td>
<td>8-15 CYP</td>
<td>9.35</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>75</td>
<td>Overall, how well do you think you were looked after in hospital?</td>
<td>8-15 CYP</td>
<td>8.82</td>
<td>About the same as other trusts</td>
</tr>
</tbody>
</table>

(Source: CQC Children and Young People’s Survey 2016, RCPCH)

**Emotional support**

Families told us they felt staff understood the impact the condition and treatment had on their children. They told us staff offered reassurances and support. Medical and nursing staff kept families informed at every stage of their care and treatment.
We saw staff using distraction techniques in response to children’s physical discomfort or emotional distress. This included play therapists in the outpatient’s department providing therapy sessions for children who had to have a blood test.

Parents in SCBU told us they were happy with the emotional support they received from staff and felt confident leaving their baby in the care of the staff. Families could access counselling and bereavement support.

On the paediatric dental unit, they operated a circular route through the service. This ensured that newly admitted patients avoided seeing children in the post recovery area who may be distressed or upset.

On the children’s ward, those children who were fasting for theatre and or, nil by mouth staff took them out of the unit during meal times.

In the paediatric dental suite, the nurses tried to maintain consistency and have the same nurse available for each child throughout their episode of care.

A play therapist in the outpatient’s department were emotionally supportive to a child who had a birthday on the date of their clinic appointment. They gave the child a birthday present from the department.

**CQC Children and Young People’s Survey 2016**

The trust performed about the same as other trusts for four questions relating to emotional support in the CQC Children and Young People’s Survey 2016.

**CQC Children and Young People’s Survey 2016 questions, emotional support, The Rotherham NHS Foundation Trust**

<table>
<thead>
<tr>
<th>Question Number</th>
<th>Question</th>
<th>Age group</th>
<th>Trust score</th>
<th>RAG</th>
</tr>
</thead>
<tbody>
<tr>
<td>7</td>
<td>Was your child given enough privacy when receiving care and treatment?</td>
<td>0-7 adults</td>
<td>9.27</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td></td>
<td>If your child felt pain while they were at the hospital, do you think staff did everything they could to help them?</td>
<td>0-15 adults</td>
<td>8.73</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>29</td>
<td>Were you treated with dignity and respect by the people looking after your child?</td>
<td>0-7 adults</td>
<td>9.28</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>45</td>
<td>Were you given enough privacy when you were receiving care and treatment?</td>
<td>8-15 CYP</td>
<td>7.58</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>65</td>
<td>If you felt pain while you were at the hospital, do you think staff did everything they could to help you?</td>
<td>8-15 CYP</td>
<td>No Score</td>
<td>No Score</td>
</tr>
</tbody>
</table>

(Source: CQC Children and Young People’s Survey 2016, RCPCH)
Understanding and involvement of patients

CQC Children and Young People’s Survey 2016

The trust performed about the same as other trusts for 16 questions relating to understanding and involvement of patients and those close to them in the CQC Children and Young People’s Survey 2016.

CQC Children and Young People’s Survey 2016 questions, understanding and involvement of patients, The Rotherham NHS Foundation Trust

<table>
<thead>
<tr>
<th>Question Number</th>
<th>Question</th>
<th>Age group</th>
<th>Trust score</th>
<th>RAG</th>
</tr>
</thead>
<tbody>
<tr>
<td>11</td>
<td>Did members of staff treating your child give you information about their care and treatment in a way that you could understand?</td>
<td>0-15 adults</td>
<td>8.98</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>12</td>
<td>Did members of staff treating your child communicate with them in a way that your child could understand?</td>
<td>0-7 adults</td>
<td>7.65</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>13</td>
<td>Did a member of staff agree a plan for your child’s care with you?</td>
<td>0-15 adults</td>
<td>8.69</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>15</td>
<td>Did staff involve you in decisions about your child’s care and treatment?</td>
<td>0-15 adults</td>
<td>8.37</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>16</td>
<td>Were you given enough information to be involved in decisions about your child's care and treatment?</td>
<td>0-15 adults</td>
<td>8.73</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>17</td>
<td>Did hospital staff keep you informed about what was happening whilst your child was in hospital?</td>
<td>0-15 adults</td>
<td>8.19</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>18</td>
<td>Were you able to ask staff any questions you had about your child’s care?</td>
<td>0-15 adults</td>
<td>8.93</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>31</td>
<td>Before your child had any operations or procedures did a member of staff explain to you what would be done?</td>
<td>0-15 adults</td>
<td>9.58</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>32</td>
<td>Before the operations or procedures, did a member of staff answer your questions in a way you could understand?</td>
<td>0-15 adults</td>
<td>9.20</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>34</td>
<td>Afterwards, did staff explain to you how the operations or procedures had gone?</td>
<td>0-15 adults</td>
<td>9.24</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>39</td>
<td>When you left hospital, did you know what was going to happen next with your child’s care?</td>
<td>0-15 adults</td>
<td>8.24</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>41</td>
<td>Do you feel that the people looking after your child listened to you?</td>
<td>0-7 adults</td>
<td>8.41</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>59</td>
<td>Did hospital staff talk with you about how they were going to care for you?</td>
<td>8-15 CYP</td>
<td>9.67</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>60</td>
<td>When the hospital staff spoke with you, did you understand what they said?</td>
<td>8-15 CYP</td>
<td>8.09</td>
<td>About the same as other trusts</td>
</tr>
</tbody>
</table>
We spoke with six parents who told us staff discussed their child’s care and treatment in a way which they understood. They were also involved in the planning and decision-making process, and were given time to ask questions. Two parents from the same family gave negative feedback. This was because they did not feel they were kept up to date with what was happening.

Parents in the outpatient department spoke positively about how they were kept informed and provided with information to take home.

**Is the service responsive?**

**Service delivery to meet the needs of local people**

The children’s ward had previously had input into the design of the ward from a team of young inspectors.

There were facilities available for parents to stay with their children on the children’s ward and assessment unit. There were two parent rooms available for people to stay when their child was in the high dependency unit. The neonatal unit had three bedrooms for parents. Each area had a kitchen and sitting room.

The neonatal unit had a viewing area, where family members that were not allowed onto the unit could see the babies.

On the SCBU the mothers had access to a breast-feeding room to enable them to express their milk for their baby in private. Mothers were advised to express their milk for the first 24 hours.
following delivery and then it could be frozen and given to their baby when needed; donor baby, breast milk was also available. Dependent on the mother’s choice there were electric and hand breast pumps available on the ward. Mothers who were breast feeding were offered support.

In all the play areas there were age-appropriate toys and games to meet the educational and play needs of the children. This included books, computerised games, television, table tennis, snooker, table hockey and football memorabilia. One parent told us they were pleased with the playroom on the children’s ward and the games available.

The children’s ward had a play room for younger children and an adolescent room for those children 12 years and over, this had a television, a games console, a table tennis table and a snooker table.

On the children’s ward there were eight cubicles and four bed bays. There was no segregation of older children from younger children and it was possible that an adolescent could be nursed in a bed at the side of a young child.

The children’s outpatient department had a play area with suitable toys and books. There was also a sensory room for children with complex needs and an outside play area.

In main theatres, children were recovered in the same area as adult patients, however they were screened from view with curtains. The paediatric dental unit ensured that those children admitted for dental surgery were seen in a child friendly environment.

A pager was given to patients whose child was in theatre. The theatre staff could then let them know when their child was ready to go back to the ward.

The children’s outpatient department provided a range of specialist clinics to meet the needs of children and young people. These included cardiology, rheumatology, respiratory medicine, ophthalmology, and diabetes. Clinicians from other trusts also provided outpatient services within the department, and these included cardiology clinics.

The play specialist was available five days a week. They also supported outpatient clinics and we saw children interacting with them positively and confidently.

Wi-Fi was readily available across the service which meant children and young people could keep in touch with family and friends whilst in hospital.

**CQC Children and Young People’s Survey 2016**

The trust performed better than other trusts for two questions and about the same as other trusts for the remaining 11 questions relating to responsiveness in the CQC Children and Young People’s Survey 2016.

**CQC Children and Young People's Survey 2016 questions, responsive domain, The Rotherham NHS Foundation Trust**
<table>
<thead>
<tr>
<th>Question Number</th>
<th>Question</th>
<th>Age group</th>
<th>Trust score</th>
<th>RAG</th>
</tr>
</thead>
<tbody>
<tr>
<td>4</td>
<td>For most of their stay in hospital what type of ward did your child stay on?</td>
<td>0-15 adults</td>
<td>9.42</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>5</td>
<td>Did the ward where your child stayed have appropriate equipment or adaptations for your child’s physical or medical needs?</td>
<td>0-15 adults</td>
<td>8.94</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>25</td>
<td>Did you have access to hot drinks facilities in the hospital?</td>
<td>0-15 adults</td>
<td>8.53</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>26</td>
<td>Were you able to prepare food in the hospital if you wanted to?</td>
<td>0-15 adults</td>
<td>3.94</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>28</td>
<td>How would you rate the facilities for parents or carers staying overnight?</td>
<td>0-15 adults</td>
<td>7.07</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>55</td>
<td>Was the ward suitable for someone of your age?</td>
<td>12-15 CYP</td>
<td>No Score</td>
<td>No Score</td>
</tr>
<tr>
<td>8</td>
<td>Were there enough things for your child to do in the hospital?</td>
<td>0-7 adults</td>
<td>8.19</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>24</td>
<td>Did your child like the hospital food provided?</td>
<td>0-7 adults</td>
<td>6.47</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>37</td>
<td>Did a staff member give you advice about caring for your child after you went home?</td>
<td>0-15 adults</td>
<td>8.96</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>38</td>
<td>Did a member of staff tell you who to talk to if you were worried about your child when you got home?</td>
<td>0-7 adults</td>
<td>9.30</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>40</td>
<td>Were you given any written information (such as leaflets) about your child’s condition or treatment to take home with you?</td>
<td>0-15 adults</td>
<td>8.93</td>
<td>About the same as other trusts</td>
</tr>
<tr>
<td>56</td>
<td>Were there enough things for you to do in the hospital?</td>
<td>8-15 CYP</td>
<td>No Score</td>
<td>No Score</td>
</tr>
<tr>
<td>57</td>
<td>Did you like the hospital food?</td>
<td>8-15 CYP</td>
<td>No Score</td>
<td>No Score</td>
</tr>
<tr>
<td>71</td>
<td>Did a member of staff tell you who to talk to if you were worried about anything when you got home?</td>
<td>8-15 CYP</td>
<td>9.41</td>
<td>Better than other trusts</td>
</tr>
<tr>
<td>73</td>
<td>Did a member of staff give you advice on how to look after yourself after you went home?</td>
<td>8-15 CYP</td>
<td>9.46</td>
<td>Better than other trusts</td>
</tr>
<tr>
<td>2</td>
<td>Did the hospital give you a choice of admission dates?</td>
<td>0-7 adults</td>
<td>No Score</td>
<td>No Score</td>
</tr>
<tr>
<td>3</td>
<td>Did the hospital change your child’s admission date at all?</td>
<td>0-7 adults</td>
<td>No Score</td>
<td>No Score</td>
</tr>
</tbody>
</table>

(Source: CQC Children and Young People’s Survey 2016, RCPCH)
Meeting people’s individual needs

Staff we spoke with told us they could access face to face and telephone interpreters and gave examples of when they had used the service.

We saw leaflets for children and families were available in the ward and outpatient areas and available in languages other than English.

A child and adolescent mental health service (CAMHS) liaison nurse was available to support the staff and young people. The staff telephoned the ward each day to check if there were any patients they should see.

Staff in the paediatric dental unit told us, that if they had children with special needs visiting the unit they worked closely with the parents to decide when the best appointment time would be.

In the children’s outpatient department there were different appointment times to meet the children’s needs. For example, the appointment for a patient with diabetes was one hour, for a patient booked for an educational assessment, 45 minutes and a looked after children appointment was one hour.

The children’s outpatient department included toilet facilities for children and young people with a disability.

Access and flow

The children’s assessment unit accepted referrals from the emergency department, GP’s, community nurses and self-referrals for those children with open access. All children and young people were admitted to the assessment unit before admission to the children’s ward. The maximum length of stay on the assessment unit was 24 hours. The children’s assessment unit and children’s ward were co-located.

Staff could explain what actions they would take if the number of patients exceeded the number of available beds.

The children’s outpatient department held rapid access clinics every day. GP’s made referrals to this clinic and children were triaged by the consultants. The patient would be then given a timely appointment, which was dependent on need.

The manager told us that routine appointments to the outpatient’s department were between eight to ten weeks and this was dependant on the speciality.

Following patient feedback, in the paediatric outpatient sitting area a patient information board displayed up to date information about the running and waiting time of the clinic.

Staff in the children’s service had access to the electronic record so that they could see the GP and community record, if the GP was using the same electronic record.
There was a backlog of 300 follow up appointments in the outpatient department. The service had experienced a problem in uploading information onto the computer system. The outpatient manager told us that additional follow up clinics were currently being held and the backlog was reducing. There was a trajectory date when the backlog was expected to be fully reduced. The manager and service leads reassured us that all the patients had been reviewed by their consultant to ensure no one had been missed or at risk.

Children and young people were admitted to the children’s ward through the paediatric emergency department or via a direct referral from a GP.

The children’s ward was supported by a children’s community nursing team. The community nurses visited the ward every morning.

The records we reviewed, showed evidence that a consultant saw the child or young person within 14 hours of admission in line with current guidance.

**Learning from complaints and concerns**

**Summary of complaints**

From June 2017 to May 2018 there were 5 complaints about children’s services. The trust took an average of 39 days to investigate and close complaints, this is not in line with their complaints policy, which states complaints should be resolved within 30 days unless complex.

*(Source: Routine Provider Information Request (RPIR) – Complaints tab)*

In the six months prior to inspection, the service had received three complaints and all were answered within the agreed timescales.

The trust advised that extensions to the 30-day deadline could be granted when the nature of the complaint was complex. This meant some complaints could be resolved within the agreed extension time frame. However, we did not receive any data which highlighted how many of the five complaints had been granted an extension and, if so, whether they had been resolved within the agreed timescale.

**Number of compliments made to the trust**

From June 2017 to May 2018 there was one compliment within services for children and young people.

*(Source: Routine Provider Information Request (RPIR) – Compliments tab)*

We saw posters and leaflets displayed in every area we visited on how to make a complaint or share a compliment with the service. Some were in large print and languages other than English.

Parents we spoke with told us they knew how to raise a concern, and felt comfortable to do so.

Staff we spoke with said they would always try to resolve complaints and concerns locally when they arose, and would inform their manager.
Staff could tell us of changes that had been made in response to complaints. For example, the doors of the cubicles on the children’s ward were to be changed in response to a complaint about staff not (hearing and therefore not) responding to monitor alarms.

Complaints were not all investigated and closed in line with the timescales of the trusts complaints policy.

**Is the service well-led?**

**Leadership**

There were clear lines of management and accountability across the service at all levels.

Staff spoke positively about the leadership of the service. They felt supported and could raise issues or concerns.

At our last inspection, there was no matron in post and the management team did not have any paediatric experience. At this inspection there was a deputy head of nursing for paediatrics and a matron in post. The deputy head of nursing for paediatrics had been in post for about a year and the matron had been in post for nearly two years. Staff spoke positively about the deputy head of nursing and the matron. They said they felt supported and able to raise new ideas. They said the matron was available to speak with and seen most day.

The chief nurse was the board lead for children and young people and one of the non-executive directors.

**Vision and strategy**

The children’s service had a two-year strategy to provide outstanding care provision to all children, young people and their families. They would do this by providing a fully integrated, comprehensive and high-quality needs led service influenced by the voice of the child / young person which is child and young person focused.

We saw the strategic goals and objectives of the service visible across children’s services. For example, at the back of the reception desk in the paediatric outpatient’s department.

The objectives were to help the trust become a high-quality need led service. Their vision was for care to be closer to home and to have the voice of the child embedded in what they did.

Staff we spoke with were aware of the vision and strategy. We saw the values and mission statement displayed in the areas we visited.
Culture

We observed good team working, with nurses and medical staff working collaboratively and with respect for each other’s roles. All staff spoke positively about the changes made to the service since our 2016 inspection.

Staff told us they were a part of a good team, and enjoyed working at the trust. They also told us, that since our last inspection their department had worked better together.

Staff described a culture of openness and honesty. Most staff felt valued and respected. They spoke positively about the service; morale was good.

Staff were encouraged to report incidents, and felt confident that if they raised a concern, managers would take appropriate action.

The trust had a Freedom to Speak Up Guardian. They reminded staff they were available and that there were different ways to raise a concern.

Governance

Children’s services were part of the family health division. There was a governance structure in place to ensure information was escalated to the trust board and from the board to ward level. There was a governance lead for the children’s services.

Monthly governance meetings were held which reported into monthly divisional performance meetings. These then reported into the executive team performance meetings, which in turn reported into the trust clinical governance committee; the governance meeting passed information down to the clinical effectiveness group, ward and department meetings.

Ward and department managers held meetings to share information with their staff.

We reviewed the minutes of the August 2018, governance meeting. The meeting attendance included ward managers, a paediatric consultant, governance lead, deputy head of nursing, and assistant chief nurse. The information discussed included compliance with the hygiene code & essential steps/saving lives audits, infection prevention and control, PEWS audit, complaints, concerns and compliments, policies, procedures and guidance and risks to be considered for adding to the risk register.

Management of risk, issues and performance

The risk register reflected the risks of the service and those identified at ward and department level. We saw good monitoring and oversight of the risk register. The register held a brief overview of each risk, together with a rating and colour coded to reflect the status. Each ward and department kept a copy of their own risk register. We saw minutes of the monthly governance meeting; August 2018, and there was evidence that risks were on the agenda to be reviewed.

During the inspection we met with members of the children’s services senior management team. They could tell us the top three risks of the organisation. These included the doors on the children’s ward, when closed staff could not hear the nurse call alarm; absence of a specialist nurse, and the third risk was the echocardiogram machine which was over five years old and in
The team were aware of the shortfalls relating to staff training and qualifications. Further training dates/courses and recruitment of staff are being made.

**Information management**

Staff had access to the information required to provide safe and effective care.

The information accessed by managers was stored in line with data security standards. For example, confidential and personal information stored on the computer was protected through the use of smart cards, issued to individual staff.

We saw on the wards confidential waste bins were in use.

Staff had access to clinical guidelines, and care pathways on the trust intranet, which meant they could access advice and guidance easily.

**Engagement**

Staff told us they received weekly email updates from the chief executive. The trust communications team distributed bulletins and a children’s services newsletters via email, and uploaded trust information onto the intranet for staff to access.

Star cards were used in recognition of staff achievements and focused on an external award. Feedback surveys, such as Friends and Family Test (FFT) were used. The service proactively engaged with children, young people and their families and sought feedback through patient experience surveys. Feedback was displayed on boards in the children’s ward and SCBU.

The service displayed information of feedback and action taken from patient surveys. This demonstrated that they listened to and took appropriate action in response to feedback.

Medical and nursing staff engaged daily with the children and young people in their care and ensured parents were included. We saw evidence of positive and caring interactions between staff of all grades with the children and their families.

A user involvement working group had been set up covering both the acute and community children’s services. The purpose of this group was to ensure there was user involvement to help service improvement.

Responses from the 2017, staff survey showed 97.5% said they worked as a team. 56% of staff said they would recommend the organisation as a place to work and 33% did not agree or disagree. 68% of staff said their appraisal made them feel valued by the organisation. 97.4% of staff said they had received an appraisal in the previous 12 months.
Learning, continuous improvement and innovation

The service had recognised the benefit of the advanced nurse practitioner role and had trained two staff, with a further one completing the training.

Funding had also been agreed for a practice development nurse, and the service had developed a neonatal outreach team.

Staff were proud of their achievements in relation to BLISS and the Baby Friendly Initiative. In SCBU, due to the regular presence of parents on the unit, staff encouraged them to proactively engage in the care of their child.

Annual awards were held in recognition of staff achievements.
Community health services for children, young people and families

Facts and data about this service

Community services for children, young people and families include the 0 to 19 service (health visiting, health promotion and school nursing) which is commissioned by the local authority. The trust successfully won the tender for this service in April 2017. The 0 to 19 service delivers the Healthy Child Programme, and also undertakes a high level of safeguarding work at all levels, including specific time allocated to child sexual abuse (CSE) and complex abuse cases. It also has an early intervention / prevention service for early attachment.

The 0 to 19 service is delivered from a wide range of community venues and includes an increasing level of skill mix in line with the tender proposal. Children's therapies are based in Kimberworth interagency hub for special educational needs and disabilities. They include: speech and language therapy, occupational therapy and physiotherapy.

There is close working with early years settings and schools with a ‘traded services’ arm of therapies, offering additional input to schools if they choose to fund this. Traded services allows schools and early years settings to buy additional services in addition to that funded by the local authority.

The Child Development Centre is also located at Kimberworth Place and provides a multi-disciplinary team that includes therapies, clinical psychology, nursery nurses, a specialist teacher and paediatrician input. Complex care nursing is also based at Kimberworth to enable close links with social care and other services involved with families. A respite service is provided from this location. Community paediatrics is offered from a range of community venues including clinics in special schools, and is often held jointly with special school nurses.

Information about the sites and teams, which offer community health services for children, young people and families at this trust, is shown below:

<table>
<thead>
<tr>
<th>Location / site name</th>
<th>Team/ward/satellite name</th>
<th>Services provided</th>
</tr>
</thead>
<tbody>
<tr>
<td>Anston Greenlands Junior and infant Unit</td>
<td>Speech and language therapy</td>
<td>Individual assessment and therapy sessions</td>
</tr>
<tr>
<td>Anston Medical Centre</td>
<td>0-19 service</td>
<td>Clinic - appointment only</td>
</tr>
<tr>
<td>Anston Medical Centre</td>
<td>Speech and language therapy</td>
<td>Individual assessment and therapy sessions</td>
</tr>
<tr>
<td>Arnold Children’s Centre</td>
<td>0-19 service</td>
<td>Clinic - drop in</td>
</tr>
<tr>
<td>Aston Customer Service Centre</td>
<td>Children's Speech and Language Therapy</td>
<td>Individual assessment and therapy sessions</td>
</tr>
<tr>
<td>Location / site name</td>
<td>Team/ward/satellite name</td>
<td>Services provided</td>
</tr>
<tr>
<td>--------------------------------</td>
<td>-------------------------------------</td>
<td>-----------------------------------------------------------------------------------</td>
</tr>
<tr>
<td>Aston Customer Service Centre</td>
<td>Rother Valley South</td>
<td>Co-located Office space for 0-19 service and social care. Rooms available to book clinics</td>
</tr>
<tr>
<td>Aston Customer Service Centre</td>
<td>Rother Valley West Locality</td>
<td>Clinic - appointment only</td>
</tr>
<tr>
<td>Brinsworth Medical Centre</td>
<td>0-19 service</td>
<td>Clinic - drop in</td>
</tr>
<tr>
<td>Cottonwood Children's Centre</td>
<td>0-19 service</td>
<td>Clinic - appointment only</td>
</tr>
<tr>
<td>Dalton Willows</td>
<td>0-19 service</td>
<td>Clinic - appointment only</td>
</tr>
<tr>
<td>Dinnington Children's Centre</td>
<td>0-19 service</td>
<td>Clinic - drop in</td>
</tr>
<tr>
<td>Eastwood Village Community Centre</td>
<td>0-19 service</td>
<td>Clinic - drop in</td>
</tr>
<tr>
<td>Greasborough Library</td>
<td>0-19 service</td>
<td>Clinic - appointment only</td>
</tr>
<tr>
<td>Hilltop School</td>
<td>Children's Physiotherapy Service</td>
<td>Individual assessment and therapy sessions</td>
</tr>
<tr>
<td>Hilltop School</td>
<td>Children's speech and language therapy Service</td>
<td>Individual assessment and therapy sessions and staff training</td>
</tr>
<tr>
<td>Hilltop School</td>
<td>Community paediatrics</td>
<td>Medical assessments and reviews</td>
</tr>
<tr>
<td>Kelford School</td>
<td>Children's Physiotherapy Service</td>
<td>Individual assessment and therapy sessions</td>
</tr>
<tr>
<td>Kelford School</td>
<td>Community paediatrics</td>
<td>Medical assessments and reviews</td>
</tr>
<tr>
<td>Kimberworth Place</td>
<td>Child Development Centre</td>
<td>MDT developmental assessment and follow up as required.</td>
</tr>
<tr>
<td>Kimberworth Place</td>
<td>Children's Complex Needs</td>
<td>Provides care in the community for children and young people aged 0-19, including complex care and continuing health care – incorporating respite facility.</td>
</tr>
<tr>
<td>Kimberworth Place</td>
<td>Children's Occupational Therapy Service</td>
<td>Individual assessment and therapy sessions</td>
</tr>
<tr>
<td>Kimberworth Place</td>
<td>Children's Physiotherapy Service</td>
<td>Individual assessment and therapy sessions and staff training</td>
</tr>
<tr>
<td>Kimberworth Place</td>
<td>Children's Speech &amp; Language Service</td>
<td>Main base for school based therapy. Non-routine based intervention sessions on this site</td>
</tr>
<tr>
<td>Kimberworth Place</td>
<td>Early attachment service</td>
<td>Individual assessment and therapy sessions</td>
</tr>
<tr>
<td>Kiveton Park Medical Centre</td>
<td>0-19 service</td>
<td>Clinic - drop in</td>
</tr>
<tr>
<td>Liberty Church, Masbrough</td>
<td>0-19 service</td>
<td>Clinic - drop in</td>
</tr>
<tr>
<td>Maltby Joint Service Centre</td>
<td>0-19 service</td>
<td>Co located office space for 0-19 service. Clinics running on site - appointment only</td>
</tr>
<tr>
<td>Location / site name</td>
<td>Team/ward/satellite name</td>
<td>Services provided</td>
</tr>
<tr>
<td>----------------------</td>
<td>--------------------------</td>
<td>-------------------</td>
</tr>
<tr>
<td>Maltby Joint Service Centre</td>
<td>Speech and language therapy</td>
<td>Individual assessment and therapy sessions</td>
</tr>
<tr>
<td>Maltby Joint Service Centre</td>
<td>Wentworth Valley Locality</td>
<td>Co located office space for 0-19 service. Rooms available to book clinics</td>
</tr>
<tr>
<td>Newman School</td>
<td>Children's Speech and language therapy</td>
<td>Individual assessment and therapy sessions</td>
</tr>
<tr>
<td>Newman School</td>
<td>Children's Physiotherapy Service</td>
<td>Individual assessment and therapy sessions</td>
</tr>
<tr>
<td>Newman School</td>
<td>Community paediatrics</td>
<td>Medical assessments and reviews</td>
</tr>
<tr>
<td>Rawmarsh Children's Centre</td>
<td>0-19 service</td>
<td>Co located Office space for 0-19 service and social care. Clinic - appointment only - running from this location</td>
</tr>
<tr>
<td>Rawmarsh Customer Service Centre</td>
<td>Children's speech and language therapy</td>
<td>Individual assessment and therapy sessions</td>
</tr>
<tr>
<td>Rawmarsh Customer Service Centre</td>
<td>Wentworth South Locality</td>
<td>Co located Office space for 0-19 service and social care.</td>
</tr>
<tr>
<td>Rotherham Community Health Centre</td>
<td>Child Information Department</td>
<td>Child Information Department</td>
</tr>
<tr>
<td>Rotherham Community Health Centre</td>
<td>Children's Speech and Language Therapy</td>
<td>Individual assessment and therapy sessions</td>
</tr>
<tr>
<td>Rotherham Community Health Centre</td>
<td>Community paediatrics</td>
<td>Medical assessments and reviews</td>
</tr>
<tr>
<td>Rotherham Community Health Centre</td>
<td>Looked After Children</td>
<td>coordinates and ensures compliance with initial and review health assessments</td>
</tr>
<tr>
<td>Stepping Stones Centre, Maltby</td>
<td>0-19 service</td>
<td>Clinic - appointment only</td>
</tr>
<tr>
<td>Swinton Brookfield Children's Centre</td>
<td>0-19 service</td>
<td>Co located office space for 0-19 service and social care. Also, a Children's centre facility. Clinics held on site</td>
</tr>
<tr>
<td>Swinton Brookfield Children's Centre</td>
<td>Wentworth North Locality</td>
<td>Co located office space for 0-19 service and social care. Also, a Children's centre facility.</td>
</tr>
<tr>
<td>Swinton Customer Service Centre</td>
<td>0-19 service</td>
<td>Office space for school nursing with outreach</td>
</tr>
<tr>
<td>Swinton Customer Service Centre</td>
<td>Wentworth South Locality</td>
<td>Office space for school nursing with outreach</td>
</tr>
<tr>
<td>Tesco Extra</td>
<td>0-19 service</td>
<td>Clinic - drop in</td>
</tr>
<tr>
<td>The Place</td>
<td>Rotherham South Locality</td>
<td>Hub environment for social care and Health. Rooms available to hold baby clinics and used by children centre staff</td>
</tr>
<tr>
<td>The Village Surgery Thucroft</td>
<td>0-19 service</td>
<td>Clinic - appointment only</td>
</tr>
<tr>
<td>Thrybergh Children's Centre</td>
<td>0-19 service</td>
<td>Clinic - appointment only</td>
</tr>
<tr>
<td>Treeton Medical Centre</td>
<td>0-19 service</td>
<td>Clinic - by appointment</td>
</tr>
<tr>
<td>Wath Health Centre</td>
<td>Community paediatrics</td>
<td>Medical assessments and reviews</td>
</tr>
<tr>
<td>Location / site name</td>
<td>Team/ward/satellite name</td>
<td>Services provided</td>
</tr>
<tr>
<td>------------------------------</td>
<td>--------------------------</td>
<td>--------------------------------------------------------</td>
</tr>
<tr>
<td>Wath Victoria Children's Centre</td>
<td>0-19 service</td>
<td>Clinic - appointment only</td>
</tr>
<tr>
<td>Wickersley Health Centre</td>
<td>0-19 service</td>
<td>Clinic - by appointment</td>
</tr>
<tr>
<td>Wickersley Health Centre</td>
<td>Children's Speech and language therapy</td>
<td>Individual assessment and therapy sessions</td>
</tr>
<tr>
<td>Wickersley Health Centre</td>
<td>Community paediatrics</td>
<td>Medical assessments and reviews</td>
</tr>
</tbody>
</table>

(Source: Universal Routine Provider Information Request (RPIR))

Is the service safe?

Mandatory training

Mandatory Training completion

The trust set a target of 85% for completion of mandatory training.

A breakdown of compliance for mandatory training courses from April 2017 to May 2018 for qualified nursing staff in community health services for children, young people and families is shown below:

<table>
<thead>
<tr>
<th>Training module name</th>
<th>Number of staff trained (YTD)</th>
<th>Number of eligible staff (YTD)</th>
<th>Completion (%)</th>
<th>Target (%)</th>
<th>Target met (Yes/No)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Dementia Awareness (inc Privacy &amp; Dignity standards)</td>
<td>91</td>
<td>96</td>
<td>95%</td>
<td>85%</td>
<td>Yes</td>
</tr>
<tr>
<td>Information Governance</td>
<td>90</td>
<td>96</td>
<td>94%</td>
<td>95%</td>
<td>No</td>
</tr>
<tr>
<td>Equality and Diversity</td>
<td>86</td>
<td>96</td>
<td>90%</td>
<td>85%</td>
<td>Yes</td>
</tr>
<tr>
<td>Conflict Resolution</td>
<td>84</td>
<td>96</td>
<td>88%</td>
<td>85%</td>
<td>Yes</td>
</tr>
<tr>
<td>Infection Prevention (Level 1)</td>
<td>84</td>
<td>96</td>
<td>88%</td>
<td>85%</td>
<td>Yes</td>
</tr>
<tr>
<td>Fire Safety</td>
<td>81</td>
<td>96</td>
<td>84%</td>
<td>85%</td>
<td>No</td>
</tr>
<tr>
<td>Preventing Radicalisation (Levels 1 and 2)</td>
<td>77</td>
<td>96</td>
<td>80%</td>
<td>85%</td>
<td>No</td>
</tr>
<tr>
<td>Hand Hygiene</td>
<td>72</td>
<td>96</td>
<td>75%</td>
<td>85%</td>
<td>No</td>
</tr>
<tr>
<td>Raising concerns and whistleblowing</td>
<td>31</td>
<td>96</td>
<td>32%</td>
<td>85%</td>
<td>No</td>
</tr>
<tr>
<td>Health, Safety and Welfare</td>
<td>27</td>
<td>96</td>
<td>28%</td>
<td>85%</td>
<td>No</td>
</tr>
</tbody>
</table>

In community health services for children, young people and families the trust's target was met for four of the 10 mandatory training modules for which qualified nursing staff were eligible.

(Source: Universal Routine Provider Information Request (RPIR) – P38 Training)
Staff we spoke with told us that they could access online training. One member of staff we spoke with told us that they did not have time to attend their mandatory training as their workload was so heavy.

Staff we spoke with told us that they had a specific training day, this made it easier to complete the training at the same time rather than having to do different courses at different times. However, some staff we spoke with told us that there were not enough places on the training days and this meant that they were completing their mandatory training after it was due to be completed.

During our inspection we saw up to date training matrices, which showed that staff were completing their mandatory training and they were on track to meet the trust target for compliance for this year, for all subjects.

**Safeguarding**

Staff we spoke with understood their responsibilities with regards to safeguarding children and young people. They spoke positively of the support from the safeguarding team.

Staff were aware how and when to make referrals to social care. However, referrals were not copied to the safeguarding team. This meant that there was no oversight of referrals made and there was no quality assurance process or a mechanism for regular audit. Referrals were not routinely attached to children’s records, we heard inconsistencies in staff knowledge as to whether they could save or how to save and attach a copy of the referral. This meant the patient’s record was incomplete.

The multi-agency safeguarding hub (MASH) nurse advisor was part of the trust safeguarding team. We were told that the health practitioner in the multi-agency safeguarding hub (MASH) audited referrals on a yearly basis, however the last audit was 2016 and a recent audit of 30 referrals from September to October 2018 had only just begun, with only four referrals having been completed at the time of our inspection.

Children and young people identified as being at risk of Child Sexual Exploitation (CSE) benefited from a dedicated multi agency specialist team. There was a lead nurse for CSE who was the health representative based in the multi-agency ‘EVOLVE Team’ which included police, social care and Barnardo’s children’s charity.

Weekly risk assessment meetings (RAMs) were held to discuss referrals which had come from either MASH or via direct consultation with a social worker, if the case was open to social care. The Evolve team worked with medium to high risk cases; lower risk cases were passed to Barnardo’s outreach workers. This meant that vulnerable children and young people identified at risk of CSE had their needs assessed and met through tailored support in a timely manner.

Practitioners were proactive in identifying domestic abuse. Routine enquiries about domestic abuse were asked as part of the risk assessment tool.

In the sexual health service, we saw robust risk assessments for under 18-year olds. However, there was no clear under 13’s pathway. We were told that this was documented in a draft standard operating procedure (SOP) which was to be presented at a governance meeting in November. We therefore did not see this.
The electronic record system used by the 0-19 team, community children’s nursing team and therapists contained a flagging system for safeguarding alerts where risks and vulnerabilities had been identified. However, there were no appropriate safeguarding alerts entered onto the electronic patient record in the sexual health service. This meant that staff were not immediately alerted, when accessing the case record, that there was a vulnerable young person.

Staff in the community children’s services benefited from routine supervision to strengthen safeguarding practice. Quarterly one to one safeguarding supervision took place with a named supervisor using the signs of safety model and reflective discussion. The supervision included case specific discussion and action planning, which was documented in the client’s records. Data provided by the trust showed that 82% of practitioners holding a caseload had received supervision. Those that hadn’t were on long term sick leave or maternity leave.

**Safeguarding Training completion**

The trust set a target of 85% for completion of safeguarding training.

A breakdown of compliance for safeguarding training courses from April 2017 to May 2018 for qualified nursing staff in community health services for children, young people and families is shown below:

<table>
<thead>
<tr>
<th>Training module name</th>
<th>Number of staff trained (YTD)</th>
<th>Number of eligible staff (YTD)</th>
<th>Completion (%)</th>
<th>Target (%)</th>
<th>Target met (Yes/No)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Safeguarding Adults (Level 2)</td>
<td>85</td>
<td>91</td>
<td>93%</td>
<td>85%</td>
<td>Yes</td>
</tr>
<tr>
<td>Safeguarding Children (Level 3)</td>
<td>89</td>
<td>96</td>
<td>93%</td>
<td>85%</td>
<td>Yes</td>
</tr>
</tbody>
</table>

In community health services for children, young people and families the 85% target was met for both safeguarding training modules for which qualified nursing staff were eligible.

*(Source: Universal Routine Provider Information Request (RPIR) – P38 Training)*

Although staff were compliant with completion of their safeguarding training, the trust were unable to demonstrate that the arrangements to ensure their staff were trained in safeguarding children were compliant with intercollegiate guidance. Mandatory level three safeguarding training was via E-learning with multi-agency face-to-face training as optional. The Royal College of Paediatrics and Child Health (RCPCH) intercollegiate guidelines (2014) say that E-learning can be used at level three as preparation for reflective team based learning. Level three training should be multi-disciplinary and inter-agency, and delivered internally and externally.

The looked after children (LAC) team was not adequately staffed to undertake their duties. Children who were looked after were not receiving timely, thorough health assessments. Service leads told us that there was a new staff member due to start in January 2019. A nurse practitioner for LAC and care leavers was responsible for completing review health assessments, whilst 0-19 practitioners were completing the assessments on under 14-year olds. There were plans in place to have a practitioner in each locality that would be responsible for looked after children.
In records we reviewed, we saw some key sections of the assessment left blank, including current health problems, health history, family history and emotional and behavioural issues.

The recording of the children’s and young people’s voice was variable, the assessments were not clear on whether the child or young person had offered their perspective of why they were there or what had happened. Seeking the child’s view adds meaning and context to the assessment. We saw that incorporating user involvement and the voice of the child had been identified as an area of work in the work plan for the service. The electronic patient record templates were to be developed to incorporate the voice of the child.

**Safeguarding referrals**

A safeguarding referral is a request from a member of the public or a professional to the local authority or the police to intervene to support or protect a child or vulnerable adult from abuse. Commonly recognised forms of abuse include: physical, emotional, financial, sexual, neglect and institutional.

Each authority has their own guidelines as to how to investigate and progress a safeguarding referral. Generally, if a concern is raised regarding a child or vulnerable adult, the organisation will work to ensure the safety of the person and an assessment of the concerns will also be conducted to determine whether an external referral to Children’s Services, Adult Services or the police should take place.

Community health services for children, young people and families made 253 safeguarding referrals from June 2017 to May 2018, all of which concerned children.

Looking at safeguarding referrals for children across the 12-month period, overall there was a general no discernible trend in referrals, although there were peaks in November 2017 and March 2018.

*(Source: Universal Routine Provider Information Request (RPIR) – P11 Safeguarding)*

**Cleanliness, infection control and hygiene**

All areas we visited were visibly clean.

We observed staff working in clinics and on home visits. All staff we saw complied with the arms bare below the elbows policy and cleaned their hands as required.

We saw changing mats and weighing scales wiped after every use. Staff used paper roll to line the scales and this was replaced for each new patient.

In those areas that had toys available, we saw cleaning schedules for the toys. We observed staff in the child development centre cleaning toys after a group session.

In the child development centre, we saw wipeable chairs. However, there were also two suede sofas and a material chair that could not be easily wiped. We also saw two sofas, in the asthma nurses room, that had rips in the fabric.
The child development centre and short break facility were housed in a building that did not belong to the trust. These rooms had carpets. However, no clinical procedures took place in these environments and staff had access to spillage kits to clear up any waste products, such as vomit and urine.

We observed staff using personal protective equipment, such as gloves, when required.

**Environment and equipment**

All equipment that we saw had up to date electrical testing. Scales were regularly calibrated.

The continuing care team held a database of all the equipment that was held in patient’s houses and this indicated when servicing was due. Patient records also contained a record of the equipment held at home.

Staff we spoke with told us they had no problems obtaining equipment they needed.

We attended a well-baby clinic and development assessment session, which was held in a building owned by another provider. There was no receptionist available for the community children’s services and there was no information displayed where the parents waited. Staff we spoke with told us that the parents would be advised how the clinic ran, when they were visited by the health visitor for the birth visit.

**Assessing and responding to patient risk**

Practitioners from the 0-19 service held well baby clinics and development assessment sessions in buildings owned by other providers. Staff we spoke with told us these environments had been risk assessed. However, we observed babies changing mats placed on couches in examination rooms with no signage warning parents not to leave their baby unattended.

Staff in the short break service had completed basic life support training and tracheostomy life support training. They had access to a manual resuscitator and suction if needed in an emergency and would dial 999 if a child’s condition deteriorated.

The children’s community nursing team included the paediatric acute rapid response outreach team (PARROT). This team facilitated early discharge from hospital and helped to prevent hospital admissions. The PARROT team used the paediatric early warning score (PEWS) to detect changes in a child’s condition.

Whilst on inspection we saw a community nurse and 0-19 practitioner responding to a deterioration in a child’s condition. We observed liaison between services and discussions took place with the ambulance service about the existence of a limitation of treatments agreement (LOTA).

The community children’s nursing service completed a rapid response assessment sheet and a home visit assessment sheet. These included any risks that there may be to practitioners visiting the home.
The community children’s nursing service had pathways for common illnesses, such as bronchiolitis, diarrhoea and vomiting, fever and wheeze. These pathways assisted others in deciding where they should refer a child to and whether a referral to the PARROT team was appropriate.

Staff could place a flag on the electronic record to highlight those families where there may be a risk. Practitioners completed a domestic abuse template on the electronic record.

Staff in the 0-19 service told us that they met for a face to face handover on complex, vulnerable families.

**Staffing**

Although the staffing figures shown below appear to show a good fill rate at June 2018, during our inspection we were told that there were staffing shortages, particularly in the physiotherapy service due to long term sickness and maternity leave. The service leads had worked with the physiotherapy service on a system of prioritisation. Interviews were being held for the vacant posts.

The 0-19 service had a vacancy rate of 10.86 whole time equivalent (WTE). However, they were in a transition phase with a reduction in band six practitioners and an increase in skill mix. As part of the new contract the trust had secured in April 2017, there had been a reduction in the budget for staffing. The new model for the service was to develop skill mix teams. The skill mix was being reviewed and competencies had been written for the different bands across the 0-19 pathway. We were told that the band six competencies had been through the governance process and signed off, whilst the other bands were still to go through the process.

The plan to increase the skill mix in teams would see an increase in the number of band 5, 4, 3 and 2 practitioners, with the rationale that band three and four staff could pick up direct work with families under the supervision of a band six public health nurse.

The looked after children team (LAC) had one WTE vacancy for the named nurse for looked after children.

**Planned v Actual Establishment**

Details of staffing levels within community health services for children, young people and families by staff group as at June 2018 are below.

<table>
<thead>
<tr>
<th>Staff group</th>
<th>Planned staff WTE</th>
<th>Actual Staff WTE</th>
<th>Staffing rate (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Support to ST&amp;T staff</td>
<td>2.0</td>
<td>2.1</td>
<td>103.1%</td>
</tr>
<tr>
<td>Qualified Allied Health Professionals</td>
<td>31.6</td>
<td>31.9</td>
<td>101.0%</td>
</tr>
<tr>
<td>(Qualified AHPs)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Other Qualified Scientific, Therapeutic</td>
<td>0.7</td>
<td>0.7</td>
<td>100%</td>
</tr>
</tbody>
</table>
& Technical staff (Other qualified ST&T) & Support to doctors and nursing staff & 63.7 & 61.4 & 96.4% 
Qualified nursing & health visiting staff (Qualified nurses) & 102.0 & 94.1 & 92.2% 
NHS infrastructure support & 2.0 & 1.5 & 75.7% 
**Grand Total** & **202.0** & **191.7** & **94.9%**

(Source: Universal Routine Provider Information Request (RPIR) – P16 Total Staffing)

**Vacancies**

Following our inspection, we requested data for vacancies in the service.
In October 2018, there was a 0.87 WTE vacancy for a band four practitioner in the child development centre, an 0.8 WTE vacancy in physiotherapy, 4.51 WTE health care assistant vacancies in the children's community nursing team, 1 WTE specialist epilepsy nurse - this had been recruited to, 1.2 WTE specialist enuresis nurses - these had been recruited to, 1.6 WTE vacancies in the looked after team and 10.86 WTE vacancies in the 0-19 team.

**Turnover**

The trust did not set a turnover rate target. From July 2017 to June 2018 the trust reported an overall turnover rate of 9.6% in community health services for children, young people and families.

A breakdown of turnover rates by staff group in community health services for children, young people and families at trust level is below:

**Community health services for children, young people and families total**

<table>
<thead>
<tr>
<th>Staff group</th>
<th>Total number of substantive staff</th>
<th>Total number of substantive staff leavers in the last 12 months</th>
<th>Total % of staff leavers in the last 12 months</th>
</tr>
</thead>
<tbody>
<tr>
<td>Qualified nursing &amp; health visiting staff (Qualified nurses)</td>
<td>89.6</td>
<td>10.7</td>
<td>12.0%</td>
</tr>
<tr>
<td>Support to doctors and nursing staff</td>
<td>64.6</td>
<td>6.3</td>
<td>9.8%</td>
</tr>
<tr>
<td>Qualified Allied Health Professionals (Qualified AHPs)</td>
<td>30.8</td>
<td>1.0</td>
<td>3.2%</td>
</tr>
<tr>
<td>NHS infrastructure support</td>
<td>1.5</td>
<td>0</td>
<td>0.0%</td>
</tr>
<tr>
<td>Other Qualified Scientific, Therapeutic &amp;</td>
<td>0.7</td>
<td>0</td>
<td>0.0%</td>
</tr>
</tbody>
</table>
### Technical staff (Other qualified ST&T)

<table>
<thead>
<tr>
<th></th>
<th>Total available permanent staff days</th>
<th>Total permanent staff sickness days</th>
<th>Total % permanent staff sickness overall</th>
</tr>
</thead>
<tbody>
<tr>
<td>Support to ST&amp;T staff</td>
<td>1.7</td>
<td>0</td>
<td>0.0%</td>
</tr>
<tr>
<td><strong>Grand Total</strong></td>
<td><strong>188.9</strong></td>
<td><strong>18.1</strong></td>
<td><strong>9.6%</strong></td>
</tr>
</tbody>
</table>

(Source: Universal Routine Provider Information Request (RPIR) – P18 Turnover)

### Sickness

The trust set a target of 3.95% for sickness rates. From July 2017 to June 2018 the trust reported an overall sickness rate of 4.7% in community health services for children, young people and families. This did not meet the trust’s target.

A breakdown of sickness rates by staff group in community health services for children, young people and families at trust level is below:

**Community health services for children, young people and families total**

<table>
<thead>
<tr>
<th>Staff group</th>
<th>Total available permanent staff days</th>
<th>Total permanent staff sickness days</th>
<th>Total % permanent staff sickness overall</th>
</tr>
</thead>
<tbody>
<tr>
<td>Support to doctors and nursing staff</td>
<td>22,871.6</td>
<td>1,570.7</td>
<td>6.9%</td>
</tr>
<tr>
<td>Qualified nursing &amp; health visiting staff (Qualified nurses)</td>
<td>30,983.4</td>
<td>1,332.2</td>
<td>4.3%</td>
</tr>
<tr>
<td>Qualified Allied Health Professionals (Qualified AHPs)</td>
<td>10,657.5</td>
<td>151.2</td>
<td>1.4%</td>
</tr>
<tr>
<td>Support to ST&amp;T staff</td>
<td>603.2</td>
<td>7.7</td>
<td>1.3%</td>
</tr>
<tr>
<td>Other Qualified Scientific, Therapeutic &amp; Technical staff (Other qualified ST&amp;T)</td>
<td>245.6</td>
<td>3.0</td>
<td>1.2%</td>
</tr>
<tr>
<td>NHS infrastructure support</td>
<td>528.8</td>
<td>5.0</td>
<td>0.9%</td>
</tr>
<tr>
<td><strong>Grand Total</strong></td>
<td><strong>65,890.2</strong></td>
<td><strong>3,069.7</strong></td>
<td><strong>4.7%</strong></td>
</tr>
</tbody>
</table>

(Source: Universal Routine Provider Information Request (RPIR) – P19 Sickness)

### Suspensions and supervisions

During the reporting period from 1 June 2017 to 15 June 2018, community health services for children, young people and families reported that there was one case where a member of staff had been suspended.
At our last inspection, we found that school nursing staff were carrying high numbers of safeguarding cases and staff were responsible for two secondary schools, which was not in line with national guidance. At this inspection, this situation remained unchanged and there were less band six school nurses in post at this inspection than at the last.

The matron for the service told us that health visitors held caseloads of between 250-300 children. However, some health visitors we spoke with told us that they had caseloads of 500-600 children. The Institute of Health Visiting recommends an average of one health visitor to 250 children to deliver comprehensive health improvement. Service leads told us they were looking for a suitable caseload profiling tool to use to ensure appropriate allocation of workload dependent on indices of deprivation and need. Individual caseloads had been reviewed and there was a plan to make amendments to ensure equity across teams.

Following our inspection, we requested the caseload numbers, this showed that for most practitioners their caseloads exceeded 300. The highest caseload for one practitioner was 697.

Health visitor caseloads included children who were receiving universal, universal plus and universal partnership plus services. The service was in the process of rolling out a pilot scheme in one area which would see the allocation of work to dedicated teams for universal work and universal partnership plus (targeted). This would help caseloads to be more appropriately allocated and managed. There was a plan in place that team structures and staffing allocations would be fully implemented from January 2019.

Each health visiting team held weekly allocation meetings where new referrals were discussed and allocated depending upon health visitor capacity.

The staffing numbers in the community children’s nursing team had increased since our last inspection. At the time of our inspection, there were 2.2 whole time equivalent (WTE) specialist nurse vacancies, 1.2 WTE enuresis role and 1 WTE epilepsy role. These had been appointed to but were awaiting start date confirmation.

Therapies caseloads for physiotherapy and occupational therapy were lower than the national average per WTE, however, the community physiotherapy and occupational therapy teams saw the most complex patients and therefore had smaller caseloads.

Speech and language therapists had higher caseloads per WTE than the national average.

**Quality of records**

At our last inspection, we found that there was a risk that information contained within records was not contemporaneous as staff did not use their laptops in home visits or during clinics and would record their visits when they returned to base. At this inspection, we had similar concerns as some staff we spoke with told us that they were so busy they did not have time to complete their records. We were given examples of some records not been written for up to two weeks after the child had been seen.
Staff we spoke with told us that records audits had been completed in the individual services and that they had now devised an audit tool that would be used across the services in the community children’s teams.

Records were electronic and different templates were used, including domestic violence and maternal mood.

We saw health visitors recording information in the parent held child health record (red book).

Although staff could tell us about the importance of the voice of the child in documentation, we saw limited evidence of this in the records we reviewed.

The sexual health service used a different electronic record to the 0-19 team. There was therefore a risk that practitioners may not have access to up to date information. All other teams were using the same electronic system and therefore had up to date information.

**Medicines**

We saw that vaccinations within the immunisation team were stored securely and at the correct temperature. Fridge temperatures were checked and we saw completed record sheets, however, no minimum or maximum temperatures were recorded.

We saw appropriate containers and processes in place to maintain the cold chain. The cold chain is a term used to describe the cold temperature conditions that certain products need to be kept during storage and distribution. Maintaining the cold chain ensures that vaccines are transported and stored at the correct temperature.

In the short break service, staff followed the medicine management policy. Patients would bring their own labelled medicine in from home and staff would complete a medication sheet for their records with the name of the medication, strength, dosage and time of administration. This record was signed by the parents. All medicines were kept securely in locked cupboards.

The community children’s nursing team gave intravenous antibiotics in patient homes. The team kept the prescription and the medicines and would double check the antibiotic before leaving the base. We saw completed checklists for recording checks on the drug cupboard.

Staff told us they completed yearly medicine updates.

Prescription pads were kept secure.

We saw patient group directives, used for giving medicines such as vaccinations. These were signed and dated and all were up to date.

**Incident reporting, learning and improvement**

Staff we spoke with knew how to report incidents using the electronic reporting system and they told us that they received feedback from incidents they had reported.
We asked the trust for details of incidents in the last six months and any lessons learned. There were 42 incidents reported in the last six months, the main theme was staffing for the complex care team following staff sickness calls. We were not provided with any evidence of any lessons learned from incidents.

Incidents were discussed at monthly area team meetings and the minutes were stored on the shared drive for all staff to access. However, some of the staff we spoke with told us that they could not access the shared drive.

In all the areas we visited we saw posters displayed around the duty of candour. The duty of candour requires staff to be open and honest with people about the care and treatment they receive. As soon as reasonably practicable after becoming aware that a notifiable safety incident has occurred a health service body must notify the relevant person that the incident has occurred, provide reasonable support to the relevant person in relation to the incident and offer an apology. At our last inspection, we found that staff had limited understanding of the duty of candour. At this inspection we found similar issues. Although some staff appeared to understand the meaning of duty of candour and knew the process that managers would follow, other staff knew it was about being open and honest with patients but related it to when they received a complaint rather than when incidents had taken place.

**Never events**

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.

From August 2017 to July 2018, the trust reported no never events for community health services for children, young people and families.

*(Source: Strategic Executive Information System (STEIS))*

**Serious Incidents**

Trusts are required to report serious incidents to Strategic Executive Information System (STEIS). These include ‘never events’ (serious patient safety incidents that are wholly preventable).

In accordance with the Serious Incident Framework 2015, the trust reported no serious incidents (SIs) in community health services for children, young people and families, which met the reporting criteria, set by NHS England from August 2017 to July 2018.

*(Source: Strategic Executive Information System (STEIS))**
Is the service effective?

Evidence-based care and treatment

At our last inspection, we saw that policies and procedures were out of date. At this inspection, we saw that policies were up to date. Service leads told us they now had one database for all guidelines and staff were alerted when they were due for review. Staff had access to all policies and guidelines on the trust intranet.

Children and young people’s needs were assessed and treatment was delivered in line with current legislation, standards and recognised evidence based guidance. Policies and procedures were based on national guidance, such as that produced by the National Institute for Health and Clinical Excellence (NICE). We saw that Nursing and Midwifery Council (NMC) guidance was adhered to in the vaccines standard operating procedure (SOP).

The 0-19 service did not have UNICEF baby friendly initiative (BFI) accreditation. Staff we spoke with told us they were going to start working towards accreditation. The UNICEF baby friendly initiative is a national intervention that has been found to have a positive effect on breastfeeding rates in the UK.

The service provided the Healthy Child Programme (HCP) and National Child Measurement Programme (NCMP). The HCP is an early intervention and prevention public health programme offered to every family and is an opportunity to identify families in need of further support. The NCMP measures the height and weight of children in reception class (aged 4 to 5 years) and year 6 (aged 10 to 11 years) to assess overweight and obesity levels in children within primary schools. The NCMP was set up in line with the Government's strategy to tackle obesity.

During observation of practitioners, we saw advice given based on up to date evidence with regards to issues such as weaning and sleep.

The early attachment service offered a Solihull antenatal programme to first time parents. The Solihull Approach is an evidence based programme that improves emotional health and wellbeing through relationships from the antenatal period through childhood into adulthood.

Nutrition and hydration

Staff supported breastfeeding mothers and offered breastfeeding support in the home. Staff had access to an infant feeding coordinator and an infant feeding policy.

The continuing care team completed competencies to care for those children with nasogastric tubes and gastrostomies.

The children’s community nursing team supported families at home with complex feeding needs. We observed a children’s community nurse visit to a family to change the gastrostomy feeding button, this meant that the parents did not have to attend the hospital every time the feeding button needed changing.

Practitioners could refer children to a dietician for support. The dieticians prescribed specialised formulas if required.
Patient outcomes

At our last inspection there were limited audits completed. At this inspection, we were told that audits had been started, but there was no audit plan in place at the time of our inspection. We were told that an audit plan was being developed and the plan was to roll out these audits from November 2018. We saw that audits had been completed in 2017 for administration of intravenous antibiotics in the home, medication in respite, social communication pathway and paperwork provided at looked after children (LAC) clinic. In 2018 there were limited audits, but we saw results for audits for the children’s community clinics and safe sleep. All audits had appropriate action plans.

At our last inspection, the service was failing to meet several performance targets for the mandated healthy child programme contacts. At this inspection, there were still a couple of areas, such as antenatal contacts and six to eight weeks contact, where they were not meeting the targets but in other areas the figures had improved. For quarter two of 2018/2019 the percentage of mothers receiving an antenatal contact was 63%, against a target of 90%. The matron told us they had worked hard with practitioners to improve antenatal contacts and this had improved from quarter one when it was 52.5%, however, it was a drop from 2017/2018 when the percentage of mothers receiving an antenatal contact was 70%. Antenatal contacts had been prioritised for first time mothers and vulnerable families. The percentage of children receiving a six to eight week contact by eight weeks was 86.5%, against a target of 97%. The percentage of mothers who received a maternal mood review by the time their baby was eight weeks old was 54.4% in quarter one of 2018/2019 and 60.7% in quarter two. The percentage of births that received a face to face new birth visit within 14 days had improved to 97.2%, against a target of 97%. The percentage of babies breastfeeding at six to eight weeks was 31.6%, against a target of 31%. The percentage of children receiving a 12-month review by the time they were 15 months was 97.2%, against a target of 95% and the percentage of children receiving a two to two and a half review was 90.6% against a target of 90%.

The number of health screenings performed at school entry was 86% for the 2017-2018 academic year against a target of 95%. The number of health reviews for looked after children completed within timescales were slightly below the 98% target.

The service had a work plan in place, which hoped to address some of the performance issues. Introduction of greater skill mix in teams, review of exceptions with commissioners and restructuring of the workforce were actions to support improvement.

The immunisations team had figures above 90% for immunisations for 2017/2018, however, it was not clear what the target was.

At our last inspection, it was identified that there was poor compliance with looked after children initial health assessments been completed within timescales. There is a statutory initial health assessment target of 20 working days from the date of becoming looked after. At this inspection, there were still concerns around compliance with this target. The compliance rates were as low as 30% in February 2018. There had been an increase in rates in July 2018, up to 88%, but these had reduced to 62% in August 2018. Joint meetings were held between the trust, the local clinical commissioning group and the local authority to address the timeliness of looked after children accessing initial health assessments. The first meeting had taken place in September 2018. There
was a work plan and monitoring log in place and reports were provided weekly to the general manager and monthly to the quality assurance committee.

**Competent staff**

**Appraisal rates**

From April 2017 to March 2018, 65% of permanent non-medical staff within the community health services for children, young people and families core service had received an appraisal compared to the trust target of 90%.

**Community health services for children, young people and families total**

<table>
<thead>
<tr>
<th>Staffing group</th>
<th>Number of staff appraised</th>
<th>Number of staff required</th>
<th>Appraisal rate (%)</th>
<th>Trust target (%)</th>
<th>Target met (Yes/No)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Other Qualified Scientific, Therapeutic &amp; Technical staff (Other qualified ST&amp;T)</td>
<td>4</td>
<td>4</td>
<td>100%</td>
<td>90%</td>
<td>Yes</td>
</tr>
<tr>
<td>Support to ST&amp;T staff</td>
<td>5</td>
<td>7</td>
<td>71%</td>
<td>90%</td>
<td>No</td>
</tr>
<tr>
<td>Qualified nursing &amp; health visiting staff (Qualified nurses)</td>
<td>65</td>
<td>99</td>
<td>66%</td>
<td>90%</td>
<td>No</td>
</tr>
<tr>
<td>Support to doctors and nursing staff</td>
<td>49</td>
<td>78</td>
<td>63%</td>
<td>90%</td>
<td>No</td>
</tr>
<tr>
<td>Qualified Allied Health Professionals (Qualified AHPs)</td>
<td>29</td>
<td>47</td>
<td>62%</td>
<td>90%</td>
<td>No</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>152</strong></td>
<td><strong>235</strong></td>
<td><strong>65%</strong></td>
<td><strong>90%</strong></td>
<td><strong>No</strong></td>
</tr>
</tbody>
</table>

(Source: Universal Routine Provider Information Request (RPIR) – P39 Appraisals)

Staff we spoke with told us they had completed their appraisals for this year. However, some staff we spoke with told us they felt that their appraisals were not effective and no action came from issues raised.

Health care assistants in the children’s community nursing team completed competencies. We saw these recorded and kept together in a folder. The specialist health care coordinator for the children’s community nursing team and the lead nurse for complex needs ran simulation days, which included suctioning, tracheostomy, home ventilation, feeding, medicine management and basic life support. These were based around the competency packages to ensure all staff were signed off on all aspects of care.

Senior leaders told us that they were producing competencies for each band for the 0-19 pathway, this was to give practitioners working across the 0-19 pathway clear roles and responsibilities. The band six competencies had been through the sign off process but the other band competencies were waiting to go through governance. At the time of our inspection, staff were still undertaking the roles they were competent for in either a health visiting or school nursing capacity.
Eight practitioners had enrolled on a 0-19 university module, to allow them to work across the 0-19 pathway. Service leads told us that they planned for every qualified practitioner to complete this training.

Clinical supervision was variable. The introduction of clinical supervision was a workstream on the work plan, with plans to implement and roll out supervision in November 2018.

Practice development days took place twice a year. Staff were asked what they would like included on these days and external speakers were invited to attend.

**Multidisciplinary working and coordinated care pathways**

We saw evidence of effective multidisciplinary working. In many of the locations that practitioners worked from they were co-located with social workers and other health services. The paediatric acute rapid referral outreach team (PARROT) visited the acute hospital ward every day to discuss discharges.

The child development centre assessments included speech and language therapists, a nurse, nursery nurses, a psychologist and teachers. Multidisciplinary reports were produced.

There were clear pathways to follow for practitioners to make appropriate referrals PARROT. The PARROT team could make referrals for children to be seen in the children’s assessment unit in the trust.

The 0-19 service worked closely with children’s centre staff. We heard of an example where the 0-19 health improvement practitioner had worked jointly with an outreach worker at a children’s centre to deliver a session to parents around potty training.

**Health promotion**

Practitioners gave advice and support related to smoking cessation, healthy eating, safe sleep and breastfeeding. Practitioners promoted oral health with the provision of toothbrushing packs at development assessments.

Some of the 0-19 team provided health education within schools. However, some of the practitioners we spoke with told us that they were so busy with safeguarding cases that they did not have time for any health promotion and in some areas they were unable to offer drop in sessions in schools. Service leads told us there were ongoing discussions with commissioners about the best way to deliver drop in sessions.

The health improvement team offered and additional and specialised support around areas such as dental health, healthy eating, weight management and feeding.

**Consent, Mental Capacity Act and Deprivation of Liberty Safeguards**

Staff we spoke with had a good understanding of Gillick competence and Fraser guidelines. The ‘Gillick Test’ helps clinicians to identify children aged under 16 who have the legal capacity to
consent to medical examination and treatment. Fraser guidelines relate specifically to contraception and sexual health.

The electronic record system contained a template for mental capacity assessments. The team leader for the continuing care team completed mental capacity assessments for those young people aged 16 and over in their care. We saw an appropriately completed mental capacity assessment. Packages were kept in the young person’s home, which included a mental capacity act standard operating procedure.

Consent was obtained from families regarding their records and access to their records. This consent was recorded after the first contact. When a referral to another service was required, a separate consent to share information was recorded.

Is the service caring?

Compassionate care

We observed nursing and therapy staff providing compassionate care to children, young people and their families. Staff had a positive and friendly approach. We observed active listening, personalised conversations and caring responses. Staff interacted with the children in an age appropriate way.

We saw that staff treated children, young people and their families with dignity and respect.

Friends and family (FFT) responses from August 2018 showed that 97% of families would recommend the children and families community services.

Families that we spoke with described staff as caring and supportive.

Emotional support

We observed staff supporting parents emotionally. Staff in well baby clinics and development assessments were observed asking mothers about their emotional wellbeing.

Staff in the 0-19 teams undertook maternal mood assessments and provided support to those parents that needed it.

The short break service provided respite care and supported parents emotionally.

The early attachment service offered support to families where a relationship difficulty between parent and child had been identified.

Understanding and involvement of patients and those close to them

We saw practitioners involving parents in discussions and decisions around their child’s care.
We observed a group session in the child development centre. Parents were fully involved in their child’s assessment. We observed staff conducting parent interviews and providing feedback sessions, staff ensured that the parents understood what was happening and the process that would be followed leaving the clinic.

We observed practitioners in different settings allowing time for families to raise any questions they may have.

Is the service responsive?

Planning and delivering services which meet people’s needs

Delivery of the 0-19 service was one of the key priorities of Rotherham’s Integrated Health and Social Care Place Plan. The trust was working in partnership with others to develop integrated pathways to achieve positive outcomes for children and young people. Service leads told us that they were working closely with the clinical commissioning group and local authority to discuss how they will tackle the strain placed on the 0-19 service by the level of complex abuse cases they had.

Well baby clinics were held in various locations, including in local supermarkets. Clinics had recently changed to appointment only instead of a drop-in clinic, this meant that families did not have to wait to be seen and had protected time. One parent we spoke with told us they found it difficult to obtain an appointment when they rang to book one. However, we observed the health visitor in clinic assisting the mother with booking her next appointment. Staff told us that they had changed one clinic back to a drop in after feedback from parents.

When the child development centre had undertaken a service review they had involved the parent’s forum to give feedback.

Service leads told us they were going to devise a children and young people’s charter, they planned to ask children and young people for their views to contribute to this.

The 0-19 service had developed a single point of access (SPA) service, consisting of a skill mixed team. This was the first point of contact for parents and young people to access the 0-19 service. This ensured that calls were dealt with efficiently, rather than having to wait for a specific practitioner to call them back.

The occupational therapy service provided an assessment and advice service. They provided equipment but they were not commissioned to provide treatment. This meant that children and young people were discharged from the service after assessment and there was no review. Schools and families were required to monitor progress and report any concerns.

Physiotherapists prioritised cases using high, medium and low categories due to temporary shortages in staffing numbers whilst recruitment was underway. Staff said this had been a positive step but that low priority children were not seen, in order to see high priority cases. Therapists we spoke with were concerned about the risks of not seeing these children. Staff told us a risk assessment had been done by the clinical team lead and concerns raised with the service leads.
Service leads told us they had worked with the therapists around prioritisations to try to reduce any risk. Interviews were planned for more physiotherapy staff.

**Meeting the needs of people in vulnerable circumstances**

The short breaks service offered six-hour sessions from 10am until 4pm, three days a week, for children with complex needs who had a technical nursing need. The team also provided overnight and weekend care at home.

Staff could access interpreter services, either face to face or on the phone. We saw practitioners communicating with a family using an interpreter during our inspection.

At our previous inspection, we identified that there were no leaflets available in alternative languages. Service leads told us they had considered this but they felt it was more important for information to be given to parents using an interpreter so that they could be sure that families had understood the information provided. Staff could access leaflets in alternative languages if necessary.

There was a system in place to identify young people who visited the emergency department with alcohol or drug related problems. A member of staff from the 0-19 team based in the single point of access (SPA) routinely followed these young people up to ensure they were receiving the right support.

The health improvement team provided support to families with additional needs. They supported families to access appointments, acting as advocates for families.

**Access to the right care at the right time**

The paediatric acute rapid response outreach team (PARROT) worked between 8am and 8pm, seven days a week, supporting unwell children in the home to prevent or reduce the length of admission to hospital.

The integrated sexual health service had improved accessibility for young people. Young people had been engaged in the service development and clinics were held in various locations.

**Accessibility**

The largest ethnic minority group within the trust catchment area is Asian/Asian British; Pakistani with 3% of the population.

<table>
<thead>
<tr>
<th>Ethnic minority group</th>
<th>Percentage of catchment population (if known)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Asian/Asian British; Pakistani</td>
<td>2.96%</td>
</tr>
<tr>
<td>White; Other White</td>
<td>1.33%</td>
</tr>
<tr>
<td>Black/African/Caribbean/Black British; African</td>
<td>0.65%</td>
</tr>
<tr>
<td>Asian/Asian British; Other Asian</td>
<td>0.50%</td>
</tr>
</tbody>
</table>
The waiting times for the child development centre had significantly reduced from 33 weeks in October 2017 to three weeks in October 2018. Appointments were now planned based on individual need.

The median waiting times for therapies in April 2018 was four weeks for paediatric speech and language therapy and paediatric occupational therapy, two weeks for paediatric physiotherapy and three weeks for community paediatricians.

**Learning from complaints and concerns**

**Complaints**

From June 2017 to May 2018 there were four complaints about community health services for children, young people and families. The trust took an average of 39 days to investigate and close complaints, this is not in line with their complaints policy, which states complaints should be dealt with within 30 working days.

(Source: Universal Routine Provider Information Request – P52 Complaints)

In the six months prior to inspection, the service had received three complaints and all were answered within the agreed timescales.

The trust advised that extensions to the 30-day deadline could be granted when the nature of the complaint was complex. This meant some complaints could be resolved within the agreed extension time frame. However, we did not receive any data which highlighted how many of the four complaints had been granted an extension and, if so, whether they had been resolved within the agreed timescale.

Staff we spoke with were aware of the procedure to follow to deal with complaints. Staff would try to deal with families concerns before they were raised as an official complaint.

Staff we spoke with told us that they received feedback about complaints during team meetings.

We saw information displayed for staff on how to manage informal concerns and complaints.

**Is the service well-led?**

**Leadership**

There had been several changes in leadership and staff had found this an unsettling time. The pace of change to a 0-19 service had been slow and there was nothing fully embedded in practice. At the time of our inspection, there was a leadership team in place, which included a general manager, a service manager, a new interim head of midwifery, nursing and professions and a deputy head of nursing. There was an interim matron in post for the 0-19 service. The service leads told us that they felt there was now a strong leadership team in place with the ability to effectively manage the service.
Although there had been some improvements and action had been taken on some of the issues identified in our last inspection, there were still some areas identified as concerns at our last inspection that remained a concern.

Most of the staff we spoke with talked positively about the new leaders. Staff in the 0-19 service told us they had seen positive changes since the appointment of the interim matron and that engagement sessions had been held with the staff. Staff felt that they could make suggestions and that their hard work was recognised.

However, some of the therapists that we spoke with felt unhappy about a proposed restructure in the service and told us they felt unsupported. Staff felt devalued and did not feel supported by senior management. The service leads acknowledged that communication was not right and there was a need to feedback further information to staff.

Staff we spoke with told us that their immediate leaders were supportive and visible. However, a few staff told us that they did not see senior leaders, above matron level.

**Vision and strategy**

The trust had an overarching vision and values. Staff we spoke with were aware of these and how they aligned with their service.

Services in the children’s community teams had their own visions and strategies. For example, the 0-19 service had their own strategy and objectives, the community children’s nursing team had their own vision.

Services aimed to deliver a child and family focussed service in line with the principles of the Rotherham Charter. The Rotherham Charter promotes partnership with parents, carers, children and young people.

**Culture**

Staff we spoke with told us they felt they worked well as individual teams and supported each other. There was a desire to do the best for the children and families.

Some members of staff that we spoke with told us that morale was good. However, other staff members we spoke with in the 0-19 service felt that morale was low, due to the heavy caseloads that practitioners were carrying and short staffing. Some practitioners in the 0-19 team told us that they were unsure what was happening with the service. Results from the staff survey 2017, for the 0-19 service showed that 77% of respondents did not think there was a clear plan for the service and how it will move forward. Morale was low in the therapies team as there had been a consultation about a restructure and staff were unhappy.

Service leads acknowledged that morale was low in some areas but said that they were trying to keep staff informed of changes through area team meetings, although some members of staff told us they were unable to attend the team meetings and unable to access the presentations stored on the shared drive. Service leads had also set up task and finish groups to work on key areas of development, that included frontline practitioners. A communication strategy had been developed that detailed what leaders would commit to doing to improve communication.
Governance

There was a governance structure in place which ensured that relevant information was escalated from the community up to board level.

The service held monthly community governance meetings, which fed in to the children's clinical service unit governance meeting, this in turn reported to the family health divisional meeting. The divisional governance meeting reported in to the clinical governance and quality assurance committees, which fed in to the board meetings.

A governance lead supported the children and young people’s services.

Management of risk, issues and performance

At our previous inspection, we found that there was a risk that the risk register did not reflect current risks, contain appropriate mitigating actions and wasn’t regularly reviewed. At this inspection, we found that risks registers were reviewed regularly at the community governance meetings. Service leads could tell us their top risks and the mitigating actions in place.

We reviewed minutes from the children and young people’s governance group. This group had representation from the acute and community services. We also reviewed meeting minutes from the community governance meetings. We saw that discussions took place around incidents, risks, complaints and policies.

Within the 0-19 service, operational meetings took place monthly which were attended by team leaders, the looked after children’s nurse, safeguarding nurse and a clinical analyst, who would share exception reporting.

Performance meetings were held with between the 0-19 service leads and the executive team and commissioners to discuss performance in relation to the healthy child programme.

A lone worker standard operating procedure was in place to ensure practitioners were kept safe. Practitioners undertook joint visits in those areas where they may be a potential risk.

We saw a business continuity plan for the 0-19 service. This contained an activation flow chart and the action staff should take in response to certain adverse events, such as adverse weather conditions, IT outage and major incidents.

The service had not yet introduced an audit plan for the year. It had been identified at our last inspection that there were limited audits. The service leads had a work plan in place for the 0-19 service. This had various workstreams to help implement changes to the service.

Information management

Performance dashboards allowed leaders to see how teams were performing, this included performance related to the mandated contacts under the healthy child programme.

All computers accessed by staff were password protected and access to the electronic patient record was via a smartcard, this ensured there was no unauthorised access.
Service leads told us that staff could access meeting minutes and presentations on the shared drive. However, there were a few members of staff who we spoke with that told us they were unable to access the shared drive.

Staff had access to laptops, although some staff told us they did not use them in home visits as they felt they were a barrier between themselves and the parents. Some staff experienced connectivity issues with the laptops in the community. In this instance, practitioners printed off their work for the next day and hand wrote the notes during the visit, completing the electronic record on return to the office.

**Engagement**

The service leads had conducted a survey with staff. This had highlighted concerns with communication. Following this feedback any proposed changes now had task and finish groups allocated so that staff could be involved.

The service told us that they had designed new forms to gather feedback from parents. Any feedback that was received was shared with practitioners.

Team meetings and area meetings were held monthly. We saw a copy of the team and area meeting minutes. The team minutes included a monthly team briefing from the Chief Executive Officer (CEO), trust board updates, operational plan 2018/19, annual report on learning from deaths and the quality governance review, data quality and cyber security report, and acknowledgement of staff for their hard work.

Newsletters were sent to staff to keep them up to date, practitioners were asked to contribute to these. These included good news, updates within the trust and the service, and learning from incidents.

We saw evidence on a staff notice board of staff drop in sessions that had been arranged. These were a forum for staff to give positive feedback, share concerns and share learning.

Staff were given sharing star cards in recognition of what they had done.

A user involvement working group had been set up covering both the community and acute children’s services. The purpose of this group was to ensure there was user involvement to help service improvement.

A charter for children and young people was to be developed and there were plans to ask young people their views on services and what the charter should include. School children had contributed to ‘what good looks like’ with regards to the voice of the child.

The 0-19 service had a Facebook page to promote their service and provide advice and guidance.

The child development centre had a review group, which included parent representatives that had been involved in discussions about what needed to be included in an updated service specification.
Learning, continuous improvement and innovation

The immunisation team had been nominated for a trust proud award for meeting key performance indicators (KPI) and the early attachment team had been nominated by the public.

In October 2017, the paediatric acute rapid response outreach team (PARROT) was set up to promote early discharge and hospital avoidance. Practitioners worked closely with the children’s ward. In May 2018, the PARROT service was extended to include referrals from the urgent and emergency care centre.