

# The Rotherham NHS Foundation Trust

## Inspection report

Rivelin House  
Moorgate Road  
Rotherham  
South Yorkshire  
S60 2UD  
Tel: 01709304115  
www.therotherhamft.nhs.uk

Date of inspection visit: 25 Sep to 24 Oct 2018  
Date of publication: 31/01/2019

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






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

This report is a summary of our inspection findings. You can find more detailed information about the service and what we found during our inspection in the related Evidence appendix.

## Ratings

### Overall rating for this trust

Requires improvement 

Are services safe?	Requires improvement 
Are services effective?	Requires improvement 
Are services caring?	Good 
Are services responsive?	Good 
Are services well-led?	Requires improvement 

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

# Summary of findings

## Background to the trust

The Rotherham NHS Foundation Trust was awarded foundation status in 2005 and provides a wide range of acute and community health services to the people of Rotherham (population approximately 261,000).

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.

From June 2017 to May 2018, there were 94,649 attendances in the emergency department and 317,385 patients attended the outpatient department.

## Overall summary

**Our rating of this trust stayed the same since our last inspection. We rated it as **Requires improvement****



## What this trust does

The Rotherham NHS Foundation Trust provides acute and community services to a population of 252,000, from seven registered locations across the Rotherham area:

- Rotherham General Hospital is the main site and has 418 general and acute inpatient beds across 23 wards; there are 23 maternity beds and 15 critical care beds. Clinical services are supported by comprehensive pathology, medical physics and imaging services including MRI and CT facilities.
- Barnsley Community Dental Service provides specialised community dental care for adults and children for whom there is evidence that treatment is not possible within the general dental service. The service also provides oral health promotion programmes for priority groups in targeted areas.
- Breathing Space is a long-term conditions service which provides pulmonary rehabilitation for adult patients with Chronic Obstructive Pulmonary (COPD) in Rotherham. Breathing space provides assessment and diagnosis of COPD in a nurse led unit with 20 inpatient beds. Breathing Space also provides outpatient care and respite care for patients already known to the service.
- Rotherham Community Health Centre provides a range of community services for adults, children and young people. This includes community nursing, physiotherapy, speech and language therapy, sexual health and a GP-led minor surgery and vasectomy service.

# Summary of findings

- The Flying Scotsman provides specialised community dental care for adults and children for whom there is evidence that treatment is not possible within the general dental service. The service also provides oral health promotion programmes for priority groups in targeted areas.
- The Park Rehabilitation Centre provides outpatient physiotherapy, occupational therapy and speech and language therapy to patients with musculoskeletal and neurological conditions and who have experienced an amputation. The centre also provides an adult psychology service.
- The Rotherham Intermediate Care Centre provides a day rehabilitation service for adults with physical problems, to facilitate hospital discharge as well as preventing admission into hospital or long-term care. The centre aims to improve patients' independence and to enable people to live at home as independently as possible for as long as possible.

## Key questions and ratings

We inspect and regulate healthcare service providers in England.

To get to the heart of patients' experiences of care and treatment, we ask the same five questions of all services: are they safe, effective, caring, responsive to people's needs, and well-led?

Where we have a legal duty to do so, we rate the quality of services against each key question as outstanding, good, requires improvement or inadequate.

Where necessary, we take action against service providers that break the regulations and help them to improve the quality of their services.

## What we inspected and why

We plan our inspections based on everything we know about services, including whether they appear to be getting better or worse.

Between 25 and 27 September 2018, we carried out an unannounced inspection at Rotherham General Hospital of urgent and emergency services, medical care, maternity services, and acute services for children and young people. Between 16 and 18 October 2018, we carried out an unannounced inspection of community health services for children and young people.

We inspected urgent and emergency care services at Rotherham General Hospital because services were previously rated as requires improvement. There had been a breach of Regulation 18 (Staffing) as there was an insufficient number of suitably qualified, competent, skilled and experienced staff in the emergency department. There was also a breach of Regulation 17 (Good Governance) as not all staff were aware of their responsibility to report incidents and learning was not shared with all relevant staff within the department. A focussed inspection, undertaken in July 2018, also identified concerns about the management of deteriorating paediatric patients in the department following a number of serious incidents. Following this inspection, we asked the trust to submit an action plan and evidence of ongoing implementation of actions.

We inspected medical care at Rotherham General Hospital because services were previously rated as requires improvement. There had been a breach of Regulation 11 (Need for Consent) as mental capacity assessments and discussions were not always clearly documented. There was also a breach of Regulation 18 (Staffing) as there was an insufficient number of suitably qualified, competent, skilled and experienced staff in the emergency department, although the trust had taken action to mitigate risk.

A focussed inspection, undertaken in July 2018, identified concerns about the management of non-invasive ventilation patients on medical wards and the trust.

# Summary of findings

We inspected maternity services at Rotherham General Hospital because services were previously rated as requires improvement. There had been a breach of Regulation 17 (Good Governance) because there was a backlog of incidents requiring a review and risks were not always recognised or recorded on the risk register.

We inspected acute services for children and young people at Rotherham General Hospital, because services were previously rated as requires improvement. There had been a breach of Regulation 17 (Good Governance) because the risk register did not reflect current risks, contain appropriate mitigating actions, and was not regularly reviewed or monitored. In addition, policies and procedures were not up to date and there was no process for review.

We inspected community health services for children and young people because services were previously rated as requires improvement. There had been a breach of Regulation 17 (Good Governance) because the risk register did not reflect current risks, contain appropriate mitigating actions, and was not regularly reviewed or monitored. In addition, policies and procedures were not up to date and there was no process for review. Services did not have a regular or effective clinical audit schedule, performance against waiting time targets for therapy services required improvement as did performance against the target for the completion of looked after children assessments.

A further announced inspection took place between 22 and 24 October 2018 where we looked at the quality of leadership at the trust and how well the trust managed the governance of its services.

## What we found

### Overall trust

Our rating of the trust stayed the same. We rated it as requires improvement because:

- We rated safe, effective and well-led as requires improvement, and rated caring and responsive as good. All ratings were the same as the previous inspection except for responsive, which had improved one rating.
- Rotherham General Hospital was rated as requires improvement overall. Safe, effective, responsive and well-led remained as requires improvement and caring remained good.
- Community Healthcare Services remained as requires improvement overall. We inspected one core service (community healthcare services for children and young people) at this inspection and the overall ratings for effective and well-led remained as requires improvement while safe, caring and responsive remained as good.
- The trust was rated as requires improvement overall at its first comprehensive CQC inspection in July 2015. The outcome from a second inspection in March 2017 produced the same overall rating and the trust continued this trend. Issues we identified at previous inspections, such as culture, mandatory training compliance, staffing and high caseloads for practitioners in the 0-19 service had demonstrated the trust had not fully addressed ongoing concerns. There was evidence of some progress and the trust recognised further improvement was required.
- In addition, we also undertook a focussed unannounced inspection in July 2018 and found that appropriate and timely action had not been taken to address the immediate concerns.

### Are services safe?

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

- There were significant concerns within urgent and emergency care services that impacted upon patient safety. The service was rated as inadequate for safe, which was down one rating from the previous inspection. There was a shortage of suitable skilled staff and not all staff had the right skills, knowledge and experience to do the job they were asked to do.

# Summary of findings

- Patients had long waits to be assessed in the emergency department and there had been serious incidents resulting in patient harm due to those delays. Senior staff had not made any correlation between staffing levels and the number of serious incidents and had not taken timely action in response to the concerns raised by staff.
- Nurse staffing was an ongoing issue, particularly within medical wards. Fill rates were low on some wards and there was a high number of nurse vacancies across the trust. In the maternity service, midwives were frequently deployed from other areas to support the delivery suite, and there had been a reduction in specialist midwives to meet the needs of vulnerable women.
- There was a shortage of junior doctors and medical wards were frequently below the minimum levels. Locum and bank staff were utilised to cover shortfalls and the trust did not have substantive consultants in post in stroke and gastroenterology services.
- There was poor compliance with mandatory training across some core services, which was identified as a concern at the previous inspection. The majority of core services inspected did not meet the 85% trust target.
- Although the medicines omission rate (missed doses) was largely in line with national data the proportion of critical medicines missed remained higher than average. There was a lack of ownership regarding medicines safety at ward level and incidents of medicines causing harm placed the trust at the top end of the interquartile range [NHS England Medicines Optimisation Dashboard]. Some wards did not receive a regular clinical pharmacy service and there was no dedicated pharmacist in the emergency department. 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).
- Safeguarding adults and children was not always given sufficient priority and there was a lack of strategic oversight of the issues we identified during this inspection. We found the quality of safeguarding referrals was poor in some services, looked after children did not receive initial health assessments in a timely manner, and safeguarding training did not comply with the Royal College of Paediatric and Child Health intercollegiate document.

However;

- We found evidence of improvement in maternity and services for children and young people in relation to incident reporting. There was no backlog of incidents for review in maternity and there were systems to share learning with staff.
- There were processes in place to safeguard children and adults from abuse and risk of harm. Staff understood their responsibilities and could articulate what action they would take. However, in community healthcare services for children and young people, there was minimal oversight of safeguarding children referrals and no process for quality assurance.
- Wards and departments were visibly clean and met infection control standards.
- The trust used a sepsis screening tool, staff had access to sepsis guidelines and followed the nationally recognised sepsis pathway to care for patients.

## Are services effective?

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

- In urgent and emergency care services, care and treatment did not always reflect evidence-based guidance. The service did not meet Royal College of Emergency Medicine audit standards, which was a concern at the previous inspection.
- Health visiting and school nursing services continued to fail to meet performance targets, although an improvement plan was in place and the service prioritised the needs of vulnerable families.

# Summary of findings

- Not all staff had received an appraisal and there were some gaps in support arrangements, such as clinical supervision and professional development. Some staff spoke negatively about the quality of their annual 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 made them feel their work was valued. This was worse than the national average.
- Although staff understood their responsibilities towards patients in relation to the requirements of the Mental Capacity Act, the assessment documentation was brief, lacked detail and did not demonstrate the rationale behind the decision.
- Not all patients felt their pain was managed appropriately. In the urgent and emergency care service, pain scores were not consistently recorded or reassessed, while women and staff in maternity told us the service did not always offer pain relief in a timely way.

However;

- There had been improvements in medical care and services for children and young people which were rated as good.
- The maternity service had made improvements and regularly reviewed clinical outcomes in formal meetings. Policies and procedures were up to date and there a review system in place.
- There was evidence of good multidisciplinary working throughout the trust. Staff with specialist skills and knowledge worked well together to benefit patients.
- Staff understood consent requirements for adults, children and young people and gained consent prior to performing care.

## Are services caring?

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

- Staff were caring and compassionate and worked in partnership with patients, relatives and carers.
- Staff recognised the important of people's privacy and dignity and treated patients, relatives and carers with respect and kindness, and involved them in their care.
- Staff communicated with people and provided information in a way that they could understand.
- Patients told us they received compassionate care and that staff supported their emotional needs.
- Results from the Friends and Family test were better than 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.

However;

- Feedback from relatives of patients attending the emergency department was mixed. Although staff cared about patients and worked hard to meet their needs, due to staffing pressures, they acknowledged they could not always offer the level of care and support they wanted to.

## Are services responsive?

Our rating of responsive improved. We rated it as good because:

- There had been improvements in services for children and young people (acute and community) which were rated as good.
- Services were planned and delivered in a way to meet the individual's needs and the local population. Services took account of people with complex needs and there was access to specialist support and expertise.

# Summary of findings

- Care and treatment was co-ordinated with other services and other providers and reasonable adjustments were made where appropriate.
- The management of medical outliers had improved since our last inspection. There were clear arrangements for the daily review of medical patients cared for on non-medical wards.
- Patients knew how to complain, and staff knew how to deal with complaints they received. Complaints were investigated, and learning was shared.
- The trust had applied measures to manage flow in medical wards. A new frailty team had helped prevent unnecessary admissions and reduce length of stay in hospital.

However;

- Flow arrangements within the urgent and emergency care centre (UECC) were less responsive. Patients often had long waits, from the decision to admit to actual admission on a ward. In addition, the median time for arrival to treatment in the UECC, and the number of patients who left the department before being seen, was worse than the national average.
- The looked after children (LAC) service did not meet the statutory initial health needs assessment target of 20 working days from the date of becoming looked after. This was also identified as an issue at our last inspection. There was an inter-agency action plan to address the timeliness of the assessments. Regular assurance reports were provided to the service manager and the quality assurance committee.

## Are services well-led?

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

- Our rating of urgent and emergency care services went down one rating to inadequate. The leadership team had failed to identify significant safety concerns within the department and failed to address those already identified.
- Our rating of medical care went down one rating to requires improvement. The divisional leadership did not always listen to concerns raised by staff, or take appropriate action.
- Staff did not always feel listened to by their immediate managers and, although managers, including the executive leadership team, felt they had an 'open door' arrangement, frontline staff described a lack of visibility and inaccessibility.
- There was a governance structure in place with integrated performance reports and supporting dashboards, which were embedded at corporate and divisional level, and used to support the overall performance framework. However, managers recognised the need to introduce more consistent practice within the four divisions.
- Although there were systems to identify, record and manage risk within each service, the process for escalating and de-escalating risk was not fully embedded within the trust. This was particularly evident within the urgent and emergency care centre where there was a lack of timely action in response to the ongoing patient safety concerns we identified within the unit.
- Staff did not feel engaged with senior leaders. Results from the NHS Staff Survey 2017 reported 30% of staff who responded felt that communication between senior management and staff was effective. Only 25% of all responders felt that senior managers tried to involve staff in important decisions whilst 23% reported senior managers acted on staff feedback.

# Summary of findings

- The culture of the organisation was reported as improving from a low base. In urgent and emergency care services, we found the culture was defensive and not open or transparent. The trust had updated its Whistleblowing policy to ensure staff members raising concerns were protected and supported and to prevent any discrimination consequently. In addition, there 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.

However;

- There had been improvements in maternity services and in services for children and young people (acute), which were rated as good.
- The trust had a five-year strategy with five strategic themes and three core values, linked the priorities of the wider health economy across South Yorkshire and Bassetlaw. The trust worked collaboratively with all key stakeholders across the regional Integrated Care System. However, the trust lacked some key supporting strategies to support the implementation of its vision, such as patient experience and equality and diversity.
- At executive level, the recent focus on finance and performance had improved financial performance and performance against the 62-day standard, which had been done in the context of ensuring that patients and quality were the trust's priority. The commissioning of the external quality governance review in 2018, demonstrated the importance that the trust placed on strengthening quality and clinical governance.
- The trust had achieved national recognition for several initiatives that have improved patient care, such as Acupin therapy, which supported women experiencing nausea and vomiting in pregnancy.

Click or tap here to enter text.

## Ratings tables

The ratings tables show the ratings overall and for each key question, for each service, hospital and service type, and for the whole trust. They also show the current ratings for services or parts of them not inspected this time. We took all ratings into account in deciding overall ratings. Our decisions on overall ratings also took into account factors including the relative size of services and we used our professional judgement to reach fair and balanced ratings.

## Outstanding practice

We found examples of outstanding practice across the trust.

For more information, see the Outstanding practice section of this report.

## Areas for improvement

We found areas for improvement including 47 breaches of legal requirements that the trust must put right. We found 27 things that the trust should improve to comply with a minor breach that did not justify regulatory action, to prevent breaching a legal requirement, or to improve service quality.

For more information, see the Areas for improvement section of this report.”

## Action we have taken

We issued four requirement notices to the trust. This meant the trust had to send us a report stating what action it would take to improve services.

Our action related to breaches of legal requirements at a trust-wide level and in the following core services: urgent and emergency care, medical care, and acute and community services for children and young people.



# Summary of findings

## What happens next

We will check that the trust takes the necessary action to improve its services. We will continue to monitor the safety and quality of services through our continuing relationship with the trust and our regular inspections.

## Outstanding practice

The trust had made good progress with its digital agenda and we saw evidence of innovative use of technology. The in-house clinical IT portal provided operational and clinical staff with overarching information about patients and their progress through the trust.

## Areas for improvement

Action the trust **MUST** take is necessary to comply with its legal obligations. Action a trust **SHOULD** take is to comply with a minor breach that did not justify regulatory action, to prevent it failing to comply with legal requirements in future, or to improve services.

### Trust-wide:

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

- The trust must ensure there are robust systems in place to support people to raise concerns about patient safety and these concerns are listened to and acted upon in a timely way.
- The trust must ensure there are robust governance arrangements in place to identify risk at core service level, and ensure the reporting arrangements for board committees provides effective oversight of the overall system of internal control.
- The trust must conclude the streamlining of operational risk management processes to ensure there are embedded arrangements for escalating and de-escalating risk from ward to board.
- The trust must review the arrangements in the organisation to ensure there are robust mechanisms in place to support people in relation to equality and diversity.
- The trust must ensure safeguarding adults and children are given sufficient priority and there is sufficient management oversight of processes, practices and procedures for safeguarding adults and children.
- The trust must ensure safeguarding children training fully complies with the Royal College of Paediatric and Child Health intercollegiate document, and ensure all appropriate staff are up to date with safeguarding level 3 training.
- The trust must ensure all staff are up to date with mandatory training.

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

- The trust should ensure there are key supporting strategies and appropriate policies to support the implementation of the trust's vision, and embed a quality and safety culture across the organisation.
- The trust should ensure all staff receive a quality appraisal.
- The trust should continue to work towards improving the response and resolution times for complaints to meet the trust policy of 30 days.

### Urgent and Emergency Care:

# Summary of findings

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

- The trust must ensure there are sufficient skilled qualified and experienced nursing and medical staff deployed within the department to meet the need of patients across the department but particularly in the paediatric and resuscitation department.
- The trust must reassess the nursing and staffing needs of the department using a recognised tool to ensure staffing levels in the department remain safe, and ensure workforce planning does not leave the department short staffed for junior doctors and registered sick children's nurses as is currently the situation.
- The trust must improve initial assessment processes to reduce the risk of sick patients having long waits to be seen to ensure that care and treatment is provided in a timely way.
- The trust must improve the process for recognising and escalating deteriorating patients to ensure this is done in a timely manner and that appropriate documentation is completed in line with local and national guidance.
- The trust must improve working with specialty teams so patients do not have long waits for decisions about admission or discharge, to improve flow through the department.
- The trust must improve the recording and reporting of safeguarding of vulnerable patients and make sure staff are given time and training to improve the standard of safeguarding referrals. Staff must be supported to improve their level of professional curiosity and provided with scheduled safeguarding supervision support. Safeguarding processes should include improved communication with external agencies including the police and local authorities.
- The trust must carry out clinical audit and other quality assurance activity to ensure patients are receiving care and treatment in line with national and RCEM guidance.
- The trust must ensure the departmental risk register fully reflects the risks faced by the department and has appropriate actions to mitigate the risks.
- The trust must emphasise with medical staff their responsibility to report patient safety incidents themselves and not ask other staff to do this on their behalf. At our last inspection we classed this as a 'Should Do'. As a recurrent issue this is now a 'Must do'.
- The trust must ensure workforce planning considers and accurately reflects the needs of the department and does not leave the department short staffed for junior doctors and registered sick children's nurses as is currently the situation.
- The trust must improve lines of communication between front line, leadership, management and executive staff to ensure executive staff are fully sighted on concerns within the department.
- The trust must work with staff to improve the culture in the department and make sure all staff feel they are treated fairly and equally, and improve communication with staff to ensure staff feel listened to, supported and informed.

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

- The trust should ensure staff receive training about how to support patients living with a mental health condition including their responsibilities in relation to the Mental Health Act.
- The trust should introduce a cleaning rota for toys in the paediatric ED waiting room and make sure staff are aware of who is responsible for cleaning.
- The trust should carry out regular checks to make sure medicines are stored safely and in line with guidelines.
- The trust should participate in RCEM clinical audits as a method of benchmarking against other services nationally.

# Summary of findings

- The trust should continue to support the clinical nurse education team to ensure staff skills and competencies meet the needs of the department.
- The trust should support staff to provide compassionate care to patients, ensure patients have access to call bells and acknowledge patients shouting for assistance.
- The trust should improve communication with patients and their families, thus reducing anxiety and uncertainty for patients.
- The trust should strengthen the pathways for patients with specific conditions to allow them to access the appropriate care and treatment in an efficient way, thus improving the flow and capacity of the department.
- The trust should ensure professional interpreters are used rather than family members when a patient's first language is not English to ensure patient confidentiality and accuracy of interpretation.
- The trust should consider how to improve pastoral support to staff to demonstrate they are valued and listened to.

## **Medical Care:**

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

- The trust must ensure that at all times there are sufficient numbers of suitably skilled, qualified and experienced staff in line with best practice and national guidance taking into account patient's dependency levels.
- The trust must ensure that patients receive their appropriate medication and that if doses are missed, staff record a clear explanation on the medicines administration chart to indicate the reason a medicine has not been given.
- The trust must ensure that all drugs fridges are checked daily and the temperature of treatment rooms for medicines storage is monitored, in accordance with trust policy and action is taken if they are out of range.
- The trust must ensure that all hypo-boxes are checked daily in accordance with trust policy and consistently across all medical wards.
- The trust must ensure that oxygen is appropriately prescribed including the documentation of target blood oxygen levels.
- The trust must ensure there is a specific risk assessment tool to identify and manage risks associated with a patient's mental health which includes a specific risk management plan to address challenging behaviours and manage them safely.
- The trust must ensure that all staff working in medical care services are compliant with the mandatory training relevant to their role, including safeguarding training.
- The trust must ensure they address the backlog of overdue incident reports.
- The trust must ensure that when staff complete a mental capacity assessment they clearly document the rationale behind the decision. This includes the documentation of any decisions made in a patient's best interest which must give details of who made the decision and the options considered.
- The trust must ensure that all risks on the divisional risk register are regularly reviewed and updated to ensure they are managed and mitigated effectively.
- The trust must ensure that when staff raise concerns about patient safety they are taken seriously, escalated if appropriate and acted upon. Staff should receive feedback on what action has been taken.

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

# Summary of findings

- The trust should ensure the patients medication to take home is provided to patients within a reasonable time scale and does not delay them going home.
- The trust should ensure that staff receive training in mental health.
- The trust should ensure that all staff decontaminate their hands and replace aprons between every patient contact when providing clinical care.
- The trust should ensure that staff are clear on the standard operating procedure for cleaning commodes and they adhere to this.
- The trust should ensure that all equipment is maintained and safety tested within manufacturers guidelines. They should also ensure that all single use equipment on the tracheostomy and chest drain trolley is within the sterile expiry date.
- The trust should ensure that the ligature risk of the wall mounted drip hooks in the acute medical unit to patients with a mental health condition is more formally managed and monitored.
- The trust should ensure that paper waste containing confidential patient information is not left unattended in an unlocked room.
- The trust should ensure that the senior nurse ward assurance tool is consistently applied across all wards in the CSU and the results are monitored.
- The trust should ensure that nursing staff receive regular clinical and practice supervision in line with trust policy.

## **Maternity:**

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

- The trust must ensure staff undertake child sexual exploitation assessments for any woman aged under 18.
- The trust must ensure all identified risks affecting the service in line with trust policy are escalated to the risk register.
- The trust must ensure ongoing audit of delivery suite acuity and resulting staffing needs are carried out and documented to enable optimum staffing.
- The trust must ensure midwifery staffing and staffing escalation procedures are reviewed to meet the needs of women using the service and to enable lead midwives with specialist roles to carry out those responsibilities.
- The trust must ensure there is sufficient specialist midwife provision to support the needs of vulnerable women.
- The trust must ensure all midwives understand and use Gillick competence checks or Fraser guidelines before discussing consent for care and treatment with young women.
- The trust must ensure staff teams, in particular on delivery suite and postnatal ward, share patient information effectively.
- The trust must ensure women experience timely postnatal discharge from the ward.
- The trust must ensure antenatal clinics run to time.

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

- The trust should ensure all patient information leaflets are regularly reviewed and are of good quality, and references and maternity guidance contained within them are correct and up to date.
- The trust should review the provision of clinics to reduce waiting times for appointments.

# Summary of findings

## **Services for Children and Young People:**

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

- The trust must ensure that all medicines refrigerator temperatures checks are recorded in line with the trust policy, and action is taken if they are out of range.
- The trust must ensure they have enough staff in the Special Care Baby Unit (SCBU) qualified in speciality, in line with the national guidance.
- The trust must ensure on each shift there is a nurse trained in European Paediatric Life Support (EPLS) or Advanced Paediatric Life Support (APLS) and their competencies are maintained.
- The trust must ensure all staff know what action they would take if they felt a parent didn't have the capacity to consent.

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

- The trust should ensure that all staff are up to date with their mandatory training; including the management of sepsis training.
- The trust should ensure that the nurse in charge of the SCBU, is supernumerary in line with the British Association of Perinatal Medicine Standards, August 2010.
- The trust should ensure that the felt notice boards are replaced with ones which can be appropriately cleaned.

## **Community Health Services for Children and Young People:**

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

- The trust must ensure that there are sufficient suitably qualified, skilled and experienced staff to meet the needs of the local population.
- The trust must ensure that there are processes in place for quality assurance of safeguarding referrals and that there is a system in place in the sexual health service for safeguarding alerts to be placed on the patient record.
- The trust must ensure that staff receive clinical supervision, in line with national guidance.
- The trust must ensure it improves the number of looked after children assessments carried out within the target timescale.

## Is this organisation well-led?

- The trust was rated as requires improvement overall at its first comprehensive CQC inspection in July 2015. The outcome from a second inspection in March 2017 produced the same overall rating and the trust continued this trend. Issues we identified at previous inspections, such as culture, mandatory training compliance, staffing and high caseloads for practitioners in the 0-19 service had demonstrated the trust had not addressed ongoing concerns.
- In addition, we also undertook a focussed unannounced inspection in July 2018 and found that appropriate and timely action had not been taken to address the immediate concerns.
- There had been changes within the executive team which had caused some instability in terms of leadership and oversight. There had been three different chief nurses since the original comprehensive inspection in 2015, the last chief nurse being in post for 12 months. The current chief nurse position was an interim arrangement.

# Summary of findings

- We identified issues around culture in some areas of the organisation and staff did not always feel listened to by their immediate managers.
- We identified a disconnect between frontline staff and senior leadership. Staff did not feel engaged with the executive leadership team. Results from the staff survey showed 30% of staff felt communication between senior management and staff was effective. Only 25% felt senior managers tried to involve staff in important decisions whilst 23% reported senior managers acted on staff feedback.
- Although the trust had a whistleblowing policy and staff did raise concerns, evidence showed the trust did not always take immediate or timely action in relation to staff concerns about patient safety. This was evidenced by the significant concerns raised repeatedly by staff about staffing levels in the paediatric emergency departments and the care of non-invasive ventilation patients on medical wards.
- A number of results from the most recent staff survey were poor. There were 19 key findings worse than the average for similar trusts. This included the quality of appraisals, staff recommendation of the trust as a place to work or receive treatment, recognition and value of staff by managers and the organisation, and staff motivation at work.
- Although there were strong arrangements for financial and performance governance, there was less assurance in respect of quality and safety governance. The trust had commissioned an externally facilitated review of its quality governance arrangements and had developed an action plan in response to the findings. Executive leaders were in the process of implementing changes within each division to ensure consistency within the trust.
- The executive team was clear on the risks and priorities of the organisation, however we found evidence that in some areas there had not been sufficient improvement since the last inspection.
- The process for escalating and de-escalating risk was not fully embedded within the trust and we found there was a lack of assurance in the reporting and monitoring of risks. This was particularly evident within the urgent and emergency care centre where there was a lack of timely action in response to the ongoing patient safety concerns we identified within the unit.
- In Rotherham, there have been historical high profile incidents and criminal activities in relation to safeguarding children. Significant multi-agency working had taken place to address and improve safeguarding arrangements. However, further improvement was still required in some areas. For example, the quality of safeguarding referrals was poor in some services, looked after children did not receive initial health assessments in a timely manner, and safeguarding training did not fully comply with the Royal College of Paediatric and Child Health intercollegiate document. In addition, there were no safeguarding alerts on the electronic patient record in the sexual health service, and there had been a reduction in the number of specialist midwives to support vulnerable women.
- Although the trust had a five-year strategy with strategic themes and core values, linked the priorities of the wider health economy across the local region, the trust lacked some key supporting strategies to support the implementation of its vision. This included patient experience and equality and diversity. Staff described a weak culture across the trust in respect of the latter.
- The trust had a strong external focus and worked collaboratively with key stakeholders within the Integrated Care System (ICS) and there was a good focus on financial and national performance. However, there was a lack of strong clinical leadership to support the chief executive and improve the focus on quality, safety and patient experience.
- The trust was engaged with the wider economy hospital services review but there was a need for early clarity on the future service portfolio to bring much needed stability to some of the trust's clinical services which have challenging workforce gaps.

However;

# Summary of findings

- The trust used an internally developed assured kite marking system of data quality and were compliant with information governance requirements.
- The trust had made good progress with its digital agenda and we saw evidence of robust IT programmes with good governance arrangements. The in-house clinical IT system had won a national award.
- The trust had made good progress in identifying recurrent cost improvement schemes in the current year to stabilise the financial position.
- The executive leadership team was committed to rolling out a quality improvement programme and the trust was in the early stages of adopting quality improvement methodology.
- The trust had achieved national recognition for several initiatives that have improved patient care, such as Acupin therapy, which supported women experiencing nausea and vomiting in pregnancy.

## Use of resources

Please see the separate use of resources report for details of the assessment and the combined rating. The report is published on our website at [www.cqc.org.uk/provider/RFR/Reports](http://www.cqc.org.uk/provider/RFR/Reports)

## Ratings tables

Key to tables					
Ratings	Not rated	Inadequate	Requires improvement	Good	Outstanding
Rating change since last inspection	Same	Up one rating	Up two ratings	Down one rating	Down two ratings
Symbol *	↔	↑	↑↑	↓	↓↓
Month Year = Date last rating published					

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

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

### Ratings for the whole trust

Safe	Effective	Caring	Responsive	Well-led	Overall
Requires improvement ↔ Jan 2019	Requires improvement ↔ Jan 2019	Good ↔ Jan 2019	Good ↑ Jan 2019	Requires improvement ↔ Jan 2019	Requires improvement ↔ Jan 2019

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



## Ratings for Rotherham General Hospital

	Safe	Effective	Caring	Responsive	Well-led	Overall
Urgent and emergency services	Inadequate ↓ Jan 2019	Requires improvement ↔ Jan 2019	Requires improvement ↓ Jan 2019	Requires improvement ↔ Jan 2019	Inadequate ↓ Jan 2019	Inadequate ↓ Jan 2019
Medical care (including older people's care)	Requires improvement ↔ Jan 2019	Good ↑ Jan 2019	Good ↔ Jan 2019	Good ↔ Jan 2019	Requires improvement ↓ Jan 2019	Requires improvement ↔ Jan 2019
Surgery	Good Mar 2017	Good Jul 2015	Good Jul 2015	Good Mar 2017	Good Jul 2015	Good Mar 2017
Critical care	Good Mar 2017	Good Mar 2017	Good Jul 2015	Good Jul 2015	Requires improvement Mar 2017	Good Mar 2017
Maternity	Good Jan 2019	Good Jan 2019	Good Jan 2019	Requires improvement Jan 2019	Requires improvement Jan 2019	Requires improvement Jan 2019
Services for children and young people	Good ↔ Jan 2019	Good ↑ Jan 2019	Good ↔ Jan 2019	Good ↔ Jan 2019	Good ↑ Jan 2019	Good ↑ Jan 2019
End of life care	Good Jul 2015	Requires improvement Mar 2017	Good Jul 2015	Good Jul 2015	Good Jul 2015	Good Mar 2017
Outpatients and diagnostic imaging	Good Mar 2017	N/A	Good Jul 2015	Good Jul 2015	Good Jul 2015	Good Mar 2017
<b>Overall*</b>	Requires improvement ↔ Jan 2019	Requires improvement ↔ Jan 2019	Good ↔ Jan 2019	Requires improvement ↔ Jan 2019	Requires improvement ↔ Jan 2019	Requires improvement ↔ Jan 2019

\*Overall ratings for this hospital are from combining ratings for services. Our decisions on overall ratings take into account the relative size of services. We use our professional judgement to reach fair and balanced ratings.

## Ratings for community health services

	Safe	Effective	Caring	Responsive	Well-led	Overall
Community health services for adults	Good Mar 2017	Requires improvement Mar 2017	Good Jul 2015	Good Jul 2015	Requires improvement Mar 2017	Requires improvement Mar 2017
Community health services for children and young people	Requires improvement →← Jan 2019	Requires improvement →← Jan 2019	Good →← Jan 2019	Good ↑ Jan 2019	Requires improvement →← Jan 2019	Requires improvement →← Jan 2019
Community health inpatient services	Good Mar 2017	Good Mar 2017	Outstanding Mar 2017	Good Mar 2017	Good Mar 2017	Good Mar 2017
Community end of life care	Good Mar 2017	Requires improvement Mar 2017	Good Mar 2017	Good Mar 2017	Requires improvement Mar 2017	Requires improvement Mar 2017
Community dental services	Good Jul 2015	Good Jul 2015	Good Jul 2015	Good Jul 2015	Good Jul 2015	Good Jul 2015
<b>Overall*</b>	Good →← Jan 2019	Requires improvement →← Jan 2019	Good →← Jan 2019	Good →← Jan 2019	Requires improvement →← Jan 2019	Requires improvement →← Jan 2019

\*Overall ratings for community health services are from combining ratings for services. Our decisions on overall ratings take into account the relative size of services. We use our professional judgement to reach fair and balanced ratings.

# Acute health services

## Background to acute health services

The Rotherham NHS Foundation Trust provides a range of hospital based medical, surgical, paediatric and obstetric services at Rotherham General Hospital. The facilities include:

- 430 inpatient beds
- Intensive Therapy and Coronary Care Units
- Cardiac Catheterisation Suite
- Breast Screening Suite
- Endoscopy Unit
- Day Surgery Unit
- Theatre Assessment Unit
- Stroke Unit
- GP Out of Hours Service
- GP in Urgent and Emergency Care Centre

## Summary of acute services

**Requires improvement** ●

We did not give an overall rating to acute health services at our last inspection.

At this inspection, we rated acute health services as requires improvement, because we rated the domains of safe, effective and well-led as requires improvement, and we rated caring and responsive as good.

# Rotherham General Hospital

Moorgate Road  
Rotherham  
South Yorkshire  
S60 2UD  
Tel: 01709820000  
[www.rotherhamft.nhs.uk](http://www.rotherhamft.nhs.uk)

## Key facts and figures

Rotherham General Hospital has 418 general and acute inpatient beds across 23 wards; there are 23 maternity beds and 15 critical care beds. Clinical services are supported by comprehensive pathology, medical physics and imaging services including MRI and CT facilities.

From June 2017 to May 2018, there were 94,649 attendances in the emergency department and 317,385 patients attended the outpatient department.

## Summary of services at Rotherham General Hospital

**Requires improvement** ● → ←

Our rating of services stayed the same. We rated the hospital as requires improvement because we rated the domains of safe, effective, responsive and well-led as requires improvement, and we rated caring as good.

# Urgent and emergency services

Inadequate ● ↓

## Key facts and figures

The Urgent and Emergency Care Centre 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 (maxillofacial, 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.

## Summary of this service

Our rating of this service went down. We rated it as inadequate because:

- Patients were not always safe. There was a shortage of suitably skilled staff, particularly overnight. Not all staff had the right skills, knowledge and experience to do the job they were asked to do.
- We found evidence of times when there were insufficient staff on duty in the resuscitation and paediatric emergency departments to ensure patients were safe.
- Patients had long waits to be initially assessed by qualified and experienced staff, thus we found; evidence of delays to patients receiving treatment, harm and potential harm to patients due to delays and missed diagnoses.
- We found safeguarding processes were not fit for purpose. Staff did not show professional curiosity and we found evidence of patients, who were at risk of sexual exploitation or physical harm and should have been referred to safeguarding authorities, being missed. Safeguarding supervision did not take place regularly and involve all relevant staff.
- Deteriorating patients were not always escalated in a timely manner and clinical records did not provide evidence of escalation when patients deteriorated.
- Staff were not up to date with mandatory training and the list of mandatory training staff must attend was limited. Staff were not receiving appraisals in a timely manner and some staff felt disengaged and not listened to when they escalated concerns.
- The department had not taken part in all Royal College of Emergency Medicine (RCEM) audits and for those it participated in, was not achieving RCEM audit standards.
- The department was not meeting national standards such as patients being initially assessed within 15 minutes, ambulance handover within 15 minutes, time to initial treatment within 60 minutes or decision to admit or discharge within four hours. Patients had long waits in the department because flow through the department in to the rest of the hospital did not happen as the ED was often blocked due to lack of availability of beds on wards.
- The department was not well led. Although there were plans in place to improve future staffing levels, managers had failed to focus on the immediate safety concerns in the department despite concerns being raised by staff. This had left the department unsafe at times and staff under unacceptable pressure which was affecting their physical and mental health.

# Urgent and emergency services

- Staff generally felt disengaged. There was insufficient communication with staff and staff felt as though they were 'done to' rather than involved in changes within the department.
- There were continued historic concerns about the culture in the department with some staff talking of favouritism and preferential treatment of colleagues. Many staff felt there was a closed, defensive culture from some of the management and senior leadership team.
- Although governance arrangements were in place, they had failed to identify the significant safety concerns in the department and failed to ensure the departmental risk register accurately reflected the actual risks in the department. Significant issues that threatened the delivery of safe and effective care were not identified nor adequate action to manage them taken.
- Leaders did not lead effectively and there was a disconnect between department leaders, directorate leaders and executive leaders within the Trust. Senior and executive leaders did not appear to be sufficiently aware of what was happening on the front line in the department.

## Is the service safe?

**Inadequate** ● ↓

Our rating of safe went down. We rated it as inadequate because:

- Safety was not a sufficient priority in either the paediatric ED or the adult ED. There had been serious incidents resulting in patient harm due to delays in initial assessment or escalation.
- There were substantial and frequent staff shortages and poor management of agency or locum staff. Rota gaps were not always covered on both medical and nursing rotas. This increased risks to people who used services because there were not always sufficient staff, or staff did not always have the appropriate competencies to work in the area they were designated. We identified staffing levels as a concern at our last comprehensive inspection in 2016 and our focused inspection in July 2018.
- There was insufficient attention to safeguarding children and adults. Staff did not always recognise abuse and did not always demonstrate professional curiosity. When staff made safeguarding referrals, they did not always contain sufficient detail to enable other agencies to act to protect vulnerable people. This was due to staff not having time to spend on referrals because they were caring for sick patients.
- Most staff recognised concerns, incidents and near misses and reported them; however, there was still a culture of some medical staff not taking responsibility for incident reporting. This was also identified at our inspection in 2016.
- Senior staff had not correlated poor staffing levels with serious incidents and taken sufficient action to improve staffing levels to ensure there were sufficient experienced and skilled staff deployed to ensure the department was safe.
- Staff raised concerns; however, these were not recognised by senior staff and sufficient action was not taken. When concerns were raised or when things went wrong, the approach to reviewing and investigating causes was insufficient or too slow. There was little evidence of learning from events or action taken to improve safety, such as increasing staffing levels in the paediatric ED and provision of a dedicated doctor for the paediatric ED.
- Staff did not assess, monitor or manage risks to people who used the services in a timely manner. Opportunities to prevent or minimise harm were missed because patients had long waits for initial assessment and for treatment. Regularly, initial assessment did not happen within 15 minutes and time to treatment was frequently longer than 60 minutes from arrival at the department.

# Urgent and emergency services

- The department had a high number (437) of ambulance black breaches between May 2017 and June 2018. Black breaches occur when a patient waits more than 60 minutes to be handed over to hospital staff.
- Changes were made to services without due regard for the impact on people's safety. There were inadequate plans in place to assess and manage risks associated with anticipated future events or emergency situations. Workforce planning had failed to take in to account changes to the local health economy and had underestimated the department's need for junior doctors and registered sick children's nurses (RSCNs).
- Records did not demonstrate action taken by staff to monitor and observe patients and records were not consistently completed fully. There were gaps in recording clinical information about patients such as allergies, pain scores and safety assessments.
- The department had reported a number of medication incidents in the past 12 months and there was no dedicated ED pharmacist.

However;

- The department was clean and tidy and met infection control standards.
- Equipment in the department was fully serviced and maintained in line with manufacturer guidance.
- Medicines were stored safely and appropriately, in line with local and national guidance.

## Is the service effective?

**Requires improvement** ● → ←

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

- Care and treatment did not always reflect current evidence-based guidance, standards and best practice. Implementation of evidence-based guidance was variable. Care assessments did not consider the full range of people's needs.
- Outcomes for people who used services were below expectations compared with similar services. Participation in external audits and benchmarking was limited and the department was not achieving RCEM audit standards. We identified this as an issue at our last comprehensive inspection in 2016.
- Not all staff had the right skills, knowledge and experience to do the job they were asked to do. Staff were not always supported to participate in training and development or the opportunities that were offered did not fully meet their needs. This was often because there was not enough staff in the department to release staff to attend training.
- There were gaps in management and support arrangements for staff, such as appraisal, supervision and professional development. We identified this as an issue at our last comprehensive inspection in 2016.
- Patients were not always offered food and drinks and pain scores were not consistently recorded or reassessed. At our comprehensive inspection in 2016, we identified recording of pain scores as inconsistent, therefore this was a recurring theme.
- We were not assured staff had attended consent training because it was not mandatory training as a separate module, but incorporated in safeguarding training, and compliance was low. Additionally, staff had not attended Mental Health Act training because nobody was eligible to do so, therefore we were not assured staff were up to date with their knowledge of how to manage such patients within the legal framework associated with the Act.

However;

# Urgent and emergency services

- Staff had the information they needed before providing care and treatment. Systems to manage and share care records and information were coordinated.
- Multi-disciplinary teams included all necessary staff, were coordinated and met frequently to provide effective care. Discharge and transfer planning considered all of the person's needs.
- Staff understood their responsibilities to patients in relation to the Mental Capacity Act, assessed capacity when appropriate and necessary and ensured patients were involved in discussions about their care and treatment.
- We observed the team work together effectively and efficiently to manage the department in a lockdown situation.

## Is the service caring?

**Requires improvement** ● ↓

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

- Although staff cared about patients and worked hard to meet their needs, due to staffing pressures, they acknowledged they could not always offer the level of care and support they wanted to.
- We saw, and some relatives told us, patients were sometimes ignored when they were calling out or buzzing for assistance. We saw this mostly happening when nursing staff were supporting other patients and were unable to leave them to assist someone else. However, we also witnessed senior staff ignore a patient shouting for support.
- Call buzzers were not always placed within reaching distance of patients meaning they could not always buzz for help.
- Feedback from people who used the service and those who were close to them was mixed. Some relatives told us they had not been informed about what was happening to their family member.

However:

- Staff were motivated to offer care that was kind and promoted people's dignity. People's privacy and confidentiality were respected during their treatment.
- Staff discussed care with patients in a way that they could understand. People's emotional and social needs were assessed by staff and included in their care and treatment.
- Staff mostly responded when people needed help and supported them to meet their personal needs although this was not always in a timely manner due to responsibilities with other patients.
- Staff helped people and those close to them to cope emotionally with their care and treatment.
- Most patients told us they received compassionate care and support for their emotional needs.

## Is the service responsive?

**Requires improvement** ● → ←

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

- We observed patients waiting more than 15 minutes for initial assessment and more than four hours to be discharged or admitted. Evidence showed the trust was not meeting national waiting time standards any month between August 2017 and July 2018. We observed targets not being met at our last inspection in 2016.



# Urgent and emergency services

- Flow through the department was a problem. Moving patients to beds on wards did not happen quickly and meant patients had long waits in the department from decision to admit to actual admission on a ward.
- Information sent by the trust showed the median time for arrival in the department to treatment was worse than the England average and the standard.
- The number of patients who left the department before being seen was worse than the England average.
- Services were planned in a way to meet the needs of the local population, however workforce planning had underestimated the impact of changes to the local health economy and this had impacted on the department's ability to meet the needs of patients in a timely manner.
- It was unclear from evidence provided by the trust what action was taken within the department because of complaints by patients.

However:

- The number of patients waiting more than four hours from decision to admit to admission was similar to the England average at 9% compared to 12%.
- The department had a dedicated room for relatives to spend private time with a family member when they had died and there was a dedicated relatives' room for the family to wait.
- There were some pathways in place for patients with specific conditions to ensure they did not have unnecessary waits before being seen. However, there was scope for the pathways to be expanded and strengthened.
- The care and treatment needs of patients were met with specialist equipment if needed, language support (although not always from professional interpreters), and there was support available for people of different faiths or none.
- Patients knew how to complain and staff knew how to deal with complaints they received. Complaints were investigated.

## Is the service well-led?

**Inadequate** ● ↓

Our rating of well-led went down. We rated it as inadequate because:

- After our focused inspection in July 2018 we wrote to the trust asking for information and evidence of how the department planned to address the concerns we had identified. When we received this information, we were not satisfied that the plans were sufficiently robust or effective.
- Governance arrangements were in place; however, they had failed to identify the significant safety concerns in the department relating to incidents and had not acted robustly to address concerns with sufficient urgency. Senior staff were not fully sighted on the risks to patient and staff safety in the department and these risks remained despite CQC identifying them and taking enforcement action.
- The department had a medium and long-term strategy but management had failed to address immediate safety concerns in the department. It had not acted quickly or robustly to previous enforcement action by CQC in July 2018 to manage day to day activity in the department.
- Staff were not aware of the vision of the department and there was minimal engagement with staff, people who used services or the public, for example, in the design or layout of the new department. Staff were informed rather than consulted with.

# Urgent and emergency services

- There were low levels of staff satisfaction, high levels of stress and work overload. Staff did not always feel respected, valued, supported and appreciated. There was poor collaboration or cooperation between the adult and paediatric teams within the ED.
- The culture was top-down and directive. It was not one of fairness, openness, transparency, challenge and candour. Some staff described a culture of favouritism or preferential treatment. When staff raised concerns, they were not always treated with respect or felt appropriate action was taken in response.
- There was a system for identifying, capturing and managing issues and risks at team, directorate and organisation level; however, the risk register we saw did not fully capture the risks we saw throughout the inspection.
- Significant issues that threatened the delivery of safe and effective care were not identified nor was adequate action taken to manage them.
- Leaders did not lead effectively and there was a disconnect between department leaders, directorate leaders and executive leaders within the trust. Senior and executive leaders did not appear to be sufficiently aware of what was happening on the front line in the department.
- Safety did not appear to be the top priority for leadership and senior leaders were not fully sighted on the lack of safety in some areas of the department.
- Although the department structure and provision had changed over the last three to four years with modelling sessions, perfect day events and simulation events taking place, the department could not always safely manage the patients who attended.
- The impact of service changes on the quality of care was not understood by staff or managers inside and out with the department.

However;

- The department had introduced an integrated IT system to present overarching information about the department. This was innovative and designed in house by a member of trust staff.
- In response to our inspection and subsequent enforcement action, the executive leadership of the trust, senior leadership team and management within the department had worked together to formulate and deliver an immediate short-term solution to our concerns. They had also formulated short, medium and long-term plans to meet the requirements of our enforcement notice.

## Areas for improvement

We found areas for improvement in this service. See the Areas for Improvement section above.

# Urgent and emergency services

Inadequate ● ↓

## Key facts and figures

The Urgent and Emergency Care Centre 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 (maxillofacial, 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.

## Summary of this service

Our rating of this service went down. We rated it as inadequate because:

- Patients were not always safe. There was a shortage of suitably skilled staff, particularly overnight. Not all staff had the right skills, knowledge and experience to do the job they were asked to do.
- We found evidence of times when there were insufficient staff on duty in the resuscitation and paediatric emergency departments to ensure patients were safe.
- Patients had long waits to be initially assessed by qualified and experienced staff, thus we found; evidence of delays to patients receiving treatment, harm and potential harm to patients due to delays and missed diagnoses.
- We found safeguarding processes were not fit for purpose. Staff did not show professional curiosity and we found evidence of patients, who were at risk of sexual exploitation or physical harm and should have been referred to safeguarding authorities, being missed. Safeguarding supervision did not take place regularly and involve all relevant staff.
- Deteriorating patients were not always escalated in a timely manner and clinical records did not provide evidence of escalation when patients deteriorated.
- Staff were not up to date with mandatory training and the list of mandatory training staff must attend was limited. Staff were not receiving appraisals in a timely manner and some staff felt disengaged and not listened to when they escalated concerns.
- The department had not taken part in all Royal College of Emergency Medicine (RCEM) audits and for those it participated in, was not achieving RCEM audit standards.
- The department was not meeting national standards such as patients being initially assessed within 15 minutes, ambulance handover within 15 minutes, time to initial treatment within 60 minutes or decision to admit or discharge within four hours. Patients had long waits in the department because flow through the department in to the rest of the hospital did not happen as the ED was often blocked due to lack of availability of beds on wards.
- The department was not well led. Although there were plans in place to improve future staffing levels, managers had failed to focus on the immediate safety concerns in the department despite concerns being raised by staff. This had left the department unsafe at times and staff under unacceptable pressure which was affecting their physical and mental health.

# Urgent and emergency services

- Staff generally felt disengaged. There was insufficient communication with staff and staff felt as though they were 'done to' rather than involved in changes within the department.
- There were continued historic concerns about the culture in the department with some staff talking of favouritism and preferential treatment of colleagues. Many staff felt there was a closed, defensive culture from some of the management and senior leadership team.
- Although governance arrangements were in place, they had failed to identify the significant safety concerns in the department and failed to ensure the departmental risk register accurately reflected the actual risks in the department. Significant issues that threatened the delivery of safe and effective care were not identified nor adequate action to manage them taken.
- Leaders did not lead effectively and there was a disconnect between department leaders, directorate leaders and executive leaders within the Trust. Senior and executive leaders did not appear to be sufficiently aware of what was happening on the front line in the department.

## Is the service safe?

**Inadequate** ● ↓

Our rating of safe went down. We rated it as inadequate because:

- Safety was not a sufficient priority in either the paediatric ED or the adult ED. There had been serious incidents resulting in patient harm due to delays in initial assessment or escalation.
- There were substantial and frequent staff shortages and poor management of agency or locum staff. Rota gaps were not always covered on both medical and nursing rotas. This increased risks to people who used services because there were not always sufficient staff, or staff did not always have the appropriate competencies to work in the area they were designated. We identified staffing levels as a concern at our last comprehensive inspection in 2016 and our focused inspection in July 2018.
- There was insufficient attention to safeguarding children and adults. Staff did not always recognise abuse and did not always demonstrate professional curiosity. When staff made safeguarding referrals, they did not always contain sufficient detail to enable other agencies to act to protect vulnerable people. This was due to staff not having time to spend on referrals because they were caring for sick patients.
- Most staff recognised concerns, incidents and near misses and reported them; however, there was still a culture of some medical staff not taking responsibility for incident reporting. This was also identified at our inspection in 2016.
- Senior staff had not correlated poor staffing levels with serious incidents and taken sufficient action to improve staffing levels to ensure there were sufficient experienced and skilled staff deployed to ensure the department was safe.
- Staff raised concerns; however, these were not recognised by senior staff and sufficient action was not taken. When concerns were raised or when things went wrong, the approach to reviewing and investigating causes was insufficient or too slow. There was little evidence of learning from events or action taken to improve safety, such as increasing staffing levels in the paediatric ED and provision of a dedicated doctor for the paediatric ED.
- Staff did not assess, monitor or manage risks to people who used the services in a timely manner. Opportunities to prevent or minimise harm were missed because patients had long waits for initial assessment and for treatment. Regularly, initial assessment did not happen within 15 minutes and time to treatment was frequently longer than 60 minutes from arrival at the department.

# Urgent and emergency services

- The department had a high number (437) of ambulance black breaches between May 2017 and June 2018. Black breaches occur when a patient waits more than 60 minutes to be handed over to hospital staff.
- Changes were made to services without due regard for the impact on people's safety. There were inadequate plans in place to assess and manage risks associated with anticipated future events or emergency situations. Workforce planning had failed to take in to account changes to the local health economy and had underestimated the department's need for junior doctors and registered sick children's nurses (RSCNs).
- Records did not demonstrate action taken by staff to monitor and observe patients and records were not consistently completed fully. There were gaps in recording clinical information about patients such as allergies, pain scores and safety assessments.
- The department had reported a number of medication incidents in the past 12 months and there was no dedicated ED pharmacist.

However;

- The department was clean and tidy and met infection control standards.
- Equipment in the department was fully serviced and maintained in line with manufacturer guidance.
- Medicines were stored safely and appropriately, in line with local and national guidance.

## Is the service effective?

**Requires improvement** ● → ←

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

- Care and treatment did not always reflect current evidence-based guidance, standards and best practice. Implementation of evidence-based guidance was variable. Care assessments did not consider the full range of people's needs.
- Outcomes for people who used services were below expectations compared with similar services. Participation in external audits and benchmarking was limited and the department was not achieving RCEM audit standards. We identified this as an issue at our last comprehensive inspection in 2016.
- Not all staff had the right skills, knowledge and experience to do the job they were asked to do. Staff were not always supported to participate in training and development or the opportunities that were offered did not fully meet their needs. This was often because there was not enough staff in the department to release staff to attend training.
- There were gaps in management and support arrangements for staff, such as appraisal, supervision and professional development. We identified this as an issue at our last comprehensive inspection in 2016.
- Patients were not always offered food and drinks and pain scores were not consistently recorded or reassessed. At our comprehensive inspection in 2016, we identified recording of pain scores as inconsistent, therefore this was a recurring theme.
- We were not assured staff had attended consent training because it was not mandatory training as a separate module, but incorporated in safeguarding training, and compliance was low. Additionally, staff had not attended Mental Health Act training because nobody was eligible to do so, therefore we were not assured staff were up to date with their knowledge of how to manage such patients within the legal framework associated with the Act.

However;

# Urgent and emergency services

- Staff had the information they needed before providing care and treatment. Systems to manage and share care records and information were coordinated.
- Multi-disciplinary teams included all necessary staff, were coordinated and met frequently to provide effective care. Discharge and transfer planning considered all of the person's needs.
- Staff understood their responsibilities to patients in relation to the Mental Capacity Act, assessed capacity when appropriate and necessary and ensured patients were involved in discussions about their care and treatment.
- We observed the team work together effectively and efficiently to manage the department in a lockdown situation.

## Is the service caring?

**Requires improvement** ● ↓

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

- Although staff cared about patients and worked hard to meet their needs, due to staffing pressures, they acknowledged they could not always offer the level of care and support they wanted to.
- We saw, and some relatives told us, patients were sometimes ignored when they were calling out or buzzing for assistance. We saw this mostly happening when nursing staff were supporting other patients and were unable to leave them to assist someone else. However, we also witnessed senior staff ignore a patient shouting for support.
- Call buzzers were not always placed within reaching distance of patients meaning they could not always buzz for help.
- Feedback from people who used the service and those who were close to them was mixed. Some relatives told us they had not been informed about what was happening to their family member.

However:

- Staff were motivated to offer care that was kind and promoted people's dignity. People's privacy and confidentiality were respected during their treatment.
- Staff discussed care with patients in a way that they could understand. People's emotional and social needs were assessed by staff and included in their care and treatment.
- Staff mostly responded when people needed help and supported them to meet their personal needs although this was not always in a timely manner due to responsibilities with other patients.
- Staff helped people and those close to them to cope emotionally with their care and treatment.
- Most patients told us they received compassionate care and support for their emotional needs.

## Is the service responsive?

**Requires improvement** ● → ←

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

- We observed patients waiting more than 15 minutes for initial assessment and more than four hours to be discharged or admitted. Evidence showed the trust was not meeting national waiting time standards any month between August 2017 and July 2018. We observed targets not being met at our last inspection in 2016.

# Urgent and emergency services

- Flow through the department was a problem. Moving patients to beds on wards did not happen quickly and meant patients had long waits in the department from decision to admit to actual admission on a ward.
- Information sent by the trust showed the median time for arrival in the department to treatment was worse than the England average and the standard.
- The number of patients who left the department before being seen was worse than the England average.
- Services were planned in a way to meet the needs of the local population, however workforce planning had underestimated the impact of changes to the local health economy and this had impacted on the department's ability to meet the needs of patients in a timely manner.
- It was unclear from evidence provided by the trust what action was taken within the department because of complaints by patients.

However:

- The number of patients waiting more than four hours from decision to admit to admission was similar to the England average at 9% compared to 12%.
- The department had a dedicated room for relatives to spend private time with a family member when they had died and there was a dedicated relatives' room for the family to wait.
- There were some pathways in place for patients with specific conditions to ensure they did not have unnecessary waits before being seen. However, there was scope for the pathways to be expanded and strengthened.
- The care and treatment needs of patients were met with specialist equipment if needed, language support (although not always from professional interpreters), and there was support available for people of different faiths or none.
- Patients knew how to complain and staff knew how to deal with complaints they received. Complaints were investigated.

## Is the service well-led?

**Inadequate** ● ↓

Our rating of well-led went down. We rated it as inadequate because:

- After our focused inspection in July 2018 we wrote to the trust asking for information and evidence of how the department planned to address the concerns we had identified. When we received this information, we were not satisfied that the plans were sufficiently robust or effective.
- Governance arrangements were in place; however, they had failed to identify the significant safety concerns in the department relating to incidents and had not acted robustly to address concerns with sufficient urgency. Senior staff were not fully sighted on the risks to patient and staff safety in the department and these risks remained despite CQC identifying them and taking enforcement action.
- The department had a medium and long-term strategy but management had failed to address immediate safety concerns in the department. It had not acted quickly or robustly to previous enforcement action by CQC in July 2018 to manage day to day activity in the department.
- Staff were not aware of the vision of the department and there was minimal engagement with staff, people who used services or the public, for example, in the design or layout of the new department. Staff were informed rather than consulted with.

# Urgent and emergency services

- There were low levels of staff satisfaction, high levels of stress and work overload. Staff did not always feel respected, valued, supported and appreciated. There was poor collaboration or cooperation between the adult and paediatric teams within the ED.
- The culture was top-down and directive. It was not one of fairness, openness, transparency, challenge and candour. Some staff described a culture of favouritism or preferential treatment. When staff raised concerns, they were not always treated with respect or felt appropriate action was taken in response.
- There was a system for identifying, capturing and managing issues and risks at team, directorate and organisation level; however, the risk register we saw did not fully capture the risks we saw throughout the inspection.
- Significant issues that threatened the delivery of safe and effective care were not identified nor was adequate action taken to manage them.
- Leaders did not lead effectively and there was a disconnect between department leaders, directorate leaders and executive leaders within the trust. Senior and executive leaders did not appear to be sufficiently aware of what was happening on the front line in the department.
- Safety did not appear to be the top priority for leadership and senior leaders were not fully sighted on the lack of safety in some areas of the department.
- Although the department structure and provision had changed over the last three to four years with modelling sessions, perfect day events and simulation events taking place, the department could not always safely manage the patients who attended.
- The impact of service changes on the quality of care was not understood by staff or managers inside and out with the department.

However;

- The department had introduced an integrated IT system to present overarching information about the department. This was innovative and designed in house by a member of trust staff.
- In response to our inspection and subsequent enforcement action, the executive leadership of the trust, senior leadership team and management within the department had worked together to formulate and deliver an immediate short-term solution to our concerns. They had also formulated short, medium and long-term plans to meet the requirements of our enforcement notice.

## Areas for improvement

We found areas for improvement in this service. See the Areas for Improvement section above.



# Medical care (including older people's care)

Requires improvement   

## Key facts and figures

The Rotherham NHS Foundation Trust provides medical care services including older people's care at the Rotherham General Hospital. Medical care services are managed within the Division of Integrated Medicine which includes urgent and emergency care and community services.

Medical care services provided include acute and emergency medicine, care of the elderly, gastroenterology, cardiology, respiratory medicine, dermatology, diabetes and endocrinology. There is a specialist stroke unit with hyper-acute stroke beds and dedicated oncology and haematology services. There are 215 medical inpatient beds.

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

During this inspection, we visited the acute medical unit (AMU), the coronary care unit (CCU) the stroke unit and medical wards A1, A2, A4, A5 and A7. We also visited the discharge lounge, the endoscopy unit, the cardiac catheterisation lab and the ambulatory care unit.

At the last inspection in September 2016, medical care at this hospital was rated overall as requires improvement. Safe and effective were rated as requires improvement, caring, responsive and well-led were rated as good.

We carried out a focussed unannounced inspection on 17 July 2018 because we identified concerns in relation to the management of patients on non-invasive ventilation (NIV). Following this inspection, we told the trust that they must improve the management, oversight and governance of the risks to acute NIV patients. The trust provided a detailed response which showed sufficient action had been taken to address immediate risks to patients receiving NIV. This included an action plan for future provision which would be compliant with the British Thoracic Society guidelines. Whilst the trust was working through the action plan, patients on acute NIV were cared for on the high dependency unit.

At this inspection we inspected all five domains.

Our inspection was unannounced (staff did not know we were coming) to enable us to observe routine activity.

Before the inspection, we reviewed the information about this service and information requested from the trust.

During the inspection visit, the inspection team spoke with 20 patients and relatives, and 40 staff including consultants, junior doctors, nurses, therapists, health care assistants, pharmacists, house keepers, administrative assistants and student nurses. We looked at 33 pieces of equipment and 43 patient records which included prescription charts.

## Summary of this service

Our rating of this service stayed the same. We rated it as requires improvement because:

# Medical care (including older people's care)

- Staffing shortages were still evident with low fill rates for registered nurses on most medical wards and gaps on the junior doctors' rota, which meant that medical wards were often below the minimum staffing level.
- Medicines were not always well managed. We found a high level of missed doses and gaps in medicines administration charts where staff had not signed or entered a code to indicate the reason a medicine had not been given.
- We found limited examples of staff engagement. Senior managers told us they wanted projects to be clinically led and would get staff involved in the early stages, however, we found examples where not all clinical staff were involved in plans for service changes.
- Staff told us the leadership team did not always listen and act when they raised concerns about patient safety.
- There was poor compliance with mandatory training and this was identified as an issue at our previous inspection. The trust set a target of 85% for completion of mandatory training and this target was not met in seven out of nine mandatory training modules.
- Not all staff received an annual appraisal with their line manager. The overall compliance rate for the division in August 2018 was 64.7% compared to the trust target of 90%.
- Although staff demonstrated a good understanding of the relevant consent and decision-making requirements of the Mental Capacity Act 2005, mental capacity assessment documentation was brief and did not always demonstrate the rationale behind the decision. Decisions made in a patient's best interest where a patient was deemed to lack capacity gave little detail of who made the decision or the options considered.
- There was no specific risk assessment tool to identify and manage risks associated with a patient's mental health to keep them safe. The documentation we saw did not reflect any specific assessment or intervention plan relating to patients' mental health and did not identify any subsequent risk management plans to address challenging behaviours.

However;

- Staff cared for patients with compassion. Feedback from patients confirmed that staff treated them well and with kindness. We saw that patients were treated with respect and their privacy and dignity was maintained.
- The division 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.
- The service managed flow through the hospital well. There were no extra capacity beds open at the time of our inspection and measures were in place to facilitate the timely discharge of patients back to their homes.
- 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.
- Staff with specialist skills and knowledge worked well together to provide effective patient care. Staff spoke positively about multidisciplinary team working and we observed good working relationships between professions.
- The service provided care and treatment based on national guidance and evidence of its effectiveness. There was an agreed procedure in place to ensure the service complied with national guidance.
- There were good mechanisms in place to report, feedback and learn from incidents.

# Medical care (including older people's care)

## Is the service safe?

**Requires improvement** ● → ←

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

- Medicines were not always well managed. We found a high level of missed doses and gaps in medicines administration charts where staff had not signed or entered a code to indicate the reason a medicine had not been given. Oxygen was not always prescribed and the monitoring of drugs fridge temperatures and checking of hypoboxes was poor and not consistent across medical wards.
- Nurse staffing levels were an ongoing issue, one which we identified at the previous inspection in 2016. There were a high number of registered nurse vacancies and fill rates were low on some medical wards. To minimise the risk to patient care, wards over allocated health care assistants and the trust had developed new roles within the unqualified nursing staff to bridge gaps in staffing.
- There was a shortage of junior doctors and a heavy reliance on bank and locum staff. Not all gaps could be filled on the junior doctors' rota and wards were often below the minimum level. 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.
- There was poor compliance with mandatory training and this was identified as an issue at our previous inspection. The trust set a target of 85% for completion of mandatory training. Information provided by the trust showed that the compliance rates for nursing and medical staff did not meet the target in seven out of nine mandatory training modules. Safeguarding training rates were also below target and staff did not receive any specific training on mental health.
- There was no specific risk assessment tool to identify and manage risks associated with a patient's mental health to keep them safe. The documentation we saw did not reflect any specific assessment or intervention plan relating to patients' mental health and did not identify any subsequent risk management plans to address challenging behaviours.

However;

- Staff 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.
- Staff were aware of the importance of incident reporting and how to report an incident using the electronic reporting system. There were good mechanisms to feedback and share learning from incidents with staff across the division. This included one to one feedback, safety huddles and briefings and staff meetings.

## Is the service effective?

**Good** ● ↑

Our rating of effective improved. We rated it as good because:

- The service provided care and treatment based on national guidance and evidence of its effectiveness. There was an agreed procedure in place to ensure the service complied with national guidance.

# Medical care (including older people's care)

- Patients we spoke with were happy with food choices and said the portion sizes were reasonable. Mealtimes were protected and we saw staff helped patients who needed assistance with their food and drink. Provision was made for patients requiring a specialised diet or for those who had cultural and other preferences.
- 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.
- 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.
- The trust had reasonable performance in national audits achieving a score of B in the Sentinel Stroke National Audit Programme (SSNAP) and results of the Lung Cancer Audit were as expected apart from patients seen by a cancer nurse specialist.
- Staff with specialist skills and knowledge worked well together to provide effective patient care. Staff spoke positively about multidisciplinary team working and we observed good working relationships between professions.
- The service managed pain relief well. Patients we spoke with had no concerns about how their pain was managed and staff checked with patients that pain relief administered had been effective.
- Staff we spoke with said they had opportunities to learn and develop in their roles. Newly qualified staff and students we spoke with said they had good support and opportunities to learn new skills.

However;

- 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%. The medicine performance dashboard for August 2018 showed that the overall compliance for the completion of appraisals was 64.7%.
- Although staff demonstrated a good understanding of the relevant consent and decision-making requirements of the Mental Capacity Act 2005, mental capacity assessment documentation was brief and did not always demonstrate the rationale behind the decision. Decisions made in a patient's best interest where a patient was deemed to lack capacity gave little detail of who made the decision or the options considered.

## Is the service caring?

Good   

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

- Staff cared for patients with compassion. Feedback from patients confirmed that staff treated them well and with kindness.
- We saw that patients were treated with respect and their privacy and dignity was maintained.
- 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 involved patients and those close to them in decisions about their care and treatment. Patients and relatives we spoke with told us they felt well informed by doctors and nursing staff about their condition, treatment options and plan of care.

# Medical care (including older people's care)

- Staff provided emotional support to patients to minimise their distress. Spiritual and pastoral support was available to patients from the hospital chaplaincy service.

## Is the service responsive?

**Good** ● → ←

Our rating of responsive stayed the same. We rated it as good because:

- 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) to develop shared resilience and sustainability of stroke and gastroenterology services.
- The service managed flow through the hospital well. There were no extra capacity beds open at the time of our inspection and measures were in place to facilitate the timely discharge of patients back to their homes. A new frailty team had been piloted in the acute medical unit and had proved successful in preventing unnecessary admissions and shortening length of stay.
- The management of medical outliers had improved since our last inspection. There were a small number of medical patients on non-medical wards and there were clear arrangements for ensuring medical outliers were seen daily by a relevant consultant or specialist registrar.
- 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 service treated concerns and complaints seriously. Complaints were investigated and lessons learned 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.

However;

- The trust took an average of 47 days to investigate and close complaints in medical care series. This was not in line with their complaints policy, which states complaints should be dealt with within 30 days if not of a complex nature.
- Staff told us there were sometimes delays in patients receiving their take-home medication and some patients came back to collect it later. 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.

## Is the service well-led?

**Requires improvement** ● ↓

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

- The divisional leadership team did not always listen to and take the concerns of staff seriously. Staff had raised concerns with managers about the safe care of patients on non-invasive ventilation on the respiratory ward but no immediate action had been taken. 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.

# Medical care (including older people's care)

- We found that although ward areas were well organised and tidy, there was a lack of consistency across medical wards in some areas. This included the safe checking of drugs fridges and hypo-boxes, the cleaning of commodes and the use of the senior nurse ward assurance tool.
- The division had identified their main risks to their services; however, the divisional risk register contained 178 risks. At the time of our inspection, there was no evidence to show that all risks on the risk register were regularly reviewed and updated. It was unclear what the criteria was for risks to be accepted onto the divisional risk register.
- We found limited examples of the staff engagement. 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 change in their services.
- Although the service had clear lines of reporting and new governance arrangements were in place for concerns to be escalated, staff told us that when they escalated concerns they were not always acted on. The new governance arrangements had been introduced in July 2018 and were still in the process of being embedded.

However;

- The division 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.
- 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.
- Information management systems were used effectively for 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.

## Areas for improvement

We found areas for improvement in this service. See the Areas for Improvement section above.

# Maternity

**Requires improvement** ●

## Key facts and figures

The Rotherham NHS Foundation Trust provides consultant-led maternity care and a midwifery-led unit at Rotherham General Hospital. This includes a day unit, antenatal and postnatal inpatient beds, maternity theatre, delivery suite with triage area, and a number of outpatient clinics on each site.

Services available include:

- Elective and emergency caesarean sections
- Epidural service
- Bereavement service
- Scanning, diabetic clinics and early pregnancy assessment clinics

Antenatal clinics are also undertaken in the community, which covers the city, small towns and rural areas around Rotherham.

The trust employed community midwives to care for women and their babies antenatally and postnatally.

Community midwifery services were provided by midwives employed by the trust.

The trust has 24 maternity beds with a delivery suite and Wharncliffe ward provided combined antenatal and postnatal care. The ward was laid out with four-bedded bays and some individual rooms. Delivery suite had 15 rooms, including four rooms set aside for midwifery led care and a bereavement suite. There was a triage area with three curtained cubicles close to delivery suite. There was also an antenatal clinic in the hospital.

There was one dedicated theatre in the maternity unit which was used for elective and emergency surgery. The main hospital day surgery theatre was used for elective caesarean section lists.

Between January 2017 and December 2017 there had been 2,666 babies delivered. In comparison with previous years, and in line with national figures, there had been a slight decline in the number of deliveries. The number of births varied throughout the year and this had been the trend in previous years.

The maternity service at Rotherham was previously inspected (jointly with gynaecology) in September 2016. All five domains were inspected and an overall rating of requires improvement was given. Safe and well led were rated as requires improvement, while effective, caring and responsive were rated as good.

We visited all inpatient areas of the maternity service. We spoke with five women, three partners, and three relatives, and 28 staff which included: midwives, midwife managers, matrons, doctors, consultants, senior managers and support staff. We observed care and treatment and looked at ten care records. We also reviewed the trust's performance data.

## Summary of this service

We previously inspected maternity jointly with gynaecology so we cannot compare our new ratings directly with previous ratings. We rated maternity as requires improvement because:

- Not all risks identified in meeting minutes had been escalated to the risk register.

# Maternity

Midwifery staffing was a cause for concern to staff on delivery suite and midwives were frequently brought from other areas to provide cover. Staff told us they had been advised not to incident report shortages in staffing and extra working when called in as part of escalation methods because nothing could be changed.

Midwives with clinical lead roles were regularly required to work clinically to make up numbers for qualified midwives and this meant they did not always complete specialist topics such as audits.

Although managers had produced a documented maternity strategy with the aim to adopt a community based continuity of caring model, not all staff felt fully engaged in the development of the strategy. Some staff were anxious about future plans and raised concerns that community teams were already stretched due to high caseloads and extra shifts in delivery suite.

There had been some instability in maternity leadership and differences in management styles had affected staff morale.

There was poor communication between delivery suite and postnatal ward teams and some women and partners gave negative feedback about their care during their stay on the postnatal ward.

There had been a reduction in specialist midwives, although staff told us the service had been remodelled to meet the needs of vulnerable women.

The induction of labour rate remained high, averaging at 32% compared to the current national guidance rate of less than 25%. Staff attributed this to high comorbidity rates and the reduction in caesarean sections. There were no clear plans to reduce this rate.

Antenatal clinics were over-booked especially in relation to diabetic clinics and they regularly ran late. There was no scanning consultant available at several clinics. The trust told us scanning was provided by the sonography team and scanning clinics were always available alongside all clinics. However, staff told us there were often very long waits.

Teams such as the ward and delivery suite appeared to work in isolation and this became apparent through patient comments about lack of communication, delayed discharges and information available to them.

As at our previous inspection, medical staffing mandatory training compliance rates remained low and most did not meet the trust target.

Although staff had a good understanding of safeguarding for vulnerable women and babies, training compliance for safeguarding children level three was below the trust target for all staff grades.

Although new staff were supernumerary and worked through a preceptorship package, midwives acting up in senior roles had no formal training or competency checks.

No staff groups met the trust appraisal rate target and some specialty trainees were dissatisfied with the level of clinical supervision they received.

- The trust's bed occupancy rate for maternity from February 2017 to June 2018 was 83%, compared to the England average of 58%. This could mean staff had more patients to care for on a regular basis.
- Home births were not being encouraged due to the continuing shortage of community midwifery staff regularly available on-call.
- Discharge delays from the postnatal ward were a concern for women, their families and staff. These were a regular occurrence and had been identified in patient feedback from the 2017 CQC maternity survey, the Royal College of Obstetricians and Gynaecologists (RCOG) clinical visit, and noted by senior staff but very few actions had been taken to address the problem.



# Maternity

- Patient information leaflets and guidance within them were out of date and printed information sheets were of poor quality.
- The service did not currently meet the National Guideline Alliance guidelines commissioned by the Royal College of Obstetricians and Gynaecologists with respect to smoking outcomes. They did not offer scanning to term where growth and fetal birth defects were monitored more frequently through the course of pregnancy. Some women had opted to have maternity care at a nearby Trust that could offer scanning to term.
- Records showed complaints were not dealt with within timeframes set down in trust policy. The average time taken to investigate and close complaints was 43 days when trust policy stated all complaints should be resolved within 30 days.
- There was no obvious display of learning activities or continuous professional development (CPD) events.
- Junior midwives 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, although there had been some clinical innovation.

## **However;**

Governance processes had improved. The service had a clear governance framework with staff assigned specific roles that ensured quality performance.

- The trust had implemented a process to review and investigate incidents and complaints. They reviewed maternal and neonatal deaths in regular formal meetings and completed action plans showing how and when learning had been identified to implement and support safe practice.
- At our last inspection we told the trust they must ensure staff have access to safeguarding supervision and support. At this inspection there was evidence of safeguarding support in case reviews and supervision was recorded electronically for all caseload holding midwives.
- All staff completed skills training and emergency drills.

All equipment on the delivery suite had undergone checks and calibration to ensure it was safe and suitable for use.

Patient records were legible, detailed, signed, and safely stored.

Staff used the World Health Organisation (WHO) safety checklist, modified for maternity.

We saw evidence the unit used the 'fresh eyes' approach to review fetal heart tracings.

Medicines were stored safely and securely and prescription records had been completed to a high standard.

- The rates for elective and emergency caesarean sections were similar to or better than the England average.
- At our last inspection we noted there was no clear information governance process in place but at this inspection it had improved.
- We asked the trust to review information systems to ensure they were fit for purpose and we found staff had access to sufficient and up to date information through the trust intranet.
- The trust continued to improve mandatory training compliance for midwives and met most trust targets.
- Midwifery and medical staff worked together ensuring women received care which met their needs and we saw a range of examples of multidisciplinary team working.

# Maternity

- The trust's most recent maternity Friends and Family test performance was similar to or better than the England average.
- Risks to patient safety, staffing and the environment had been identified and recorded on the risk register. Staff followed the risk assessment process and actions were recorded and risks closed appropriately.
- There was a good level of emotional and mental health support. A bereavement midwife worked to support women and families and women with a suspected mental health illness were cared for in partnership with the perinatal mental health team.
- The service provided specialist clinics including a gestational diabetic clinic and an anaesthetist specialist clinic to reduce patient risks caused by obesity in pregnancy.

Staff were open and honest and we saw examples where duty of candour had been used.

- An Afterthoughts service provided women with a means to give verbal feedback on their experiences and ask questions about their clinical care.
- Staff had been trained to carry out New Infant Physical Examinations (NIPE) in clinics on the postnatal ward or the community, thus reducing length of stay and increasing bed capacity on the postnatal ward.
- Teams had implemented the use of balloon catheters to improve women's experience during induction of labour and Acupins to prevent sickness during pregnancy.

## Is the service safe?

**Good** 

We rated safe as good because:

- In relation to incidents, improvements had been made since the last inspection where we found a backlog of incidents for review. 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. Incidents were reviewed every week in a formal multidisciplinary team meeting.
- We had previously found some equipment was not suitable for use on the delivery suite. At this inspection we found this had improved and equipment had been tested and calibrated.
- There had been some concerns about information governance. At this inspection we found there was a clear information governance process in place.
- All staff, including community midwives and medical staff, completed skills training and emergency drills including birthing pool evacuation and obstetric emergencies.
- The trust had policies, systems and processes in place to protect children and adults from neglect or abuse. Staff had a good understanding of safeguarding for vulnerable women and babies.
- The service had a stable consultant cohort with 10 substantive posts and one long term locum.
- Staff understood and carried out their responsibilities to report safety incidents. There was evidence of shared learning following incidents.
- The environment and equipment was visibly clean and regularly maintained, and systems and processes were in place to control infection and promote hygiene.

# Maternity

- During normal weekday working hours the theatres team provided scrub nurses of surgery for obstetrics cases in theatres. Midwives continued to provide this role at night and weekends.
- Patient records showed staff used appropriate systems to assess the health and wellbeing of women. Staff used the World Health Organisation (WHO) safety checklist, modified for maternity, for all interventional procedures and review of records showed these had been completed correctly.
- We saw evidence the unit used the 'fresh eyes' approach, a system that required two members of staff to review fetal heart tracings.
- We reviewed six sets of records and found them to be legible, detailed, signed, and safely stored.
- Medicines were stored safely and securely and prescription records had been completed to a high standard.
- Handovers on delivery suite were attended by the multidisciplinary team and staff provided comprehensive information for colleagues.
- The rate of safeguarding supervision had previously been low and community midwives had reported a lack of support. At this inspection there was evidence of safeguarding support in case reviews and supervision was recorded electronically for all caseload holding midwives.
- Mandatory training compliance had previously been below the trust target for some modules. At this inspection midwifery staff exceeded the 85% completion rate for most mandatory training modules.

However;

Although the service had very few midwife vacancies, most shifts on delivery suite ran with one midwife short, especially at night. Staff found this difficult to manage and midwives were frequently brought from other areas to provide cover.

Staff provided one to one care in labour for 78% of women, although senior midwives believed they included elective caesarean sections in this data and the actual rate was 100%.

As at our previous inspection, medical staffing mandatory training compliance rates remained low and most did not meet the trust target.

Training compliance for safeguarding level three was below the trust target for those required to be trained to that level.

There was poor communication between delivery suite and postnatal ward teams.

## Is the service effective?

**Good** 

We rated effective as good because:

- At this inspection the trust had made improvements by carrying out reviews of clinical outcomes including maternal and neonatal deaths in regular formal meetings. They completed action plans showing how and when learning had been identified to implement and support safe practice.
- The service carried out case reviews in monthly mortality and morbidity meetings.
- The trust monitored outcomes and most findings, including the rates for elective and emergency caesarean sections, were similar to or better than the England average.
- Maternity guidelines, policies and procedures we viewed were reviewed on time and information within them was up to date and correct.

# Maternity

- The service had an annual audit programme and actions from audits were discussed and monitored at governance meetings.
- New staff were supernumerary and worked through a preceptorship package. Staff reported this provided a clear plan for their development.
- Midwifery and medical staff worked together ensuring women received care which met their needs and we saw a range of examples of multidisciplinary team working.
- There was a practice development midwife in post and a consultant who took the lead for education of medical staff.
- Staff training, including simulation training and emergency drills was multidisciplinary and the team offered training to other departments who may treat pregnant women such as in urgent and emergency care.
- Staff had been trained to carry out New Infant Physical Examinations (NIPE) in clinics on the postnatal ward or the community, thus reducing length of stay and increasing bed capacity on the postnatal ward.
- Staff were offered opportunities to develop and work alongside midwives in a more senior role but staff felt this lacked formal training or development checks.
- Junior doctors felt well supported and able to approach senior colleagues for advice.
- The service had very good links with the perinatal mental health team who could provide assessment and treatment as necessary.
- Staff knew the importance of gaining consent before any procedure and consent was evidenced in care records.

However;

- The induction of labour rate remained high, averaging at 32% compared to the current national guidance rate of less than 25%. Staff attributed this to high comorbidity rates and the reduction in caesarean sections. There were no clear plans to reduce this rate.
- Women and staff told us the service was not always able to offer pain relief in a timely way although anaesthetist response times within 30 minutes for epidural analgesia were 100%.
- No staff groups met the trust appraisal rate target and some specialty trainees were dissatisfied with the level of clinical supervision they received.

## Is the service caring?

**Good** 

We rated caring as good because:

- From June 2017 to June 2018 the trust's maternity Friends and Family test performance was similar to or better than the England average.
- Staff interacted with women and their relatives in a polite, friendly and respectful way. There were arrangements to ensure privacy and dignity in clinical areas.
- There was a good level of emotional support, particularly for women who had experienced the loss of a baby. A bereavement midwife worked to support women and families and provided a link to the hospital bereavement team. There was a clear bereavement policy in place.

# Maternity

- Women were involved in their choice of birth at booking and throughout the antenatal period. Midwives supported women to make birth choices and produced birth plans to reflect them.
- 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.
- An Afterthoughts service provided women with a means to give verbal feedback on their experiences and ask questions about their clinical care, especially following a complex birth.
- Women were involved in making decisions about their care.

However:

- Some women and partners we spoke with gave negative feedback about their care, staff attitude and lack of communication between teams during their stay on the postnatal ward.

## Is the service responsive?

**Requires improvement** 

We rated responsive as requires improvement because:

- Although vulnerable women were supported by a specialist community midwife, only 15 hours per week were dedicated to this role. There had been a reduction in specialist midwives, although staff told us the service had been remodelled to meet the needs of vulnerable women.
- The trust's bed occupancy rate for maternity from February 2017 to June 2018 was generally higher than the England average, with the trust having approximately 83% occupancy. This could mean staff had more patients to care for on a regular basis.
- Home births were not being encouraged due to the continuing shortage of community midwifery staff regularly available on-call.
- Discharge delays from the postnatal ward were a concern for women, their families and staff. This had been identified in the latest CQC maternity survey and noted by senior staff but no actions had been taken to address the problem.
- Women experienced long waits for take home medicines before being discharged. Although pharmacists came to support the ward and health care assistants collected some medicines, this was all on an ad hoc basis.
- Antenatal clinics were over booked especially in relation to diabetic clinics and there was no scanning consultant available at several clinics.
- Women told us antenatal clinics regularly ran late, sometimes up to four hours, but the service did not record waiting times within clinics.
- Patient information leaflets and guidance within them on the delivery unit and in clinics were out of date. Printed information sheets given to women were of very poor quality, having been photocopied many times and some diagrams were too faint to be seen clearly.
- The service did not currently meet the National Guideline Alliance guidelines commissioned by the Royal College of Obstetricians and Gynaecologists with respect to smoking outcomes. They did not offer growth scanning to term, but fetal birth defects were monitored more frequently through the course of pregnancy. Staff told us they believed some women had opted for care elsewhere because of this.

# Maternity

- Records showed the average time to investigate and close complaints was 43 days, outside trust policy which stated all complaints should be resolved within 30 days. Themes from complaints involved poor staff communication with women, having access to a water tower on Wharncliffe ward, and over booked antenatal clinics, especially in relation to diabetic clinics.

However:

- Staff had access to specialist mental health support and expertise. This included referrals to the perinatal mental health team.
- Mental health specific post-natal and ante natal clinics were held in the community hubs, led by a consultant obstetrician with a special interest in mental health.
- The service provided specialist clinics including a gestational diabetic clinic and an anaesthetist specialist clinic to reduce patient risks caused by obesity in pregnancy.
- The service provided balloon catheter inductions, a non-pharmaceutical method for induction of labour which enabled women to return home until labour was established. This also provided more capacity on the antenatal ward.
- Services were accessible for women. Patients could attend triage or telephone the department with concerns or issues with their pregnancy. They could self-refer, or through their GP, or the emergency department.

## Is the service well-led?

**Requires improvement** ●

We rated well-led as requires improvement because:

Midwives with clinical lead roles were regularly required to work clinically to make up numbers for qualified midwives and this meant they did not always complete specialist topics such as audits.

Staff told us they had been advised not to incident report shortages in staffing and extra working when called in as part of escalation methods because nothing could be changed.

Although managers had produced a documented maternity strategy with the aim to adopt a community based continuity of caring model, not all staff felt fully engaged in the development of the strategy. Some staff were anxious about future plans and raised concerns that community teams were already stretched due to high caseloads and extra shifts in delivery suite.

There had been some instability in maternity leadership and differences in management styles had affected staff morale.

Results from the CQC maternity survey in 2017 had raised some cause for concern regarding discharge delays but no action had been taken to change this. Women and staff reported discharge delays from the postnatal ward throughout our inspection and staff said this was a regular occurrence.

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.

Staff gave mixed reviews about professional progression and those acting up in Band 7 midwifery roles had no formal training. There was no obvious display of learning activities or continuous professional development (CPD) events.

# Maternity

Junior midwives 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, although there had been some clinical innovation.

However:

Staff reported positive aspects of culture within the department and felt supported within their own teams.

- The service had a clear governance framework with staff assigned specific roles that ensured quality performance.

Governance processes had improved. For example, formal weekly incident meetings were held where medical and midwifery staff met to discuss individual incidents and cases.

Staff were open and honest and we saw examples where duty of candour had been used in response to complaints.

- The senior leadership team met regularly in different forums to discuss issues of quality, finance and governance.

Staff sought feedback and opinions of those who used the service. Friends and family cards were distributed around the unit.

- Staff had implemented balloon catheter inductions which had shown a range of benefits including improved access and flow for antenatal patients, reduction in pharmaceutical inductions, and initial findings showed better clinical outcomes at delivery.
- The obstetrics team had developed the use of Acupins by using them for women suffering from hyperemesis gravidarum (serious and prolonged nausea and sickness in pregnancy). Staff reported a reduction in antenatal admissions for hyperemesis since their introduction.

## Areas for improvement

We found areas for improvement in this service. See the Areas for Improvement section above.

# Services for children and young people

Good  

## Key facts and figures

Children's services at Rotherham General Hospital include a children's outpatient department; a 10-bedded children's assessment unit (CAU), where children are referred from a general practitioner (GP), the hospital emergency department, midwives and from other professional agencies; and a 12-bedded children's ward, for children requiring admission to stay for longer than 24. The service has two high dependency care beds and is located on the children's ward.

Children and young people are admitted up to the age of 16 years onto the children's ward and CAU. Young people aged between 16 and 18 years are offered a choice of being cared for on an adult ward. Wherever possible, this is based on the clinical need of the patient.

When a child is admitted, depending on their medical needs, they are cared for within that speciality. These include paediatrics, general and specialist surgery, orthopaedics, maxillofacial, and ear, nose and throat. Elective day case surgery cases are cared for on the children's ward.

The special care baby unit (SCBU) has 14 cots. The service is commissioned for two intensive care cots, two high dependency, and 10 special care cots. Admissions come to the unit via labour ward, the emergency department, midwives, re-admission, and babies born in other hospital units who need ongoing care. The children's service works closely with the Embrace transport team and Network.

At our last inspection, we rated the service overall as requires improvement. Safe, caring and responsive were rated as good, and effective and well-led required improvement.

During our inspection, we visited the children's service and spoke with three children, 12 parents/carers, and 47 members of staff. This included matrons, departmental managers, nurses, care staff, medical staff and administration staff. We observed care and treatment, looked at seven patient records and medicines charts. We also interviewed key members of staff, medical staff and the senior management team who were responsible for the leadership and oversight of the service.

## Summary of this service

Our overall rating of this service improved. We rated it as good because:

- We rated safe, effective, caring, responsive and well-led as good.
- The children's service had a strategy to provide outstanding care provision for children, young people and their families.
- They had a governance structure and managers shared information with staff who were aware of the risks of the organisation, and the actions taken to address or mitigate the risks.
- Staff spoke positively about the leadership across the service. They told us the culture had improved since we visited in 2016; there was an open culture where staff were encouraged to raise concerns.
- The service had taken appropriate action in response to most of the issues identified at the previous inspection. Policies and procedures were in date and complied with relevant standards and guidance.



# Services for children and young people

- Staff protected children and young people from avoidable harm and abuse. There were systems and processes to safeguard children and young people.
- The proportion of consultant staff reported to be working at the trust was higher than the England average in May 2018, and the proportion of junior (foundation year 1-2) staff was the same. The sickness rate was below the trust target and there were no vacancies.
- Qualified nursing staff reported the staffing levels had improved since our inspection in 2016. The nursing and care staff fill rates on the special care baby unit, paediatric assessment unit and ward exceeded or were just slightly below the planned levels.
- The wards, clinics and departments were clean. Staff managed medicines safely and the quality of healthcare records was good.
- Audit data showed most patient outcomes were the same as other trusts, or better than expected.
- Families were positive about the service they received. They described staff as being caring, compassionate, understanding and supportive.
- Effective multidisciplinary team working practices were in place, and joint medical and nursing records were kept in providing the continuity of patient care. Medical and nursing staff worked closely together and with other allied healthcare professionals such as dieticians, health visitors and GPs.
- Face to face interpreters were available, and leaflets were available in languages other than English.

However;

- Not all staff received face to face safeguarding level three training in line with the intercollegiate document, Safeguarding Children and Young People.
- The percentage of staff qualified in specialty in the special care baby unit was not in line with the British Association of Perinatal Medicine (BAPM) standards and the nurse in charge was not supernumerary.
- Not all staff were up to date with the advanced paediatric life support training.
- Complaints were not all closed in line with the timescales of the trust complaints policy.
- The refrigerator temperatures in the high dependency room were not always recorded.
- Staff had limited knowledge of the Mental Capacity Act.

## Is the service safe?

Good   

Our rating of safe stayed the same. We rated it as good because:

- Staff understood their responsibilities with regards to safeguarding children and young people. They 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 were trained to deliver safeguarding supervision, and staff had access to weekly group safeguarding supervision.

# Services for children and young people

- Staff had mandatory training which included subjects such as infection control, information governance, and equality and diversity. They were compliant for five out of eight courses and on trajectory to meet compliance by the end of the financial year.
- Staff were encouraged to report incidents and systems were in place following investigation to help disseminate learning. Learning days were identified to aid further learning. This was to ensure all staff learnt from incidents and complaints and where the existing methods of communication were not as effective.
- There were effective systems in place to monitor infection control. All areas we visited were clutter free and visibly clean.
- Staff knew how to recognise sepsis. They 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.
- In the dental surgery day unit, procedures were in place to contact the children's ward when they needed a registered children's nurse or play specialist.
- The paediatric assessment unit and ward used the paediatric acuity and nurse dependency assessment (PANDA) tool to work out staffing requirements. In March and June 2018, the staffing fill rates exceeded the planned numbers; staff reported staffing levels were safe.
- In the special care baby unit, staff monitored and reported daily staffing levels. In June 2018, the unit exceeded its staffing fill rate for both nursing and care staff, and in July, exceeded the levels for care staff and fell slightly short for qualified staffing (98.4%).
- The trust was part of the Yorkshire and Humber neonatal network and worked in collaboration with the other units in the network to provide safe care for babies and families.

However:

- Medical and nursing staff were not all receiving face to face safeguarding level three training in line with the intercollegiate document, Safeguarding Children and Young People.
- In 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.
- In the SCBU, the nurse in charge was not supernumerary in line with the British Association of Perinatal Medicine Standard, August 2010.
- In the children's ward high dependency room, daily recordings of the medicines refrigerator temperature checks were not always taking place. There was no record of the action staff took, should the temperature record not be within the recommended temperature.

## Is the service effective?

Good ● ↑

Our rating of effective improved. We rated it as good because:

- Care and treatment was planned and delivered in line with current evidence based guidance. Staff had access to up to date policies and guidance.

# Services for children and young people

- Transition to adult services was patient centred. This helped ensure they were cared for where best met their emotional and physical needs.
- 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 and young people were offered a choice of meals that were age appropriate and supported individual dietary needs. Dieticians offered advice, visited patients with weight loss, those needing a specialised diet, and followed up the patients when they were discharged from the ward in a dietician outpatient clinic.
- Children's services participated in national clinical audits to monitor and improve patient outcomes. In the 2017 National Neonatal Audit, the trust performed similar to other trusts, or better than expected.
- Child friendly pain assessment tools were used and pain relief given in a way that met the needs of the infant or child.
- Most staff had an up to date appraisal and this was confirmed by managers and their staff.
- There were specialist nurses for specific conditions, such as diabetes and asthma, and they held training days for staff.
- 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. Medical and nursing staff told us relationships with each other was good.
- Staff attended study days for mental health conditions provided by the child and adolescent mental health service (CAMHS) liaison nurse. These included training such as eating disorders. Staff had also attended a transgender study day.

However:

- Staff had limited knowledge of the Mental Capacity Act (MCA) and were unsure of what action they would take if they felt a parent did not have the capacity to consent.
- Not all staff were up to date with the advanced paediatric life support training (APLS). There was not a member of staff trained in APLS on duty on each shift and therefore not in line with current guidance.

## Is the service caring?

Good   

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

- People were supported and treated with dignity and their religious needs were respected. The clinic time of the rapid access clinic was changed to accommodate prayer time.
- Patient's privacy was respected. Curtains were used around beds when providing personal care and treatment.
- Staff introduced themselves by name, explained what they were doing and offered reassurance and support to children, young people and families.
- Staff used distraction techniques in response to children's physical discomfort or emotional distress.

# Services for children and young people

## Is the service responsive?

Good   

Our rating of responsive stayed the same. We rated it as good because:

- The children's ward received input into the design of the ward from a team of young people.
- There were facilities available for parents to stay overnight with their children.
- The neonatal unit had a viewing area, where family members that were not allowed onto the unit could see the babies.
- The service met the play and educational needs of the children and young people.
- Leaflets were available in languages other than English and interpreter services were available.
- A child and adolescent mental health service (CAMHS) liaison nurse was available to support the staff and young people.
- Consultant saw the child or young person within 14 hours of admission in line with current guidance.

## Is the service well-led?

Good  

Our rating of well-led improved. We rated it as good because:

- There were clear lines of management and accountability across the service at all levels.
- The children's service had a two-year strategy to provide outstanding care provision to all children, young people and their families
- There was a governance structure in place to ensure information was escalated to the trust board and from the board to ward level. Ward and department managers held meetings to share information with their staff.
- There were processes in place to monitor clinical governance and risk management. Managers were aware of the risks of the organisation. Actions were in place to help mitigate the risks and with timescales.
- Staff spoke positively about the leadership of the service. They felt supported and could raise issues or concerns.
- The information accessed by managers and staff was stored in line with data security standards.
- A user involvement working group had been set up covering both the acute and community children's services. This helped to ensure there was user involvement to help service improvement
- Annual awards were held in recognition of staff achievements.

## Areas for improvement

We found areas for improvement in this service. See the Areas for Improvement section above.

# Community health services

## Background to community health services

Community health services at the Rotherham NHS Foundation Trust consist of:

- Community health services for children, young people and families consists of a 0-19 team (health visiting, health promotion and school nursing), children's community nursing team, a child development centre, paediatric therapists, looked after children's team, a short break service and an integrated sexual health service.
- Community health services for adults are based at Rotherham Community Health Centre and include community nursing services, primary ear care, continence advisory service, heart nurses, physiotherapy, podiatry and speech and language therapy.
- Community dental care is provided at Rotherham Community Health Centre, the Flying Scotsman Centre and Barnsley Community Dental Centre.
- Community inpatient services are provided at the Oakwood Community Unit, which consists of step-up and step-down beds, discharge to assess beds, and neuro rehabilitation beds; and Breathing Space, which provides pulmonary rehabilitation for adult patients with Chronic Obstructive Pulmonary Disease (COPD).
- Community end of life care is provided by the community nursing team.

## Summary of community health services

### Requires improvement

We did not give an overall rating to community health services at our previous inspection. At this inspection, we rated them as requires improvement, because:

- We rated community health services for children, young people and families as requires improvement at this inspection.
- At our previous inspection, we rated community health services for adults and community end of life services as requires improvement.

However;

- At our last inspection, we rated community inpatient services for adults and community dental services as good.

# Community health services for children and young people

Requires improvement   

## Key facts and figures

Community health services for children and young people included a 0-19 team (health visiting, health promotion and school nursing), children's community nursing team, a child development centre, paediatric therapists (physiotherapists, occupational therapists, speech and language therapists), looked after children's team, a short break service and an integrated sexual health service.

At our last inspection the service was rated as requires improvement. Safe, effective, responsive and well led were rated as requires improvement. Caring was rated as good.

At this inspection, we inspected all five domains.

The service was given a short notice period of our inspection to allow for visits to be planned.

During the inspection we visited several 0-19 teams, the short break service, the child development centre, therapists, the children's community nursing team, the integrated sexual health service and the looked after team. We also spoke with practitioners in the multi-agency safeguarding hub (MASH).

We spoke with 60 members of staff and three parents, we observed care in clinics, the child development centre and on home visits. We reviewed patient records and policies and guidance.

## Summary of this service

Our rating of this service stayed the same. We rated it as requires improvement because:

- At our last inspection we rated safe, effective, responsive and well led as requires improvement. Caring was rated as good.
- At this inspection we rated safe, effective and well led as requires improvement. Caring and responsive were rated as good.
- Practitioners in the 0-19 service were holding high caseloads. There was a risk that records were not contemporaneous as high workloads meant that some practitioners were not completing their records in a timely manner. These issues had also been identified at our last inspection.
- There was no oversight of safeguarding referrals and in the sexual health service there were no safeguarding alerts on the electronic patient record. This meant that children and young people's records may not be complete and staff may not be immediately aware of a vulnerable child.
- The 0-19 service were failing to meet some of their performance targets. Antenatal contacts, six to eight week contacts and health screening at school entry were all below target. This had been a concern at our last inspection.
- There was a limited number of audits in place and there was no audit plan.
- There was no process in place for regular clinical supervision and staff had varying experiences of receiving clinical supervision. This had been identified at our last inspection.
- Looked after children were not receiving initial health needs assessments in a timely manner.

# Community health services for children and young people

- There had been a slow pace of change since moving to a 0-19 team and changes were not fully embedded. Staff were still working as separate health visiting and school nursing teams. Several changes in the management team meant that changes had not been driven forward. The service was moving to skill mix teams and competencies were written for the different staff bands, however, at the time of our inspection these competencies were not yet in place.

However;

- The new service leads were aware of the challenges to the service and there was a work plan in place for 2018/2019. The work plan incorporated workstreams including audit and clinical supervision. The service was working closely with the clinical commissioning group and the local authority to plan and deliver services.
- Staff were kind and caring. Their focus was on supporting children, young people and their families. There was effective multidisciplinary working, both internally and externally.
- New services, such as the paediatric acute rapid response outreach team (PARROT) had been set up to support unwell children in the home and avoid hospital admissions.
- The service had a vision and strategy and there were governance systems in place.
- The service provided care based on evidence based guidance and staff had access to up to date policies and guidance.
- Learning from incidents and complaints were shared at staff meetings. Presentations from the meetings were shared with staff. Service leads were attempting to engage with staff to keep them up to date with service development.

## Is the service safe?

**Requires improvement** ● → ←

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

- Practitioners in the 0-19 service were holding high caseloads. Health visitor caseloads exceeded the recommendations from the Institute of Health Visiting, which recommends an average of one health visitor to 250 children. School nurses were responsible for two secondary schools and were carrying high numbers of safeguarding cases. Our previous inspection had also highlighted concerns with staffing and caseloads.
- There was no oversight of safeguarding referrals and no process for quality assurance or a mechanism for regular audit. Safeguarding referrals were not attached to the child's records, this meant the child's record was incomplete.
- There were no safeguarding alerts entered on to the electronic patient record in the sexual health service. This meant that staff were not immediately aware when accessing the records that there was a vulnerable young person.
- Safeguarding level three training was not compliant with intercollegiate guidance as there was not the required multi-disciplinary and inter-agency training.
- There was a risk that records were not contemporaneous. We were given examples of practitioners not completing their electronic records until up to two weeks after the contact with the child. The risk of records not been contemporaneous had also been identified at our last inspection.
- At our last inspection, staff had a limited understanding of duty of candour. We found the same at this inspection as staff understood the need to be open and honest with families, but they spoke about this in relation to complaints rather than incidents.

However;

# Community health services for children and young people

- Service leads were looking at competencies and skill mix across the 0-19 pathway, a pilot was in the process of being rolled out to see the allocation of work to dedicated teams for routine and targeted work to appropriately allocate and manage caseloads.
- Mandatory training and safeguarding training compliance was above the trust target for the majority of subjects.
- Staff managed medicines consistently and safely.

## Is the service effective?

**Requires improvement** ● → ←

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

- At our last inspection, we identified that the health visiting and school nursing services were failing to meet several performance targets. At this inspection, we found that the 0-19 service were still failing to meet some performance targets, specifically for antenatal contacts, six to eight week contacts and health screening at school entry. This had been identified as a problem by the service leads and a work plan was in place to try to improve performance.
- The percentage of mothers receiving a maternal mood review by the time their child was eight weeks old was 57.6% for the year to date. This is not in line with the healthy child programme, which says that all mothers should have an assessment of their mental health at six to eight weeks.
- At our last inspection, there were limited examples of regular or robust audit or outcome monitoring in place. At this inspection, we found that there were limited audits and there was not a regular audit plan in place, although this was being developed. There had been three audits carried out in 2018.
- There was no process in place for regular clinical supervision. This had also been identified at our last inspection. This had been recognised in the work plan and a workstream added to introduce clinical supervision.
- Practitioners gave advice and support related to health eating, smoking cessation, oral and dental health and safe sleep. However, due to high caseloads, there was limited opportunity to deliver school drop in sessions.
- The looked after children (LAC) service was not meeting the statutory initial health needs assessment target of assessments being completed within 20 working days from the date of becoming looked after. This was also identified as an issue at our last inspection. Service leads were working with commissioners and the local authority on ways to improve this.

However;

- Children and young people's care was delivered in line with evidence based guidelines. Staff had access to up to date policies.
- There was evidence of good multidisciplinary working and competencies had been written for skill mix teams. Health care assistants in the children's community nursing team completed competencies and undertook basic life support and tracheostomy life support training.
- Staff understood their responsibilities with regards to consent.

## Is the service caring?

**Good** ● → ←



# Community health services for children and young people

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

- Children, young people and their families were treated with kindness and compassion.
- Staff communicated and provided information in a way that young people and parents could understand.
- Young people and parents were involved in their care. Staff allowed time for questions to be asked.
- Friends and family test responses were positive and feedback we received from parents described staff as caring and supportive.

## Is the service responsive?

**Good** ● ↑

Our rating of responsive improved. We rated it as good because:

- Services were planned to meet people's needs in discussion with the clinical commissioning group and local authority. The paediatric acute rapid response outreach team supported unwell children in the home with the aim of reducing or preventing hospital admissions.
- Services met the needs of children and young people in vulnerable circumstances or with complex needs. The complex care team provided care at home and a short break service. There were systems in place to identify those young people that presented with drug or alcohol related problems so that they could be followed up.
- The waiting times for paediatric therapies and the child development centre were good. There had been a big decrease in the waiting times for the child development centre over the last year.
- Learning from complaints was shared with staff and staff were aware how to deal with complaints.

## Is the service well-led?

**Requires improvement** ● → ←

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

- There had been several changes in leadership and this had been an unsettling time for staff. There were still issues identified as concerns at our last inspection, that were identified as issues of concern again, such as limited audits and failure to meet performance targets. The pace of change to a fully embedded 0-19 service had been slow.
- Staff morale was low in some areas. Staff in therapy services were unhappy about a proposed restructure and felt unsupported. Staff in the 0-19 service felt that heavy caseloads were affecting morale.
- Staff were carrying high caseloads. Processes were not yet embedded for the allocation of caseloads using an acuity tool or caseload management system, although service leads told us they were accessing a caseload profiling tool to ensure appropriate allocation of caseloads.
- The service had no audit plan in place for the year and clinical supervision was not in place for staff. Although there was a workplan which had identified these as areas for improvement, these were issues that had been identified at our last inspection.

However;

# Community health services for children and young people

- There was a new leadership team in place. Leaders understood what the challenges were for the service and were acting to address them, although nothing had been fully embedded at the time of our inspection. Leaders were visible and approachable. Staff felt that there had been positive changes since the appointment of new staff members.
- At our last inspection there was no clear vision or strategy. At this inspection, we saw that there was a clear vision and strategy. The service had provided a 'strategy on a page' to give to practitioners so that they were aware of the service strategy.
- There was a risk register in place that was regularly reviewed at governance meetings. At our last inspection, the register was not reviewed regularly. There was an effective governance structure in place. Service leads engaged with external partners, such as the clinical commissioning group and the local authority, to improve services.

## Areas for improvement

We found areas for improvement in this service. See the Areas for Improvement section above.

This section is primarily information for the provider

## Requirement notices

### Action we have told the provider to take

The table below shows the legal requirements that the service provider was not meeting. The provider must send CQC a report that says what action it is going to take to meet these requirements.

For more information on things the provider must improve, see the Areas for improvement section above.

**Please note:** Regulatory action relating to primary medical services and adult social care services we inspected appears in the separate reports on individual services (available on our website [www.cqc.org.uk](http://www.cqc.org.uk))

**This guidance** (see [goo.gl/Y1dLhz](http://goo.gl/Y1dLhz)) describes how providers and managers can meet the regulations. These include the fundamental standards – the standards below which care must never fall.

#### Regulated activity

Treatment of disease, disorder or injury

#### Regulation

Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment

#### Regulated activity

Treatment of disease, disorder or injury

#### Regulation

Regulation 13 HSCA (RA) Regulations 2014 Safeguarding service users from abuse and improper treatment

#### Regulated activity

Treatment of disease, disorder or injury

#### Regulation

Regulation 17 HSCA (RA) Regulations 2014 Good governance

#### Regulated activity

Treatment of disease, disorder or injury

#### Regulation

Regulation 18 HSCA (RA) Regulations 2014 Staffing

This section is primarily information for the provider

## Enforcement actions

We took enforcement action because the quality of healthcare required significant improvement.

# Our inspection team

Sarah Dronsfield, Head of Hospital Inspection, led this inspection. An executive reviewer, Deborah Needham supported our inspection of well-led for the trust overall.

The team included ten inspectors, one inspection manager, three assistant inspectors, two further executive reviewers, one national professional advisor and nine specialist advisers.

Executive reviewers are senior healthcare managers who support our inspections of the leadership of trusts. Specialist advisers are experts in their field who we do not directly employ.