We are the regulator: Our job is to check whether hospitals, care homes and care services are meeting essential standards.

The Rotherham NHS Foundation Trust

Moorgate Road, Oakwood, Rotherham, S60 2UD

Date of Inspection: 06 June 2013
05 June 2013

Tel: 01709820000

Date of Publication: June 2013

We inspected the following standards as part of a routine inspection. This is what we found:

- Consent to care and treatment: Met this standard
- Care and welfare of people who use services: Met this standard
- Cleanliness and infection control: Met this standard
- Requirements relating to workers: Met this standard
- Supporting workers: Met this standard
- Assessing and monitoring the quality of service provision: Met this standard
### Details about this location

<table>
<thead>
<tr>
<th>Registered Provider</th>
<th>The Rotherham NHS Foundation Trust</th>
</tr>
</thead>
<tbody>
<tr>
<td>Overview of the service</td>
<td>The Rotherham NHS Foundation Trust is a large acute hospital situated just 2 miles south of Rotherham town centre. They provide a wide range of health services for the people of Rotherham.</td>
</tr>
<tr>
<td>Type of services</td>
<td>Acute services with overnight beds</td>
</tr>
<tr>
<td></td>
<td>Blood and Transplant service</td>
</tr>
<tr>
<td></td>
<td>Community healthcare service</td>
</tr>
<tr>
<td></td>
<td>Diagnostic and/or screening service</td>
</tr>
<tr>
<td></td>
<td>Long term conditions services</td>
</tr>
<tr>
<td></td>
<td>Remote clinical advice service</td>
</tr>
<tr>
<td></td>
<td>Rehabilitation services</td>
</tr>
<tr>
<td>Regulated activities</td>
<td>Assessment or medical treatment for persons detained under the Mental Health Act 1983</td>
</tr>
<tr>
<td></td>
<td>Diagnostic and screening procedures</td>
</tr>
<tr>
<td></td>
<td>Family planning</td>
</tr>
<tr>
<td></td>
<td>Management of supply of blood and blood derived products</td>
</tr>
<tr>
<td></td>
<td>Maternity and midwifery services</td>
</tr>
<tr>
<td></td>
<td>Surgical procedures</td>
</tr>
<tr>
<td></td>
<td>Termination of pregnancies</td>
</tr>
<tr>
<td></td>
<td>Transport services, triage and medical advice provided remotely</td>
</tr>
<tr>
<td></td>
<td>Treatment of disease, disorder or injury</td>
</tr>
</tbody>
</table>
When you read this report, you may find it useful to read the sections towards the back called ‘About CQC inspections’ and ‘How we define our judgements’.

### Summary of this inspection:

<table>
<thead>
<tr>
<th>Why we carried out this inspection</th>
<th>4</th>
</tr>
</thead>
<tbody>
<tr>
<td>How we carried out this inspection</td>
<td>4</td>
</tr>
<tr>
<td>What people told us and what we found</td>
<td>4</td>
</tr>
<tr>
<td>More information about the provider</td>
<td>5</td>
</tr>
</tbody>
</table>

### Our judgements for each standard inspected:

<table>
<thead>
<tr>
<th>Consent to care and treatment</th>
<th>6</th>
</tr>
</thead>
<tbody>
<tr>
<td>Care and welfare of people who use services</td>
<td>8</td>
</tr>
<tr>
<td>Cleanliness and infection control</td>
<td>11</td>
</tr>
<tr>
<td>Requirements relating to workers</td>
<td>14</td>
</tr>
<tr>
<td>Supporting workers</td>
<td>16</td>
</tr>
<tr>
<td>Assessing and monitoring the quality of service provision</td>
<td>18</td>
</tr>
</tbody>
</table>

### About CQC Inspections

<table>
<thead>
<tr>
<th>How we define our judgements</th>
<th>22</th>
</tr>
</thead>
<tbody>
<tr>
<td>Glossary of terms we use in this report</td>
<td>24</td>
</tr>
<tr>
<td>Contact us</td>
<td>26</td>
</tr>
</tbody>
</table>
Summary of this inspection

Why we carried out this inspection

This was a routine inspection to check that essential standards of quality and safety referred to on the front page were being met. We sometimes describe this as a scheduled inspection.

This was an unannounced inspection.

How we carried out this inspection

We looked at the personal care or treatment records of people who use the service, carried out a visit on 5 June 2013 and 6 June 2013, observed how people were being cared for and checked how people were cared for at each stage of their treatment and care. We talked with people who use the service, talked with carers and / or family members, talked with staff and reviewed information given to us by the provider. We talked with local groups of people in the community or voluntary sector and were accompanied by a specialist advisor.

We were supported on this inspection by an expert-by-experience. This is a person who has personal experience of using or caring for someone who uses this type of care service.

What people told us and what we found

At this inspection we were able to speak with 50 patients and some of their relatives, in total over the two days. This was to ensure we captured the views and experiences of patients who used the service. We also spoke with over 40 staff ranging from care assistants, ward staff, matrons, junior doctors, clinical and medical directors and board members, to assess how they were supported and involved in the trust.

We visited maternity wards, accident and emergency department and admissions wards (B1, B2, B5) over the two days of this visit. We also looked at how the trust managed infection prevention and control. We looked at the way the trust developed policies and procedures and made decisions about how the trust was run and how they communicate with patients, staff and other key stakeholders. We refer to this as governance in the report.

Patient’s who we spoke with on the maternity wards were all positive about the care and treatment they had received. They said they were well informed about the risk and benefits of treatment, they felt their choices and birth plans were respected by staff. Others said their experience had been very good; there were no concerns about staffing on the days of the visit. Women confirmed staff attended to them quickly.

Patients in accident and emergency and on the admissions wards said they were satisfied with the care and treatment they had received since arriving at the hospital. They said they had been kept informed about their treatment and had been asked for permission before being examined by the staff. Some of the patients said they wouldn’t want to come anywhere else to be treated. One patient said “I’ll tell you what this place is. It’s the best place in the world, they’ve (doctors and nurses) just been simply fantastic.”

Staff we spoke with told us the hospital was a good trust to work for and they felt confident the care and treatment provided to patients was good. Staff told us they would be happy for a friend or relative to be cared for at the trust. Staff told us there was good leadership and
Inspection Report
The Rotherham NHS Foundation Trust
June 2013

support. Medical staff were supportive and approachable. There was an open and honest culture where concerns could be raised and staff felt these would be acted upon.

There were effective systems in place to reduce the risk and spread of infection. Patients said "The hospital is always clean." Staff were seen to maintain hand hygiene at all times. We found there were robust infection control systems and equipment in place to minimise the risks of patients acquiring an infection.

Patients received treatment from suitably qualified, skilled and experienced staff. Appropriate checks had been undertaken before staff began work. We found there were robust systems and procedures in place for professional registration and qualification checks that ensured staff were ‘fit’ to continue to practise.

The trust had processes in place to monitor patients’ views about the care and treatment offered. Patients told us they had never had cause to complain about the treatment they had received. We found the trust had effective systems in place to monitor the quality of service that patients received.

You can see our judgements on the front page of this report.

More information about the provider

Please see our website www.cqc.org.uk for more information, including our most recent judgements against the essential standards. You can contact us using the telephone number on the back of the report if you have additional questions.

There is a glossary at the back of this report which has definitions for words and phrases we use in the report.
Our judgements for each standard inspected

Consent to care and treatment

Before people are given any examination, care, treatment or support, they should be asked if they agree to it

Our judgement

The provider was meeting this standard.

Before patients received any care or treatment they were asked for their consent and the provider acted in accordance with their wishes. Where patients did not have the capacity to consent, the provider acted in accordance with legal requirements.

Reasons for our judgement

Maternity

Before patients received any care or treatment they were asked for their consent and the provider acted in accordance with their wishes. We found there was a variety of written information available for women at each stage of their pregnancy, birth and post natal period. This included an explanation of the risks, benefits and alternative options prior to procedures being carried out. The provider also had access to interpreter services if required.

We spoke with eight women who confirmed they had received sufficient information to make an informed decision about their care and treatment. They also told us staff had given them enough time to think about their consent decisions and enabled them to ask any questions they had. One woman told us, “Everything was well explained, the midwife took on board what I wanted.” Another woman told us, “I’ve received good information; the midwives have informed me all the way through my pregnancy.”

Staff we spoke with were knowledgeable about the process for seeking verbal and written consent. For example, written consent was obtained for surgical procedures such as caesarean sections and verbal consent for intimate examinations. This was consistent with consent guidelines.

Accident and Emergency and Admissions Wards

All of the patients we spoke (eighteen) with, both in A&E and on ward B1 told us they had been asked to agree to any examination, care, treatment or support they had received. Comments included: “They (the member of staff examining them) asked do you mind if you take your top off?”, “Do you mind if I take your blood pressure?” and “I was asked for my permission (by the nurse) to put a cannula in.”
Staff told us that consent to care and treatment was mostly obtained verbally as there were very few procedures which people signed a consent form for in A&E. One example given to us where consent was obtained was the procedure for manipulation of a dislocated shoulder.

On ward B1 we saw staff asked patient’s permission before helping them with their lunchtime meal. We saw they asked if patients would like any help with cutting up their food and asked them if they’d like to wear some protection over their clothing. Where patient’s said they would like some help, this was provided in a caring manner. The wishes of those people who did not wish to be helped were respected by the staff.

With their consent, we observed a patient having an ECG (Electrocardiograph) taken by a nurse. We saw the nurse explained what was happening to the patient throughout the process and provided them with reassurance. The patient’s identity was checked prior to the ECG being done. The patient was also asked by the nurse at each stage of the process for their agreement to continue. This meant the patient was actively involved in their care and treatment.

On ward B2 one patient we spoke with said “I signed the consent form once I was on the ward. I hardly had to ask any questions, they told me everything I needed to know,” and “I understood everything, staff explained everything.”

We spoke with staff in A&E and admissions wards B1, and B2 about how patients were asked for their permission to be examined or treated. They told us they introduced themselves to the patient first and asked if it was acceptable to examine them. If a patient’s first language wasn’t English, they told us they either used colleagues in the department or had access to a ‘language line’. This was a telephone service that used interpreters to enable people to understand their treatment choices.

We spoke with staff about consent to care if a patient was unconscious. They told us they would act in the best interests of the patient at the time. They also said that if time permitted they would try to talk with relatives or carers about what would be in a patient’s best interest.

The matron within A&E also said where it was uncertain if people had capacity to consent, they carried out capacity assessments in line with the Mental Capacity Act 2005 (MCA). These meant processes were in place to gain consent from patients.

The matron had a good understanding of the MCA and its practical application in A&E. Other staff we spoke with had less understanding of the MCA. The trust may find it useful to note that some staff may not have been able to fully support patient’s to make decisions and choices about their care and treatment if they did not understand the MCA.

The three records we saw on ward B2 were detailed and it was very clear from talking to patients that they understood what care and treatment they had received and were about to receive. We noted this was the same as staff had recorded in the patients’ notes. We saw that two patients who were awaiting orthopaedic surgery had signed their consent forms and the appropriate place for surgery had been marked on their body.
Care and welfare of people who use services  

Met this standard

People should get safe and appropriate care that meets their needs and supports their rights

Our judgement

The provider was meeting this standard.

Patients experienced care, treatment and support that met their needs and protected their rights.

Reasons for our judgement

Maternity

We spoke with eight women in the ante natal clinic and post natal ward. They all spoke positively about the care and treatment they had received. Some of the comments included, “It’s been brilliant. The midwife stayed with me, respected my birth plan and explained everything.” “Excellent care, good experience.” “Labour ward was fantastic looked after us both” and “Midwives were a great support. I was fully informed of why my baby went to special care, it’s been excellent.”

Care and treatment was planned and delivered in a way that was intended to ensure people’s safety and welfare. We looked at care records on the delivery and post natal wards. The records contained a clear pathway of care which described what women should expect at each stage of their pregnancy. The records showed women were given guidance and referred to other professionals where required.

We saw where women were identified as high risk they were referred for consultant led care in a timely way. The provider had a birth afterthoughts service for women who had experienced complications in previous pregnancies. This was a midwife led clinic for women to discuss any concerns.

We found specialist midwives were available to provide additional support for women. This included areas such as teenage pregnancies, screening, substance misuse and sexual abuse. Staff told us the team was expanding to include further specialist clinics including hypertension. This ensured patient’s needs were being met in the unit and local community.

We found the provider had a clear care pathway for early pregnancy loss. The unit had a specialist midwife trained to support bereaved families. There were appropriate facilities which included counselling for families following bereavement. This ensured care and support was provided in a dignified way.

We found women received good support for infant feeding. One woman told us, “The midwife has given me tips and supported me with breastfeeding; it’s been excellent and put my mind at rest.” All the women we spoke with said they had a good experience with
midwives helping them with skin to skin contact with their baby immediately at birth. Staff told us the unit had achieved level one UNICEF baby friendly accreditation and was working towards level two. The baby friendly initiative is a worldwide programme of the World Health Organisation and UNICEF. It encourages maternity units to support women in breastfeeding.

There were arrangements in place to deal with foreseeable emergencies. The records we looked at showed risk assessments were in place. This ensured early recognition, treatment and referral of women who, had or were developing, a critical illness during or after pregnancy.

Staff told us they had access to 24 hour anaesthetic cover. There was a rota to provide a theatre team for obstetrics 24 hours a day. Intensive care was also accessible for maternity admissions if required. We spoke with a consultant obstetrician. They told us the unit currently provided 60 hours of consultant presence on the labour ward. This was in line with national guidance. Women we spoke with expressed no concerns about the number of staff available. They told us they had received care in a timely way.

Staff we spoke with told us there were verbal handovers to the on-coming team at the change of each shift. They confirmed communication between medical and midwifery staff was very good. Midwives reported they were able to escalate concerns when required. Staff used a communication tool that clarified what and how clinical information should be communicated during patient transfer. The records we saw contained a handover transfer form. There were clear guidelines in place for the transfer of women who required emergency care.

We found care and treatment reflected relevant research and guidance. The unit had various evidence based guidelines and protocols for the care and treatment of women during pregnancy. Staff confirmed they received updates on new and revised guidelines. This ensured women received care which was conducted in line with nationally recommended practice.

**Accident and Emergency and Admissions Wards**

Patient’s needs were assessed and care and treatment was planned and delivered in line with their individual care plan.

The patients we spoke with were able to describe the care and treatment they had received since arriving at the hospital. They described being initially assessed and having things such a blood pressure and blood sugar measured. They told us they had been sent for x-rays when this had been deemed necessary to establish the severity of their injuries. We spoke with one patient who showed us a leaflet they’d been given prior to being discharged titled “Advice to patients following a head injury.” Everybody we spoke with said they felt they’d been kept informed by the staff about the treatment they received or were due to receive.

Patients we spoke with on B1 said, “It’s been brilliant, the staff are superb, all the way down the line.” “They (the staff) keep you informed.” “I can’t fault this place.” “I refuse to go anywhere but here now.” “It (A&E) seems to have changed a lot. Things get done now.” “The treatment has been very good, right through.” “I can’t find any faults whatsoever.” “They (the staff) have called me by my first name. I prefer that, it’s friendlier.” “Patients we spoke with on B2 said, “I was in a bay almost straight away in A&E. The care and treatment was very good. I got a sandwich at 9pm once they knew they were not going to operate until morning.” “I was offered pain relief almost straight away and I’ve had more since.”
Staff and patient interactions were seen to be positive in nature and encouraging. This reflected the comments patients had made to us. This included when people were being assessed, when staff dealt with people’s questions and when people were helped with their meal on ward B1. Staff we spoke with were aware of people’s needs and could describe to us how people had progressed since arrival at A&E or on the ward.

The care records we looked at were detailed and comprehensive. Relevant assessments had been completed for people. Where people had been transferred from other departments, their records had come with them. Records showed people were assessed on arrival at A&E and again when they arrived on ward B1. Assessments showed where people’s needs had changed, this was noted and the care provided reflected this. Assessments included nutritional screening tools, moving and handling; falls risk assessments and pressure ulcer prevention screening tools. Detailed records were present to show the involvement of medical staff. Where tests had been requested the results of the tests were present within the records. This meant care and treatment was planned and delivered in a way that was intended to ensure people’s safety and welfare.

The care we observed in A&E was good. The matron was very dedicated and compassionate. We observed a strong team spirit and staff told us they worked well as a team. They also said they had a very good leader who motivated the team. All patients we spoke with were very complimentary about the care they received in A&E.

In the minor treatment waiting area there was a TV providing information about waiting times and information on common ailments. There were also health education leaflets and posters as well as supporting information and aftercare for common accidents and incidents such as sprained ankles, nose bleeds and stitches. Information was also available explaining how the A&E department worked and who the staff were. Some information was available in languages other than English.

We spoke with ambulance staff who told us there were effective systems in place so they were able to safely transfer the care of a patient to A&E and that communication within the A&E department was good. The staff were approachable and helpful and normally they did not have to wait long to transfer a patient, the longest wait stated was 15-20 minutes, but this was rare.

We visited ward B2 which was an orthopaedic ward to follow up patients that had been admitted via A&E. We spoke with three patients and looked at three care records. These were all to a standard format and included what drugs the patients were taking, clinical observations, care bundles for example intravenous (IV) therapy, mental capacity assessment if required, nutritional screening, falls assessment, pressure area assessments, moving and handling requirements and any social services involvement. This information helped to ensure that staff were able to provide the appropriate care and treatment for people and that their wishes were respected.
Cleanliness and infection control

People should be cared for in a clean environment and protected from the risk of infection

Our judgement

The provider was meeting this standard.

Patients were protected from the risk of infection because appropriate guidance had been followed. Patients were cared for in a clean, hygienic environment.

Reasons for our judgement

There were effective systems in place to reduce the risk and spread of infection.

During our visit we spoke at length with the trust’s lead managers involved in infection prevention and control. This included the Director of Infection Prevention and Control (DIPC) and their deputy. The DIPC was also the lead Consultant Medical Microbiologist at the trust and the deputy DIPC was the lead infection prevention and control nurse. We also spoke with the intravenous (IV) nurse consultant responsible for the phlebotomy team and a phlebotomist about their roles in infection prevention and the Director of Estates and Facilities and their deputy, regarding waste management systems.

In the three clinical areas we visited we observed facilities and practices in place for infection prevention and control. We found there were robust systems and equipment in place to minimise the risks of patients acquiring an infection. There was also clearly visible infection prevention and control signage on display in all areas, including the public entrances to the hospital. All the areas we visited where people were being cared for were visibly clean and free from excessive clutter; this made cleaning easier and more effective.

We saw that personal protective equipment, such as aprons and gloves, was available next to every wash hand basin. We observed cleaning staff regularly cleaning the environment, including bed spaces and mattresses. We saw clinical wash hand basins were readily available in all clinical areas for staff to use and hand gel was available at the point of care. We observed clinical staff washed their hands between patients and all three patients we spoke with on the medical admissions unit confirmed they had observed that staff always washed their hands before examining them. We observed all staff followed the trust bare below the elbows policy and we saw evidence of audits of compliance with this initiative.

We saw the clinical areas had side rooms for isolating patients that may present an infection risk; these were being used appropriately. There was clear signage on display advising staff and relatives of the precautions required. Signs were colour coded according to the infection risk identified; for example there were separate signs for Clostridium difficile, blood-borne viruses and MRSA. There were plans in place for unexpected increases in the numbers of patients needing isolation facilities, which the deputy DIPC explained to us. This was confirmed by other staff we spoke with and the infection prevention and control policies we
looked at. Rooms and areas that had been occupied by patients needing isolation were decontaminated prior to re-use.

We visited the microbiology laboratory during our visit. The microbiology service was accredited with Clinical Pathology Accreditation and worked jointly with the microbiology service at Barnsley hospital. This ensured patients at both hospitals received a streamlined and consistent microbiology service. We spoke with the microbiology laboratory manager who told us they were planning to formalise this joint working arrangement so that laboratory staff at both hospitals could work at either site in future.

When we asked staff in the clinical areas about the turnaround time of test requests sent to the laboratories they all told us the laboratory service was excellent; most blood test results were available within two hours and urgent requests within one hour. We asked the deputy DIPC / infection control lead nurse about MRSA screening. They told us MRSA results were transmitted to them from the laboratory on a continuous basis, and the infection prevention and control team checked the system throughout the day. The deputy DIPC told us the infection prevention and control team visited most wards every morning; this was confirmed by the staff we spoke with in the clinical areas.

The microbiology laboratory manager told us the laboratory used a molecular MRSA method for urgent MRSA screens and samples from MRSA outbreak situations; this test ensured rapid results were available to the clinical and infection prevention and control teams. Routine MRSA requests took 18 hours and results were read in the laboratory twice a day. This ensured the MRSA status of patients was available as quickly as possible.

During our visit we attended an infection control committee meeting and saw that appropriate actions were being taken to continually improve infection prevention and control within the hospital and the community. From the information discussed at this meeting, and our discussions with the other staff involved in IPC at the hospital, we were assured that there was a robust infection control assurance framework in place. We were also shown examples of infection prevention and control documentation and information.

This information included infection control policies and procedures, infection control audits, evidence of mandatory training of staff in infection prevention, monthly and annual reports. At the time of our visit infection prevention and control policies and procedures were being updated to include the joint work with the local community. We also looked at examples of monthly reports to the Trust Board from the DIPC. For example cases of MRSA bacteraemia, Clostridium difficile diarrhoea and Central Line Associated Blood Stream Infection (CLABSI) were reported. Blood culture contamination rates were also monitored on a monthly basis.

The hospital had various initiatives in place for improving infection prevention and control in the hospital and community. These included: monitoring Visual Infusion Phlebitis (VIP) scores; patients with intravenous lines in were monitored every day for signs of infection. Intravenous antibiotics or fluids administered in the community; this released beds in the hospital and decreased the risk of patients acquiring an infection.

Monitoring and eradicating MRSA in patients in the community; for example patients in nursing homes or in their own homes. Treating patients colonised with MRSA in the community reduced the risks of infection with MRSA.

Catheter monitoring and management in patients going between the hospital and the community to ensure they received consistency of catheter care.
The DIPC produced an annual infection prevention and control report and, at the time of our visit, this document was awaiting approval. We discussed with the DIPC that the copy of this document on the trust’s website was a year out of date (2010-2011). They assured us this would be updated on the website.

Accident and Emergency and Admissions Wards

We looked around the A&E department and in a number of bays on ward B1. We found these areas were clean, tidy and well maintained. Hand gel dispensers were mounted on the walls throughout A&E and on the ward. Staff were seen to use these frequently. The staff we spoke with demonstrated an awareness of infection control and the precautions they needed to take in their roles. One member of staff within A&E told us responsibility was shared by all staff for maintaining a clean environment. This meant staff were acting to control the spread of infections.

We spoke with two doctors on duty about infection control. They told us that as part of the emergency medicine teaching programme in A&E there was a seminar on sepsis in June 2013. One doctor told us about a recent training session in A&E with a consultant microbiologist about septic control and another session on taking blood cultures and minimising infection. There had also been a recent simulation training session in A&E covering what to do if there was a patient who was acutely septic.

The patients we spoke with all said they were satisfied with the cleanliness of the areas of the hospital they had accessed. Patients said, “No problem, it (A&E) is clean. I always check trolleys and trays”. “It’s clean in here (A&E).” “The place is very clean. There was lots of hand washing in A&E. Ward staff wear gloves.” “The cleanliness was marvellous.”
Requirements relating to workers

Met this standard

People should be cared for by staff who are properly qualified and able to do their job

Our judgement

The provider was meeting this standard.

Patients were cared for, or supported by, suitably qualified, skilled and experienced staff.

Reasons for our judgement

There were effective recruitment and selection processes in place. Appropriate checks had been undertaken before new staff began work. We checked the personnel files for five staff including a consultant, a sister, two staff nurses and a care assistant. Each file included evidence that the provider carried out background checks on staff before they commenced work.

We saw evidence that Disclosure and Barring Service (DBS) checks were undertaken for all staff before they commenced work. The Criminal Records Bureau (CRB) and the Independent Safeguarding Authority (ISA) have merged into the Disclosure and Barring Service (DBS). CRB checks are now called DBS checks. We also found evidence of registration to appropriate professional bodies such as the General Medical Council (GMC), and the Nursing and Midwifery Council (NMC). We were told the trust had clear processes in place if staff were to lapse their professional registration requirements. We looked at the policy which demonstrated the action they would take. This included steps to prevent the lapse in registration and ensuring the staff member was not allowed to undertake their duties as a qualified clinician if this happened. The trust would also down band (for example a nurse would be down graded to a care assistant) the staff member with immediate effect until they re-registered. They would closely supervise and monitor the work undertaken until their renewal was received.

The trust told us that all staff had undertaken a thorough corporate induction programme. The programme looked at the trusts values and beliefs. It also covered attitudes and approaches which were expected by the trust as an employee. We spoke with a new care assistant and junior doctor who confirmed the induction process. They said the training was detailed and enabled them to carry out the duties. Following the corporate induction staff undertook an in-depth induction which was specific to their roles. The competency programme involved a more rigorous assessment which required line managers to mentor the staff member. Staff were not confirmed in post until the provider was satisfied that they were competent to undertake their position within the trust.

We were told that junior doctors completed a six day induction programme prior to commencement of work and this involved attendance at the trusts ‘simulation suite’ where they would be involved in practical training such as scenarios of common situations they may face in real practice. They were also expected to undertake a number of hours
computer based training (e-learning) which the trust expected to be completed within their first month of employment. A junior doctor said “The team works very well and I have been able to share my knowledge. I feel very supported.” Additionally the matron said nurses always had at least six months experience of working in an acute setting prior to being appointed to A&E. This was confirmed when we spoke with a staff nurse who had been recently appointed to the department.

Staff told us that in addition to induction there was regular training covering other topics such as device training, for example intravenous pumps and electro cardiograph (ECG) training.

A staff member said, “Training is brilliant from the consultants, I feel really well supported”.
Supporting workers

Staff should be properly trained and supervised, and have the chance to develop and improve their skills

Our judgement

The provider was meeting this standard.

Patients were cared for by staff who were supported to deliver care and treatment safely and to an appropriate standard.

Reasons for our judgement

Maternity

Staff received appropriate professional development. We spoke with the local supervising authority midwifery officer. They shared with us a recent audit which included some recommendations to improve supervisions. We discussed this with the Head of Midwifery who told us an action plan was in place and improvements had been made. We spoke with two student midwives who reported they felt well supported and had spend 100 per cent of shifts with their named mentor. This was in line with Nursing and Midwifery Council (NMC) standards.

We saw evidence that there was a system in place to ensure staff kept up to date with mandatory training. This included skills and drills study days and clinical updates. Staff confirmed they had received basic life support skills and neonatal resuscitation. Training was also provided in areas such as child protection, safeguarding vulnerable adults and equality and diversity.

We spoke with a junior doctor. They told us they received good support from senior doctors. They said they had regular reviews of their practice which assessed their clinical competencies. We also spoke with the clinical director for obstetrics who confirmed they had completed yearly appraisals for consultant medical staff.

Accident and Emergency and Admissions wards

Patients were cared for by staff who were supported to deliver care and treatment safely and to an appropriate standard.

All of the patients we spoke with said they were very happy with the staff they had been treated by during their time in hospital. Patients said “Nice male care assistant, he knew what he was doing “The staff are very caring; they tell you what’s going on all the time.” “The staff have been great, it’s been very good.” “We have a laugh with everybody.” “There’s always been someone around. That’s very reassuring.” “The staff have been quite nice.”
The staff we spoke with said they felt very supported in their roles by their colleagues and line management. One nurse told us they had completed some supervised training on the morning of our inspection. The nurse said “I think they (the provider) are helping me to progress.”

The staff also said there was always a senior member of staff around if they required advice or assistance. They also added that senior staff were always accessible and happy to discuss anything at anytime. One member of staff said “I've never had support like I've had in accident and emergency. It's been amazing.”

Staff also said they were supported with regular staff meetings, training, supervision and appraisal. One staff member said “We have regular staff meetings where we can express our views. If you cannot attend they print the minutes off. I have read the minutes. We learn lessons”.

All of the staff we spoke with said they believed there were sufficient staff on duty at all times. Our observations during the course of the inspection suggested that on these two days, that was the case. We saw people were attended to in a timely manner.

The matron told us the A&E department was fully staffed. Five extra staff had recently been recruited to cover maternity leave. Staffing was a mix of registered nurses, emergency nurse practitioners (nurses with extended skills for working in A & E), health care assistants and emergency department assistants (Who were trained to take bloods, position emergency cannulas, plastering for fractured bones and other specific skills).

We noted from the trust’s performance report that A&E was traffic lighted red for high levels of sickness. We spoke with the matron and business manager about this. We were told there were protocols in place to manage sickness. If a staff member was off work for more than two weeks their manager would hold a review and possibly refer to occupational health. Further reviews would be held and a planned return to work would be agreed once a date to return was known. This may involve a phased return and / or lighter duties.

The matron told us they did not use any external agency staff. If staff were required there was a bank of staff that the department used.

Patients we spoke with on B2 indicated they felt staff were really busy on this ward. One person said “they look understaffed, but seem to cope remarkably well.”
Assessing and monitoring the quality of service provision

The service should have quality checking systems to manage risks and assure the health, welfare and safety of people who receive care

Our judgement

The provider was meeting this standard.

The provider had an effective system in place to identify, assess and manage risks to the health, safety and welfare of patients who use the service and others.

Reasons for our judgement

People who used the service, their representatives and staff were asked for their views about their care and treatment and they were acted on.

We looked at how the trust managed and oversaw quality of care at an organisational level as well as at the local level. This was because many of the policies, procedures and processes were designed to gather information and give guidance trust wide.

During the inspection we examined documents dealing with the assurance processes used by the trust to ensure the appropriate information about the services and operation of the hospital was received by senior managers and the Trust Board. We also looked at the processes in place to ensure staff providing services were kept informed about and guided on trust policies and procedures and supported to do their roles.

There was evidence of a clear governance infrastructure which was adequately resourced and with the appropriate level of expertise. The managers and directors we spoke with gave a credible and insightful account of the trust’s assessment and monitoring quality of service provision.

We looked at governance arrangements in the maternity unit. We saw a recent patient experience survey. The results showed women had experienced a good standard of care. Women we spoke with confirmed they felt comfortable to raise any concerns with staff and these would be acted upon in a timely way.

There were appropriate clinical governance arrangements in place for the reporting and management of risk. The unit had a maternity risk management policy which included the roles and responsibility of staff to improve practice. There were clear processes for escalating risks to the trust board where required. The unit also used a maternity dashboard. A dashboard acts as a performance measure to identify patient safety issues in advance so that timely and appropriate action can be instituted.

The clinical director shared with us an external report from the Royal College of Obstetricians and Gynaecologists (RCOG). The 2012 report showed the unit was higher
than the national average for induction of labour, caesarean section rates and third/fourth degree tears. The unit was aware of these areas through their governance processes and had developed an action plan. The results from 2013 report showed improvements had been made in these areas.

Records showed an audit programme was in place. Medical staff we spoke with told us they discussed clinical outcomes at audit meetings. Staff confirmed they were actively encouraged to participate in risk management forums.

We looked at the minutes of several meetings which ensured the quality of the service was checked and regularly maintained. This included the labour ward forum, incident reviews and various safety forums. There was evidence that learning from incidents, claims and complaints took place and appropriate changes were implemented. Learning was shared with staff at all levels through patient safety newsletters, handovers and team briefs. There was also a daily report of ‘top tips’ at each shift change to inform staff of any changes to practice. We saw action was taken where necessary.

Staff we spoke with told us there was an ‘open culture’. They felt they could discuss concerns with managers and these would be acted upon. Records showed regular staff meetings were held. Areas discussed included recommendations from external reviews, teamwork, staff expectations and staffing levels.

The trust had an established mechanism whereby senior nurses and a small number of Governors would on a monthly basis walk the hospital services and wards. They spent time talking to patients to seek their views and experiences of the treatment and care received. A report outlining the feedback from the walkabout visit was produced and received by the trust’s Patient Experience and Safety Committee. If there was any cause for concern these issues were identified and escalated to the Trust’s Council of Governors.

We were informed by the Associate Director of Patient Safety and Clinical Risk that Trust Board visits to wards was something that occurred regularly up until December 2012. The trust may find it useful to note the benefits of re-instatementg these visits, in order to enable the Board to obtain ongoing first hand insights into the operational issues affecting day to day service delivery and patient care.

We found the Non Executive team and Trust Board regularly received reports on the monitoring of patient satisfaction and serious incident reports. The organisational learning arising from these ensured the trust’s recovery plan (agreed with Monitor) was on track. This included a review of the organisation’s overall governance and committee reporting structures.

Clinical risk assessment training was regularly made available to all trust departments. However, whilst it was reported that the primary responsibility was for the respective departments to ensure they had adequately trained members of staff to manage this requirement, we were unable to easily identify whether the numbers of staff trained was adequate for these respective departments. It was also reported that risk assessment trained staff moved to different areas or moved on from the trust.

The trust had recently revised and updated its Health and Safety Strategy (2012 – 2015). This document incorporated a Health and Safety Strategy Action Plan, which clearly defined requirements, action, a responsible lead and assurance methods. The trust had a Health and Safety Committee which met quarterly, with terms of reference, an agenda and minutes were provided as good examples of the committees work. Whilst the committee appeared to
have good attendance there was only one member in attendance in their capacity as lead/role or a representative from infection control. There appeared to be no other clinical representation including medical staff. The trust may find it useful to note the appropriateness and added value of additional clinical representation on its Health and Safety Committee.

The Health and Safety Committee annual report provided assurance to the Trust Board on appropriate issues. The trust reported that there remained a significant shortfall in conflict resolution training (CRT) to front line staff however we noted there were 95 planned courses throughout the 2013 – 2014 period which would improve the trusts target of 1500. This would be of particular importance given abusive behaviour towards employees was identified as a main area of concern within the Health and Safety Management 2012 – 2013 Annual Report.

The trust’s Patient Safety and Clinical Risk Team provided a robust mechanism for identifying and reporting serious untoward incidents. All incidents were reviewed weekly and those requiring escalation were actioned appropriately. Where an incident was deemed to be serious it would be reported immediately to the Associate Director for Patient Safety and Clinical Risk and Deputy Chief Nurse. An incident lead would be identified by the Associate Director for Patient Safety / Clinical Risk to undertake an investigation.

The trust had a Patient Experience Strategy for the period 2012 – 2015 which was part of the Deputy Chief Nurses portfolio. The trust’s Patient Experience Committee was reported as playing a key role in reviewing patient experience feedback; patient reported outcome measures (PROMs) and complaints.

The trust had effective processes in place for staff, people who used services and their carer’s to raise concerns and for the trust to act on them. Complaints were inputted on and managed via the trust’s information (Datix) system.
We are the regulator of health and social care in England.

All providers of regulated health and social care services have a legal responsibility to make sure they are meeting essential standards of quality and safety. These are the standards everyone should be able to expect when they receive care.

The essential standards are described in the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 and the Care Quality Commission (Registration) Regulations 2009. We regulate against these standards, which we sometimes describe as “government standards”.

We carry out unannounced inspections of all care homes, acute hospitals and domiciliary care services in England at least once a year to judge whether or not the essential standards are being met. We carry out inspections of other services less often. All of our inspections are unannounced unless there is a good reason to let the provider know we are coming.

There are 16 essential standards that relate most directly to the quality and safety of care and these are grouped into five key areas. When we inspect we could check all or part of any of the 16 standards at any time depending on the individual circumstances of the service. Because of this we often check different standards at different times.

When we inspect, we always visit and we do things like observe how people are cared for, and we talk to people who use the service, to their carers and to staff. We also review information we have gathered about the provider, check the service’s records and check whether the right systems and processes are in place.

We focus on whether or not the provider is meeting the standards and we are guided by whether people are experiencing the outcomes they should be able to expect when the standards are being met. By outcomes we mean the impact care has on the health, safety and welfare of people who use the service, and the experience they have whilst receiving it.

Our inspectors judge if any action is required by the provider of the service to improve the standard of care being provided. Where providers are non-compliant with the regulations, we take enforcement action against them. If we require a service to take action, or if we take enforcement action, we re-inspect it before its next routine inspection was due. This could mean we re-inspect a service several times in one year. We also might decide to re-inspect a service if new concerns emerge about it before the next routine inspection.

In between inspections we continually monitor information we have about providers. The information comes from the public, the provider, other organisations, and from care workers.

You can tell us about your experience of this provider on our website.
How we define our judgements

The following pages show our findings and regulatory judgement for each essential standard or part of the standard that we inspected. Our judgements are based on the ongoing review and analysis of the information gathered by CQC about this provider and the evidence collected during this inspection.

We reach one of the following judgements for each essential standard inspected.

- **Met this standard**: This means that the standard was being met in that the provider was compliant with the regulation. If we find that standards were met, we take no regulatory action but we may make comments that may be useful to the provider and to the public about minor improvements that could be made.

- **Action needed**: This means that the standard was not being met in that the provider was non-compliant with the regulation. We may have set a compliance action requiring the provider to produce a report setting out how and by when changes will be made to make sure they comply with the standard. We monitor the implementation of action plans in these reports and, if necessary, take further action. We may have identified a breach of a regulation which is more serious, and we will make sure action is taken. We will report on this when it is complete.

- **Enforcement action taken**: If the breach of the regulation was more serious, or there have been several or continual breaches, we have a range of actions we take using the criminal and/or civil procedures in the Health and Social Care Act 2008 and relevant regulations. These enforcement powers include issuing a warning notice; restricting or suspending the services a provider can offer, or the number of people it can care for; issuing fines and formal cautions; in extreme cases, cancelling a provider or managers registration or prosecuting a manager or provider. These enforcement powers are set out in law and mean that we can take swift, targeted action where services are failing people.
How we define our judgements (continued)

Where we find non-compliance with a regulation (or part of a regulation), we state which part of the regulation has been breached. Only where there is non compliance with one or more of Regulations 9-24 of the Regulated Activity Regulations, will our report include a judgement about the level of impact on people who use the service (and others, if appropriate to the regulation). This could be a minor, moderate or major impact.

**Minor impact** – people who use the service experienced poor care that had an impact on their health, safety or welfare or there was a risk of this happening. The impact was not significant and the matter could be managed or resolved quickly.

**Moderate impact** – people who use the service experienced poor care that had a significant effect on their health, safety or welfare or there was a risk of this happening. The matter may need to be resolved quickly.

**Major impact** – people who use the service experienced poor care that had a serious current or long term impact on their health, safety and welfare, or there was a risk of this happening. The matter needs to be resolved quickly.

We decide the most appropriate action to take to ensure that the necessary changes are made. We always follow up to check whether action has been taken to meet the standards.
Glossary of terms we use in this report

Essential standard

The essential standards of quality and safety are described in our Guidance about compliance: Essential standards of quality and safety. They consist of a significant number of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 and the Care Quality Commission (Registration) Regulations 2009. These regulations describe the essential standards of quality and safety that people who use health and adult social care services have a right to expect. A full list of the standards can be found within the Guidance about compliance. The 16 essential standards are:

- Respecting and involving people who use services - Outcome 1 (Regulation 17)
- Consent to care and treatment - Outcome 2 (Regulation 18)
- Care and welfare of people who use services - Outcome 4 (Regulation 9)
- Meeting Nutritional Needs - Outcome 5 (Regulation 14)
- Cooperating with other providers - Outcome 6 (Regulation 24)
- Safeguarding people who use services from abuse - Outcome 7 (Regulation 11)
- Cleanliness and infection control - Outcome 8 (Regulation 12)
- Management of medicines - Outcome 9 (Regulation 13)
- Safety and suitability of premises - Outcome 10 (Regulation 15)
- Safety, availability and suitability of equipment - Outcome 11 (Regulation 16)
- Requirements relating to workers - Outcome 12 (Regulation 21)
- Staffing - Outcome 13 (Regulation 22)
- Supporting Staff - Outcome 14 (Regulation 23)
- Assessing and monitoring the quality of service provision - Outcome 16 (Regulation 10)
- Complaints - Outcome 17 (Regulation 19)
- Records - Outcome 21 (Regulation 20)

Regulated activity

These are prescribed activities related to care and treatment that require registration with CQC. These are set out in legislation, and reflect the services provided.
## Glossary of terms we use in this report (continued)

### (Registered) Provider

There are several legal terms relating to the providers of services. These include registered person, service provider and registered manager. The term ‘provider’ means anyone with a legal responsibility for ensuring that the requirements of the law are carried out. On our website we often refer to providers as a ‘service’.

### Regulations

We regulate against the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 and the Care Quality Commission (Registration) Regulations 2009.

### Responsive inspection

This is carried out at any time in relation to identified concerns.

### Routine inspection

This is planned and could occur at any time. We sometimes describe this as a scheduled inspection.

### Themed inspection

This is targeted to look at specific standards, sectors or types of care.