North Tees and Hartlepool NHS Foundation Trust

University Hospital of North Tees

Quality Report

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This report describes our judgement of the quality of care at this hospital. It is based on a combination of what we found when we inspected, information from our 'Intelligent Monitoring' system, and information given to us from patients, the public and other organisations.

Ratings

Overall rating for this hospital	Requires improvement
Urgent and emergency services	Requires improvement
Medical care	Requires improvement
Surgery	Good
Critical care	Good
Maternity and gynaecology	Requires improvement
Services for children and young people	Good
End of life care	Good
Outpatients and diagnostic imaging	Good

Summary of findings

Letter from the Chief Inspector of Hospitals

University Hospital North Tees provides acute care services for North Tees and Hartlepool NHS Foundation Trust. The hospital has 563 beds and provides urgent and emergency care services, critical care services, medical services, surgical services, maternity services, outpatient services and children and young people's services.

The trust gained foundation status in 2007. It has a workforce of approximately 5500 staff and serves a population of around 400,000 in Hartlepool, Stockton and parts of County Durham. The trust also provides services in a number of community facilities across the areas supported, including Peterlee Community Hospital and the One Life Centre, Hartlepool.

We inspected University Hospital North Tees as part of the comprehensive inspection of North Tees and Hartlepool NHS Foundation Trust, which included this hospital and community services. We inspected University Hospital North Tees on 7-10 July and 29 July 2015.

Overall, we rated University Hospital North Tees as requires improvement. We rated it as requires improvement for safe, effective and well-led services and good for caring and responsive services.

We rated emergency and urgent care, medical services and maternity and gynaecology services as requires improvement and surgery, end of life care, children and young people's services and critical care as good.

Our key findings were as follows:

- Arrangements were in place to manage and monitor the prevention and control of infection. A dedicated infection control team to supported staff and ensured policies and procedures were implemented and adhered to. We found that areas we visited were clean. In the A&E department we saw that infection control procedures were not always being followed.
- At the time of inspection, infection rates for methicillin resistant Staphylococcus aureus (MRSA) and Clostridium Difficile (C Difficile) were within an acceptable range for this size of hospital.
- The trust had not met the A&E four hour target between January 2015 to March 2015 however performance had started to improve
- Patients were able to access suitable nutrition and hydration, including special diets. We observed the use of red trays for at risk patients who required support with feeding and coloured plates and bowls for patients living with dementia. Patients reported the food provided during their stay was satisfactory and valued the opportunity to choose the size of their meal.
- There were staffing shortages in some areas across both nursing and medical professions with some wards unable to meet the safer staffing requirements. The trust used agency nurses and locum doctors to address the staffing requirements.
- There were processes for implementing and monitoring the use of evidence based guidelines and standards to meet the needs of differing patient groups across the hospital.
- There were a significant number of policies on the intranet for medicine and maternity services that were out of date and required reviewing and revising.
- There were processes in place for the reporting of incidents and there was learning from incidents; however the root cause analyses and related action plans lacked detail. Governance processes were not fully developed or embedded across the divisions and there were concerns in some areas regarding the maintenance and use of risk registers.
- The trust was reported in July 2015 (Health and Social Care Information Centre) as among the 11 worst performing trusts in England for mortality performance. The trust had implemented actions to improve the trust position for both mortality indicators and been open to external scrutiny.
- There was concern regarding leadership capacity within midwifery services and the impact that had on professional development and clinical standards.

Summary of findings

We saw several areas of good practice including:

- The development of advanced nurse practitioners had enabled the hospital to respond to patient needs appropriately and mitigated difficulties recruiting junior doctors.
- The bariatric service had been developed as part of a consortium arrangement with neighbouring NHS trusts to ensure the local population had access to this service.
- A training suite had been set up to simulate procedures within surgery and enabled staff to practice and upskill in a safe environment.
- The critical care team achieved a network award, which recognised excellent work in relation to "target" training. The team had also achieved recognition for their work related to critical care competencies, difficult airway and skills drills.
- The critical care team achieved 58% for its consideration of patients for tissue donation. The team were the second highest achiever for corneal donations. Overall the team's approach to tissue and organ donation was impressive, demonstrating a compassionate and sensitive approach to patients and relatives.
- The paediatric and neonatal departments participated in a number of national and local research studies and were involved in a large number of clinical trials. The management team and several other staff told us the department had recently obtained a £3.5 million grant for an 'OSCAR study.' This study is for high frequency Oscillation in Acute Respiratory distress syndrome, comparing conventional positive pressure ventilation with high frequency oscillatory ventilation.
- The neonatal unit had implemented the 'Small Wonders' initiative for premature babies; this was designed by the charity Best Beginnings. Small Wonders supports parents in their baby's care in ways shown to improve health outcomes for their babies.
- Staff in the maternity day assessment unit attended training on Gestation Related Optimal Weight (GROW) software which aims to reduce the number of stillbirths by using customised growth charts.
- 'NIPE Smart' had recently been implemented within the maternity directorate. This is an information technology screening management system which has a robust system of capturing data on newborn and infant screening examinations with the aim of reducing the number of babies diagnosed with a medical congenital condition at a late stage.
- Outpatient department staff produced posters and delivered presentations at the International Society of Orthopaedic and Trauma nurses on the development of virtual fracture clinics and on the roles of speciality nurses.
- A number of staff within the outpatients department completed modules on service improvement including one current project to improve the staff engagement and sustainability in clinical supervision.
- Staff worked on the development of health promotion packs within main outpatients to be rolled out within the orthopaedic department as a pilot to explore how this can be sustained.
- The lead consultant radiologist for the specialist procedure known as CTPA (CT pulmonary angiography) presented the experiences of staff and patient outcomes to a panel at a major CT equipment manufacturer.

However, there were also areas of poor practice where the trust needs to make improvements.

Importantly, the trust must:

- Ensure there are systems and processes in place to minimise the likelihood of risks by completing the 5 Steps to Safer Surgery checklist.
- Ensure staff follow trust policies and procedures for managing medicines, including controlled drugs. Ensure that medicines are stored according to storage requirements to maintain their efficacy in maternity services.
- Ensure that risk assessments are documented along with personal care and support needs and evidence that a capacity assessment has been carried out where required.
- Ensure pain in children and young people is assessed and managed effectively.

Summary of findings

- Ensure that the competency criteria for staff who are triaging patients are clearly documented and include recognised competency–based triage training.
- Ensure that infection control procedures are followed in relation to hand hygiene and use of personal protective equipment.
- Ensure that resuscitation and emergency equipment is checked on a daily basis in line with trust guidelines.
- Ensure cleanliness standards are maintained.
- Ensure effective systems are in place which enable staff to assess, monitor and mitigate risks relating to the health, safety and welfare of people who use the service.
- Ensure that all policies and procedures in the In-Hospital care directorate are reviewed and brought up to date.
- Midwifery policies, guidelines and procedural documents must be up to date and evidence based.
- Ensure there are always sufficient numbers of suitably qualified, skilled and experienced staff to deliver safe care in a timely manner.
- Ensure that all annual reviews for midwives take place on a timely basis.
- Ensure all staff attend the relevant resuscitation training.

In addition the trust should:

- Consider strengthening the senior nurse capacity in the A&E department.
- Consider reviewing the system for documenting the follow-up of admitted head injury patients by the A&E department
- Consider a system in A&E to enable patients with allergies to be recognised quickly and easily without the presence of medical records
- Ensure that staff are following the correct procedure when dispensing medication using the Omnicell including checking the prescription at the time of dispensing.
- Consider a continuous audit of all MCA and DoLs assessments and referrals and share lessons learned.
- Consider assessing the access to the emergency resuscitation trolley on the haematology day unit.
- Consider putting engaged notices on toilet doors to protect dignity if the door is kept unlocked for staff to gain access to vulnerable patients.
- Send electronic communication to the patient's GP on discharge from the critical care unit.
- Ensure handover meetings are held in a private and confidential area in children's services.
- Ensure that all patient documentation remains confidential during patient visits to the outpatients department.
- Ensure that all outpatient treatment rooms are cleaned before use.
- Ensure that formal drugs audits and stock checks carried out regularly in outpatients.
- Ensure that medicines are stored appropriately to ensure their quality is maintained.
- Ensure that overall communication, outpatient clinic planning, room utilisation and staffing is formally managed and controlled, including clinics involving staff from other trusts.
- Ensure that patients in the children's outpatient department are afforded privacy when speaking with reception staff.
- Update the risk assessment related to paediatric resuscitation in the children's outpatient department.
- Ensure that some clean and safe methods for entertaining or distracting children are provided within the diagnostic imaging department.
- Ensure that staff adhere to the coding system for recording on medication charts
- Ensure that staff fully adhere to infection control policies and close doors on side rooms where patients are being barrier nursed.
- Ensure the processes and documentation used for appraisal of non-medical staff monitors their performance and meets their personal development needs.
- Review the process for storage of post-transfusion blood bags while retained on ward areas.
- Review whether documentation for patients living with dementia are completed and comprehensive.
- Ensure that within outpatient services, action plans from audits, risk registers and meetings are maintained, regularly revisited and amended to show where actions have been completed or remain outstanding.

Summary of findings

- Ensure that established models of regular nursing clinical supervision are implemented for all staff involved in patient care in outpatient services.
- Ensure that patients and staff are informed if clinics are cancelled, including those involving clinicians and staff from other trusts.
- Ensure that strategy and management plans regarding transforming the outpatients departments are communicated to all staff.
- Consider recording decision made at the evening medical ward rounds on the critical care unit.
- Consider how the critical outreach service will be maintained.
- Review the recruitment of medical staff, particularly junior doctors in the surgical unit.
- File maternity healthcare documentation according to the trust records management policy to avoid loss or misplacement of information
- Indicate benchmark data on the maternity performance dashboard to measure performance.
- Ensure that 'fresh eyes' checks are recorded when undertaken.
- Review the senior midwifery structure and experience resource to ensure that all the midwifery roles needed for coordination and oversight of each service are appropriately covered.
- Monitor and internally report the level of provision of 1:1 maternity care
- Hold staff handovers in maternity services in an environment that reduces the possibility of distraction and interruption.
- Have a competency based framework in place for all grades of midwives.
- Have systems in place to achieve the nationally recommended ratio of 1:15 for supervision of midwives.
- Consider safety briefings as part of daily communication with staff in maternity services.
- Include describing the reporting arrangements for Supervisors of Midwives following investigations, audits or reviews in the maternity services risk management strategy.
- Provide simulation training exercises to prevent the abduction of an infant

Professor Sir Mike Richards
Chief Inspector of Hospitals

Summary of findings

Our judgements about each of the main services

Service	Rating	Why have we given this rating?
Urgent and emergency services	Requires improvement 	We rated the Accident and Emergency department as requires improvement for safety, effectiveness and well-led and good for caring and responsive. Overall we rated the service as requires improvement. We had concerns about safety in the department. We observed that policies and procedures were not always being followed. We also had concerns about the triage process. Safeguarding processes to protect vulnerable adults and children were in place and referrals were made when necessary however this was not always done in a timely manner. There were sufficient medical and nursing staff employed by the department and on the whole staffing levels were acceptable. Most staff were up to date with mandatory training however there were some areas where the department was not meeting the trust expected compliance rate. Staff underwent annual appraisal although some staff had not been appraised in the past 12 months. Their competencies were checked regularly. There were evidence based policies and procedures in place which were easily accessible to staff. These were audited to ensure staff were following relevant clinical pathways. Information about patients such as test results were readily accessible. There was evidence of multi-disciplinary working throughout the department and the department offered a full seven day service. Staff understood their responsibilities in relation to taking consent from patients and the principles of the Mental Capacity Act 2005 however documentation to evidence this was not always present. The care given to patients by the department was good. Privacy and dignity were maintained and people were dealt with in a kind and compassionate way. Patients and families were involved in decisions about their care and emotional support was given during difficult situations. Patients who visited the department had their individual needs met. Interpreters were available and there were facilities available to assist patients

with disabilities or specific needs. Pain relief and nutrition and hydration needs of patients were met. Four hour target waiting times had improved since March 2015 and most patients were discharged within three hours of admission. The trust was performing better than the England average for a number of other performance measures relating to the flow of patients. There were however some delays in the triage of patients which had associated risks. Patient complaints were managed in line with trust policy and feedback was given to staff. Lessons were learned and where applicable, practice was changed to minimise the likelihood of recurrence.

Although staff felt they were well-led at departmental and trust level, we were concerned about the strength and visibility of nursing leadership. There were processes in place to manage governance and measure quality. Additionally we had some concerns about the type and number of risks on the risk register.

Medical care

Requires improvement

We rated medical care services as good for safe, caring and responsive and requires improvement for effective and well-led.

Areas of concern included management of risk registers, management of clinical policies and the continuing worse than expected performance related to mortality ratio. Hospital Standardised Mortality Ratio (HSMR) compares the number of deaths in a trust with the number expected given age and sex distribution. HSMR adjusts for a number of other factors including deprivation, palliative care and case mix. HSMR is usually expressed using '100' as the expected figure based on national rates. In 2014/15 the Trust had an increased HSMR of 124.5 (year to May 2015); this was higher than expected. The Summary Hospital-level Mortality Indicator (SHMI) was 123.5 (year to May 2015). The trust was among the 11 worst performing trusts in England for mortality performance but had implemented plans to improve the trust position for both mortality indicators including being open to expert scrutiny. Systems were in place to report incidents, analysis and feedback was provided to staff. Wards monitored safety and harm free care and results

Summary of findings

were positive, overall. Wards were clean and staff adhered to infection control principles, however, we did observe some doors left open on side-rooms where patients were in isolation. Some of the ward areas were cluttered and cramped. Patients' records and observations were recorded appropriately and concerns were escalated in accordance with the trust guidance. The trust had highlighted the high number of nursing vacancies as a concern and plans were in place to improve this, staffing was reviewed on a day by day and shift by shift basis, using agency staff as required. Attendance at mandatory training and safeguarding was good in all specialities.

Almost all patients and relatives told us that they or their relatives had been treated with compassion and that staff were polite and respectful. Patients were aware of what treatment they were having and understood the reasons for this and, in many cases, had been involved in the decisions. The trust had prioritised and developed a number of initiatives to improve the care of people living with dementia, including the use of therapeutic volunteer workers.

The In-Hospital care directorate had a clear vision and strategy; we spoke with staff who demonstrated pride and compassion in the care that they provided. Medical and nursing staff told us there was a positive cultural and management genuinely listened about issues. At the time of the inspection 88% of staff in the In-Hospital care directorate had received an annual appraisal. The trust was proactive in planning discharges and utilised step down wards to manage those medically fit, but not therapy fit for discharge.

Surgery

Good

We rated surgery services to be good for safe, effective, caring, responsive and well-led.

Staff were aware and familiar with the process for reporting and investigating incidents using the trust's reporting system. Staff told us feedback on reported incidents was given and felt they were appropriately supported. A training suite had been set up to simulate procedures within surgery and enabled staff to practice and upskill in a safe environment. Care records showed risk assessments were being appropriately completed

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for all patients on admission to the hospital.
Infection control information was visible in all ward and patient areas. Monthly cleanliness audits were undertaken and results were displayed through the Nursing Dashboard in ward areas.
Staffing levels for wards were calculated using a recognised tool and trust 'template'. We reviewed the nurse staffing levels on all wards visited and within theatres and found that levels were compliant with the required establishment and skill mix. We reviewed patient records and saw medical patients had been placed on surgical wards ('boarders') when beds were not available on medical wards. Although medical 'boarders' were under the care of medical clinicians, surgical staff told us they did not feel able to provide the same level of care to medical patients.
We observed patients being treated with compassion, dignity and respect throughout our inspection at this hospital. We saw ward managers and matrons were available on the wards so that relatives and patients could speak with them. We saw information leaflets and posters available for patients explaining their procedure and after care arrangements. Patients were able to access counselling services and the mental health team. Therapists worked closely with the nursing teams on the wards and staff told us they had good access to physiotherapists, occupational therapists and speech and language therapists.
The service was responsive to the needs of patients living with dementia and learning disabilities. All wards had dementia champions as well as a learning disability liaison nurse. There was access to an independent mental capacity advocate (IMCA) for when best interest decision meetings were required. Complaints were handled in line with the trust policy and were discussed at monthly staff meetings where training needs and learning was identified as appropriate.
Senior managers had a clear vision and strategy for the division and staff were able to repeat this vision and discuss its meaning with us during individual interviews. Joint clinical governance and directorate meetings were held each month. The directorate risk register was updated following these meetings and we saw that action plans were

Summary of findings

monitored across the division. Records for 2014 showed that staff across all wards in surgery and theatres had received an appraisal or had an appraisal planned. Staff said speciality managers were available, visible within the division and approachable; leadership of the service was good.

Critical care

Good

We found critical care services to be good for safe, effective, caring, responsive and well-led.
There was a real commitment to work as a multidisciplinary team delivering a patient centred and high quality service. Patients were at the centre of the service and high quality care was a priority for staff. There was a good track record on safety with lessons learned and improvements made when things went wrong. Staff knew how to report incidents. The environment was clean but there was a lack of space due to the position of the unit within the hospital. The service had recently put in place a Critical Care Outreach Team (CCOT) to identify and monitor the deteriorating patient. The purpose of this service was to assess the critically ill or deteriorating patient on wards and to stabilise the patient at ward level and so avoid the need to escalate to the unit.
Medical and nursing staffing levels were adequate and there was evidence of a cohesive team working approach to patient care. The unit was staffed according to the Core Standards for Intensive Care Units and nursing and support staff provided flexibility within the department to provide the level of care that met patients' care needs.
Patients received treatment and care according to national guidelines and the service used an audit programme to check whether their practice was up to date and based on sound evidence. The service was obtaining good-quality outcomes as evidenced by its Intensive Care National Audit and Research Centre (ICNARC) data. We found there was good multidisciplinary team working across the service. There was a clear open, transparent culture which had been established with the new leadership team. Staff felt valued and supported by their managers and received the appropriate training and supervision to enable them to meet patients' individual needs. Both medical and nursing staff we spoke with were passionate about providing a

Summary of findings

holistic and multidisciplinary approach to assessing, planning and treating patients. This was demonstrated by regular multidisciplinary meetings and excellent communication with the patients and relatives.
We observed individualised care and attention to detail given to patients and relatives evidenced by their work with the end of life team, care of patients with learning disabilities and implementation and consideration of the Deprivation of Liberty Standards (DoLS)

Maternity and gynaecology	**Requires improvement**		Overall the maternity and gynaecology services at University Hospital North Tees were rated as requires improvement; this was due to concerns in the areas of safe, effective and well-led. We found the service to be caring and responsive and rated these as good. We lacked assurance around the consistent checking of emergency equipment and full completion and management of patient records in maternity services. We observed a staff handover on the delivery suite that was not comprehensive or inclusive of matters relating potential safety issues. We also had concerns about staffing and skills mix on the maternity unit. The lack of a competency framework for midwives, out of date guidelines and the failure to achieve the recommended midwife to supervisor ratio led us to a rating of requires improvement for effective. Although we were informed the out of date guidelines had been updated on our return visit, we lacked assurance that the guidelines and learning from serious incidents were embedded with all staff. Although some areas were well-led overall, the current risk register did not give assurance that risk within the department was being managed appropriately. The staff we spoke with and observed in practice were compassionate and patient focused and patients were very happy with the care they received.
Services for children and young people	**Good**		Overall, we rated safe, effective, caring and responsive as good and well led as requires improvement. Staff knew how to report incidents and these were followed up appropriately. Lessons learned were

shared and preventive measures put in place. Staff of all grades confirmed they received appropriate mandatory training to enable them to carry out their roles effectively and safely; training included awareness of safeguarding procedures. There were sufficient well-trained and competent nursing and medical staff to ensure children and young people were treated safely. There were some gaps in the medical staffing establishment; however, several new doctors were due to start in post. Children and young people did not always have access to appropriate pain relief as and when required, there was no evidence of the use of pain assessment tools in the care records reviewed.

Children, young people, and their families told us they received supportive care. They said the staff were kind and provided them with compassionate care and emotional support. They also felt well informed and involved. Staff and families both told us they would recommend the service to their families and friends and feedback from surveys carried out by the children's service was all positive. The children's service was responsive to the individual needs of the children and young people who used it and there were effective systems and processes in place for dealing with complaints from people using the service. The management team were committed to the vision and strategy for the children's service and feedback from staff about the culture within the service, teamwork, staff support and morale was positive.

However, systems and processes for risk management within the service were not effective and timely. The need to improve risk register management was known by the trust board and a plan was in place but not yet implemented. The risk register was not regularly reviewed at the patient safety and risk management meetings and risks were not actively managed by using the risk register. There was no resuscitation trolley in the children's outpatient department. Staff were able to describe the procedure they would follow but the trust response to mitigate this risk was not clearly documented in the risk assessment or on the risk register and both documents required updating.

Summary of findings

End of life care

Good

We rated End of Life Care services as good. Patients were provided with an end of life care service that was safe and caring. We found the specialist palliative care team, mortuary and chaplaincy team were effective, responsive and well led and delivered safe and caring services. The local teams were very responsive to patient requests with evidence of end of life patients able to be discharged under the trust's Fast Track Rapid Discharge process. We saw good links with the community services, General Practitioners and care and nursing homes within the trust's geographical area.

The service provided good and effective person-centred care to patients through support of patients and their families, for example, the introduction of the Family Voice project. The Family's Voice is a diary given to relatives or friends of dying patients inviting them to be a part of care planning. By use of the diary relatives are invited to assess if the care provided by the ward achieves the expected standard. The Family Voice project and its outcomes were now being disseminated to trusts nationwide.

The staff throughout the hospital knew how to make referrals and people were appropriately referred to and assessed by the specialist palliative care team in a timely fashion, therefore individual needs were met. The hospital's new integrated technology system had improved efficiency within the specialist palliative care team and given staff better access to patient information.

The mortuary was clean and well-maintained; infection control risks were managed with clear reporting procedures in place. Staff had access to specialist advice and support 24 hours a day from a consultant on-call team for end of life care. An out-of-hours system was in place for hospital staff community colleagues to access appropriate equipment, for example, syringe drivers. The chaplaincy and bereavement service supported families' emotional needs when patients were at the end of life and continued to provide support to families afterwards.

Summary of findings

Outpatients and diagnostic imaging

Good

Overall the care and treatment received by patients in the University Hospital of North Tees outpatient and diagnostic imaging departments was safe, caring and responsive. Patients were very happy with the care they received and found it to be caring and compassionate. Staff worked within nationally agreed guidance to ensure that patients received the most appropriate care and treatment for their conditions. Patients were protected from the risk of harm because there were policies in place to make sure that any additional support needs were met. Staff were aware of these policies and how to follow them. The departments learned from complaints and incidents and put systems in place to avoid recurrences.

Senior managers were familiar with the trust's vision for the future of the outpatients department and were aware of the risks and challenges. However staff told us they felt the service was fragmented and changes to meet current and future departmental needs could not be considered because there was no clear departmental strategy following a pause in plans for a new hospital at Stockton. It was not always possible to see from the risk register which risks had been managed and which were still waiting to be actioned. The diagnostic imaging department had good leadership and management and staff told us they were kept informed and involved in strategic working and plans for the future.

University Hospital of North Tees

Detailed findings

Services we looked at
Urgent and emergency services; Medical care (including older people's care); Surgery; Critical care; Maternity and gynaecology; Services for children and young people; End of life care; Outpatients and diagnostic imaging

Detailed findings

Contents

Background to University Hospital of North Tees

University Hospital North Tees (UHNT) provides acute care services for North Tees and Hartlepool NHS Foundation Trust. The hospital has 563 beds and provides urgent and emergency care services, critical care services, medical services, surgical services, maternity services, outpatient services and children and young people's services.

The trust gained foundation status in 2007. It has a workforce of approximately 4660 staff and serves a population of around 400,000 in Hartlepool, Stockton and parts of County Durham. The trust also provides services in a number of community facilities across the areas supported, including Peterlee Community Hospital and the One Life Centre, Hartlepool.

The accident and emergency (A&E) department at UHNT is the local A&E department for people who live in Stockton, Hartlepool and the surrounding areas. It treated all accidents and emergencies except for major trauma patients which were referred to tertiary referral centres. Between April 1st 2013 and March 31st 2014 the department saw 87,708 patients. About 25% of attendances were patients under the age of 16.

The Critical Care Service at UHNT was a 17 bed facility and was funded for ten Level 3 intensive care beds and six Level 2 high dependency beds.

Medical care was delivered through the In-Hospital care directorate. On the UHNT site there were 12 medical wards, including ambulatory care, emergency assessment units and rapid access unit. There were a number of different medical specialities provided, such as general medicine, care of the elderly, cardiology, respiratory medicine, gastroenterology and stroke care. There were 30,000 medical admissions to the hospital in July 2013 – July 2014 of which 58% were emergency admissions, 2% were elective admissions and 40% were day case admissions.

Surgical services at UHNT included elective and non-elective treatments for ear, nose and throat surgery, colorectal surgery, breast surgery, trauma and orthopaedics, urology, and ophthalmology. Surgical services had 146 funded beds: 60 trauma and orthopaedics and 86 surgical, gynaecology and urological beds.

UHNT provided a full range of maternity services for women and families within the hospital site and community setting covering all areas of Stockton-on Tees. Services ranged from consultant led and specialist care for women with increased risks to midwifery led care for low risk expectant mothers.

The delivery suite had 17 delivery rooms, four of these were labour, delivery, recovery and post-partum rooms (LDRP) using the active birthing centre approach. 11 rooms were for high risk women, and two were for induction of labour. All of the rooms were en-suite. There was direct access to two dedicated obstetric theatres.

Detailed findings

Antenatal and postnatal care was provided on Ward 22 which had 28 beds; an early pregnancy clinic was located by the ward entrance and a day assessment unit was located on the ground floor.

The maternity services at University Hospital of North Tees delivered 2998 babies from April 2014 to March 2015. A women's health unit (Ward 30) provided in-patient treatment for a range of gynaecological problems, this was a female ward with 26 beds, general surgery and urology admissions were also managed on this ward.

The women's and children's services directorate at the North Tees and Hartlepool NHS Foundation Trust was responsible for providing neonatal and paediatric service services for children and young people. Inpatient services for children were provided at UHNT site on Ward 15, which had a mixture of single, two and four bedded rooms. UNHT also had a neonatal unit on Ward 23, a day care unit adjacent to Ward 15 and a children's outpatient department. There were 4275 children's admissions between July 2013 and June 2014. Of these 94% of which were emergencies, 5% were day cases and 1% were elective. There were 6612 outpatient admissions between April 2014 and March 2015.

The specialist palliative care team (SPCT) provided support and advice for the care of patients with complex needs and symptom management issues at the end of life. The Specialist Palliative Care Team at UNHT delivered a Monday to Friday 9-5 service, with the palliative care consultant support being available out of hours for telephone advice as part of a Teesside on-call rota.

The University Hospital of North Tees outpatients departments and imaging department were situated on the main hospital site in Stockton. There were a total of 132132 outpatient appointments between April 2014 and March 2015. Outpatient clinics were held in different locations within the main hospital site across a large number of specialties such as general surgery , orthopaedics, gynaecology and medicine with sub-specialities of breast, oncoplastics, upper gastroenterology , bariatric service, endocrinology, colorectal, urology, cardiology, gastrology, rheumatology, thoracic medicine, elderly care, haematology and pain management. The department was open between 9am and 5pm from Monday to Friday every week and on Saturday mornings. There was a shuttle bus to provide patient transport between the hospitals at Stockton and Hartlepool. UHNT offered a range of diagnostic imaging and interventional procedures, as well as substantial plain film reporting and ultrasound service.

Our inspection team

Our inspection team was led by:

Chair: Helen Bellairs, Non-Executive Director, 5 Boroughs Partnership NHS Foundation Trust

Head of Hospital Inspections: Amanda Stanford, Care Quality Commission

The team included CQC inspectors and a variety of specialists: a consultant in diabetology, a consultant in intensive care medicine and anaesthesia, a consultant in palliative care, a consultant paediatrician, a consultant general surgeon, a professor of gynaecological research, a junior doctor, a student nurse, senior midwives, matrons, senior nurses and three experts by experience.

Experts by experience are people who use hospital services, or have relatives who have used hospital care, and have first-hand experience of using acute care services.

How we carried out this inspection

To get to the heart of patients' experiences of care, we always ask the following five questions of every service and provider:

- Is it safe?
- Is it effective?
- Is it caring?
- Is it responsive to people's needs?
- Is it well-led?

Detailed findings

The inspection team always inspects the following core services at each inspection:

- Urgent and emergency services (or A&E)
- Medical care (including older people's care)
- Surgery
- Critical care
- Maternity and gynaecology
- Services for children and young people
- End of life care
- Outpatients and diagnostic imaging

Before visiting, we reviewed a range of information we held about the hospital and asked other organisations to share what they knew with us. These organisations included the clinical commissioning groups, local area team, Monitor, Health Education England, NHS England, General Medical Council, Nursing and Midwifery Council, Royal College of Nursing, NHS Litigation Authority and the local Healthwatch.

We held a listening event on 1 July 2015 in Stockton to hear people's views about care and treatment received at the hospital. We used this information to help us decide what aspects of care and treatment to look at as part of the inspection. The team would like to thank all those who attended the listening event.

We carried out the announced visit between 7 and 10 July 2015. During the visits we held a focus group with a range of hospital staff, including healthcare support workers, nurses (all grades including student nurses), doctors (consultants and junior doctors), physiotherapists, occupational therapists, porters and administrative staff. We talked with patients and staff from all areas of the trust, including from the wards, theatres, critical care, outpatients, maternity and A&E departments. We observed how people were being cared for, talked with carers and family members and reviewed patients' personal care or treatment records.

We completed an unannounced visit on 29 July 2015.

Facts and data about University Hospital of North Tees

University Hospital North Tees is located in Stockton and provides acute care services to a resident population of 400,000 people in Hartlepool, Stockton and parts of County Durham.

The Trust has approximately 73,438 admissions, 87,708 urgent and emergency care attendances, 132,132 outpatient attendances, 3078 births and 1513 deaths per annum.

- In the 2011 census the proportion of the population who described themselves as white was 93.4% in Stockton.
- Stockton-on-Tees ranks 137th out of 326 local authorities for deprivation (with 1st being the most deprived); and County Durham ranks 70th.
- The area covered by the Trust is in the bottom 25th percentile for both long term unemployment and children living in poverty making this worse than the England average.
- Life expectancy at birth is 78.4 years for men and 82.3 years for women in Stockton-on-Tees which is slightly worse than the England average.
- In Year 6, 21.5% (441) of children were classified as obese, worse than the average for England.
- In 2012, 26.1% of adults were classified as obese, worse than the average for England.
- The rate of alcohol related harm hospital stays was 786, worse than the average for England. This represents 1,461 stays per year.
- The rate of self-harm hospital stays was 268.6, worse than the average for England. This represents 530 stays per year.
- The rate of smoking related deaths was 334, worse than the average for England. This represents 327 deaths per year.

Our ratings for this hospital

Our ratings for this hospital are:

Detailed findings

	Safe	Effective	Caring	Responsive	Well-led	Overall
Urgent and emergency services	Requires improvement	Requires improvement	Good	Good	Requires improvement	Requires improvement
Medical care	Good	Requires improvement	Good	Good	Requires improvement	Requires improvement
Surgery	Good	Good	Good	Good	Good	Good
Critical care	Good	Good	Good	Good	Good	Good
Maternity and gynaecology	Requires improvement	Requires improvement	Good	Good	Requires improvement	Requires improvement
Services for children and young people	Good	Good	Good	Good	Requires improvement	Good
End of life care	Good	Good	Good	Good	Good	Good
Outpatients and diagnostic imaging	Good	N/A	Good	Good	Requires improvement	Good
Overall	Requires improvement	Requires improvement	Good	Good	Requires improvement	Requires improvement

Notes

1. We are currently not confident that we are collecting sufficient evidence to rate effectiveness for Outpatients & Diagnostic Imaging.

Urgent and emergency services

Safe	Requires improvement
Effective	Requires improvement
Caring	Good
Responsive	Good
Well-led	Requires improvement
Overall	Requires improvement

Information about the service

The accident and emergency (A&E) department at University Hospital North Tees in Stockton is the local A&E department for people who live in Stockton, Hartlepool and the surrounding areas. It treats all accidents and emergencies except for major trauma which is taken to other hospitals. The department has three adult resuscitation beds one paediatric resuscitation bed, 16 cubicles, a step down unit with four beds, a paediatric waiting room and three paediatric treatment rooms.

Between April 1st 2013 and March 31st 2014 the department saw 87,708. About 25% of attendances were patients under the age of 17.

During our inspection, we spoke with 15 patients, eight relatives and 44 staff of all disciplines and grades. We observed care and treatment being undertaken. We also reviewed 39 clinical records, policies and procedures and attended staff meetings.

Summary of findings

We rated the Accident and Emergency department as requires improvement for safety, effectiveness and well-led and good for caring and responsive. Overall we rated the service as requires improvement.

We had concerns about safety in the department. We observed that policies and procedures were not always being followed. We also had concerns about the triage process. Safeguarding processes to protect vulnerable adults and children were in place and referrals were made when necessary however this was not always done in a timely manner. There were sufficient medical and nursing staff employed by the department and on the whole staffing levels were acceptable. Most staff were up to date with mandatory training however there were some areas where the department was not meeting the trust expected compliance rate. Staff underwent annual appraisal although some staff had not been appraised in the past 12 months. Their competencies were checked regularly.

There were evidence based policies and procedures in place which were easily accessible to staff. These were audited to ensure staff were following relevant clinical pathways. Information about patients such as test results were readily accessible. There was evidence of multi-disciplinary working throughout the department and the department offered a full seven day service.

Urgent and emergency services

Staff understood their responsibilities in relation to taking consent from patients and the principles of the Mental Capacity Act 2005 however documentation to evidence this was not always present.

The care given to patients by the department was good. Privacy and dignity were maintained and people were dealt with in a kind and compassionate way. Patients and families were involved in decisions about their care and emotional support was given during difficult situations.

Patients who visited the department had their individual needs met. Interpreters were available and there were facilities available to assist patients with disabilities or specific needs. Pain relief and nutrition and hydration needs of patients were met. Four hour target waiting times had improved since March 2015 and most patients were discharged within three hours of admission. The trust was performing better than the England average for a number of other performance measures relating to the flow of patients. There were however some delays in the triage of patients which had associated risks. Patient complaints were managed in line with trust policy and feedback was given to staff. Lessons were learned and where applicable, practice was changed to minimise the likelihood of recurrence.

Although staff felt they were well-led at departmental and trust level, we were concerned about the strength and visibility of nursing leadership. There were processes in place to manage governance and measure quality however these were not multidisciplinary in nature. Additionally we had some concerns about the type and number of risks on the risk register.

Are urgent and emergency services safe?

Requires improvement

We have rated the safety of this department as requires improvement. This is because we identified a number of incidences of staff not following trust policy. We saw that infection control procedures were not always being followed and some pieces of consumable single use equipment were out of date in a number of areas of the department. Some pieces of equipment were not stored securely and were accessible to members of the public. Medications were not always stored or dispensed safely. Prescription pads were not stored securely and dispensed prescriptions were not sent to the pharmacy department in a timely manner.

Patient medical records showed that basic information was collected about patients however we could not find documentation to show that appropriate risk assessments had taken place in the 24 case notes we reviewed. Safeguarding processes were in place and all staff were aware of their responsibilities however some staff were not up to date with safeguarding training. Safeguarding referrals were made when necessary however not always in a timely manner. On the whole, mandatory training was meeting the trust standards; however there were some that needed to improve.

There were sufficient medical and nursing staff employed by the department and on the whole staffing levels were acceptable however we had some concerns about the deployment of staff. We found that some inexperienced or untrained staff were triaging patients. Some patients waited an hour to be triaged, presenting a risk to their health. There was little agency and locum use as regular and bank staff covered most shifts. Recruitment was underway to fill vacant posts. There were policies in place to manage major incidents and most staff had undergone training although some staff, including security staff were unclear about what action to take should the air ambulance bring patients to the trust.

Incidents

- There was one serious incident and no never events reported by the Accident and Emergency department

between March 2014 and May 2015. The serious incident was reported in December 2014 and related to an information governance breach. The information commissioner was informed.

- Between 1 December 2014 and 31 March 2015, there were 85 incidents in the A&E department. The information sent to us by the trust had not categorised these by level of harm (severe, moderate, low/no harm, near miss). We received further information from the trust for incidents in February and March 2015. These had been categorised. There was one moderate harm incident, 45 incidents with no reported harm and eight with low harm. There was evidence of the action taken to share lessons learned and change practice to reduce the risk of further incidents occurring.
- The original 85 incidents were categorised as follows: falls – 4, recording in patient notes – 4, failure or delays to act on adverse symptoms/results - 7, medication error - 10, admission, transfer or discharge related – 11, verbal, physical or racial abuse by patient - 13, miscellaneous / other - 36.
- There was evidence that action was taken to learn lessons and when patients had been informed of errors or potential harm. This demonstrated that staff were aware of duty of candour and were actively informing patients or their relatives when required to.
- Senior clinical staff attended weekly trust wide mortality meetings and shared information with colleagues in the A&E department.

Cleanliness, infection control and hygiene

- The department reported that there had been no incidents of MRSA (methicillin resistant staphylococcus aureus) or clostridium difficile in the last twelve months.
- When we visited the department, we found it to be clean. Patient rooms were cleaned quickly in between patients and waiting area floors and seating were in good order. Patient toilets were noted to be clean.
- We however noted that three chairs in the eye examination room had split covers. This was contrary to good infection control practice.
- There was a cleaner present in the department during the whole of our inspection. Cleaners could be called to the department out of hours if required. Health care assistants took responsibility for cleaning cubicles between patients.
- We observed staff and on the whole saw that gloves were used when required. We however noted that hand washing and hand gel use did not always happen either before or after patient contact despite all staff having access to hand gel and washing facilities. We also observed some staff writing up patient notes in communal areas, still wearing the gloves they had worn when examining a patient.
- Staff were observed failing to clean small equipment such as blood pressure machine cuffs between patients on a number of occasions.
- We observed six patients who attended the department with diarrhoea and vomiting. Patients were usually placed in cubicles; however we saw that staff did not always use personal protective equipment (PPE) when entering patient rooms. We saw one patient who was placed in the step down area where cubicles were divided by curtains rather than walls. This increased the risk to other patients in the area of becoming infected.
- Staff hand hygiene procedures are routinely monitored. The trust informed us that compliance at the time of inspection was 98%.
- The department had an unannounced visit from the infection prevention and control team in May 2015. This highlighted a number of areas of good practice and some areas in need of improvement such as finding some areas dusty, a number of PPE dispensers empty, no masks for staff and information posters missing. At our inspection we found that these problems had been rectified.
- During our inspection we saw that infection control issues were occasionally discussed at daily safety huddles. Infection control was a standing item on the monthly A&E nurse meeting agenda where a number of different issues were discussed relating to cleanliness and infection prevention and control.

Environment and equipment

- The A&E department underwent a PLACE assessment (patient led assessment of the care environment) on 19th of February 2015. A number of problems such as cleaning and damaged facilities were identified. An action place was put in place to ensure that the problems were resolved. On inspection, we saw that they had been completed.
- The waiting area used by patients was large and well-lit and there was a separate waiting area for children. This was open and staffed by clinical staff 24 hours a day.

- Consulting and treatment rooms were an acceptable size and contained the necessary patient equipment. Rooms had doors so that privacy could be maintained. There were child appropriate treatment rooms available.
- The department was in the process of creating a room suitable for adolescents however at the time of our inspection this had not been completed.
- Two treatment rooms had close circuit television (CCTV) installed. These rooms were used routinely without the CCTV being used however if patients who needed observation were admitted, CCTV could be switched on. Staff told us that images were not stored and only a live feed was available. The clinical director told us that the CCTV was very rarely used. There was a standard operating procedure which advised staff about when CCTV could be used. This made sure that patient privacy was protected.
- We found that equipment in the department had been PAT (portable appliance test) checked. All of the equipment we looked at had up to date tests. There were maintenance contracts in place to ensure that equipment was serviced and maintained in line with manufacturer guidelines. This was managed by the medical electronics team who coordinated servicing and repairs throughout the trust. The medical electronics team also ensured that equipment was regularly calibrated to ensure accuracy.
- We saw that there was at least two of every piece of equipment. This meant that if one suffered a mechanical breakdown a spare machine was available.
- We checked the resuscitation trolleys and found that these were checked daily in line with trust policy. However we found some equipment that was out of date. For example, there was equipment in the paediatric resuscitation take-out bag that was past its use by date. When we checked at our follow up inspection two weeks later, the out of date equipment remained. Some splints in one of the treatment rooms were past their use by date and the major haemorrhage bags had some out of date pieces of equipment.
- We noted that there was an unlocked storage area where expensive equipment was stored.
- We asked the trust for their lockdown policy for accident and emergency. We were informed that there was a policy for the hospital, but no specific policy for the accident and emergency department.
- There was no security in place in the accident and emergency department. Security staff were based outside of the department. This meant that there was an increased risk to the safety of patients and staff due to delays in the arrival of security staff in response to an incident.
- All treatment rooms and the reception desk had panic buttons which staff could use if there were any security concerns.

Medicines

- Medicines management was part of mandatory training. Compliance was at 94% across the department.
- The department used Omnicell, a computerised storage and dispensing system to store medication. This is automatically temperature controlled and flashes an alert should the temperature rise above the safe storage temperature. There had been no temperature alerts by the system.
- Omnicell only allows staff to access medication once they have entered an access code or scanned their thumb. It requires two appropriate staff to sign in before dispensing medication which has been prescribed. Medication can however be dispensed without being assigned to an individual patient.
- Staff were not always adhering to trust policy about the dispensing of medication using Omnicell. On four occasions we observed nursing staff dispensing medication from Omnicell without the prescription present. This meant that the second person checking had not seen the prescription and therefore could not say if the dispensed medication was correct or not.
- During our inspection we observed fluid bags being stored in an unsecured area which was accessible to the public. This meant that the bags were not protected from being tampered with.
- Controlled stationery was not secure. We found that spare prescription pads were stored in an unsecured area in the matron's office rather than in a locked drawer. There was a risk that these pads could be stolen and used to get unauthorised medication from a pharmacy.
- In the area where drugs were stored in Omnicell, we saw a large pile of dispensed prescriptions. These dated back up to two weeks. Dispensed prescriptions should be sent to pharmacy on a frequent basis.
- Staff told us that on occasions when agency and locum staff were used in the department, there were times

when they had not been registered to use Omnicell in advance. This could lead to either delays in being able to access medication for patients, or temporary staff using the passwords of permanent staff to access the system. This meant that there was a risk to patients from delays to receiving medication and a risk to staff whose passwords were being shared, if errors occurred.

- Patient group directives are written instructions for the supply and administration of medicines prescribed by a doctor and agreed by a pharmacist that may be administered by a nurse using their own assessment of need. These were used in the department. We saw that staff had signed to say that they understood them however there was no evidence recorded on the PGD as required to show that staff had been assessed as competent to use them.

Records

- The department used a dual record keeping system, with some information being stored on an electronic patient system called EDIS and some being written in paper records. This was a risk since patient information was stored in two different places for the same attendance and information could be missed by staff.
- The department had an action plan in place to introduce a new electronic records system to the department in the coming three months.
- We discussed record keeping audits with the management team of the department. They assured us that record keeping audits took place every month. They informed us that the department performed well in these audits. We saw that there was an annual action plan which was monitored by the trust wide health care record committee.
- We looked at the paper records of 38 patients during our inspection. All patients had been in the department for longer than 60 minutes.
- We found that the notes completed by medical staff were comprehensive and included the relevant information required.
- Of the 38 sets of nursing records we looked at, none had any personal care or personal hygiene assistance needs documented. None had any evidence that a mental capacity assessment had taken place despite a number of patients with dementia being amongst the sample. Additionally we saw that only two of 38 patients had undergone a pressure area assessment.
- We observed the triage process and noted that most patients were assessed for their pain levels, however when we looked at patient records, pain scores were infrequently documented (5/38) and there was little evidence being recorded that patients had been offered pain relief and declined.
- We found that staff were not routinely printing the ambulance handover sheet and placing this in patient records.

Safeguarding

- We looked at the processes and policies the trust had in place for safeguarding vulnerable adults and children. They provided staff with good, detailed information about the action they should take if they had concerns about any patients who attended the department.
- We spoke with a number of staff from all disciplines about the action they would take if they were concerned about the safety and welfare of patients. They demonstrated good working knowledge.
- We saw evidence that external trainers were invited to speak with staff about specific safeguarding topics such as sexual exploitation, people trafficking and female genital mutilation (FGM)
- We saw evidence that each patient who attended the department had a named nurse and named doctor. Where safeguarding concerns were identified, the named staff were responsible for ensuring that referrals were made to the safeguarding team. We saw examples of this happening. We did however note that on one occasion, the referral was not made until the day after the patient attended the department. Because of this, there was a risk that patients could 'slip through the net'.
- During our inspection, we saw three referrals being made. When we looked at the patients' notes, we found that there was nothing documented in the patient records about the referrals. This meant that there was no audit trail and also that there was no evidence in the records of the referral should the patient have subsequent visits to this or other departments.
- The IT system used by the department (EDIS) routinely displayed the number of attendances patients had made during the previous 12 months. Where there were concerns about a patient's welfare, the system also displayed an alert to staff which gave specific details about any risks to the patient or to staff.
- Safeguarding training was below the trust expected standard of 100%. Training figures showed compliance

as follows: Safeguarding adults level one 93%, safeguarding adults level two, 50%, safeguarding children level two, 75% and safeguarding children level three 92%.

Mandatory training

- Staff told us they had no problems accessing mandatory training.
- Information sent to us by the trust showed overall good compliance of mandatory training.
- There were some aspects of mandatory training that needed to improve. For example, non-clinical staff had not undergone object handling training and both doctors and nurses were less than the 100% compliance level for safeguarding children level three and safeguarding adults level one. Medical staff were 71% compliant for resuscitation training and 61% compliant for fire training. This was below the trust expected standard of compliance.
- The trust organised l mandatory training days on a quarterly basis as well as using work books to enable staff to complete mandatory training.

Assessing and responding to patient risk

- As part of our inspection we looked at the triage process in place within the department. We saw that patients who attended by ambulance were greeted by staff in the majors department and a rapid verbal handover from ambulance staff took place. On the whole, this meant that patients who attended by ambulance were placed in the correct area of the department quickly.
- In the case of trauma patients, a trauma triage guide was used to assist in deciding the most appropriate place for the patient to be treated.
- When patients attended on foot, they were required to report to the reception desk where reception staff took brief details of their presenting symptoms. These were then passed to the triage nurse who saw patients to triage them formally. We had concerns about the walk-in triage process related to training and the length of time taken to triage.
- The trust aimed to triage all patients within 15 minutes of arrival. During the inspection we saw that walk-in patients frequently had to wait more than 60 minutes before being triaged in the minors department. This was when the department was not very busy, for example at 9.30am. We saw one example of a child who was believed to have swallowed a highly toxic substance who was not seen for an hour and an unwell diabetic patient who also waited an hour to be triaged. Although both patients suffered no lasting harm, these delays posed potential serious risks to their health.
- The trust average waiting time from ambulance to initial assessment was worse than the government target of 15 minute for every month between April 2014 and March 2015 other than September 2014. The worst months were November and December 2014 when the average wait was 22 minutes.
- We also saw that a newly qualified (less than one year) band five nurse was triaging paediatric patients. The nurse had worked for the trust for less than two months at the time. We asked managers about the training provided to undertake triage. The trust told us that all staff who triaged had formal triage training through local induction and that competency was formalised through the induction pack. The trust sent us a power point presentation updated in June 2015 which was part of the triage training package. The staff we spoke with told us they had not undergone formal triage training.
- Reception staff monitored the waiting room and told us they used their common sense to identify if patients needed to be given priority to be seen. There were no formal guides for them to refer to about signs for identifying deteriorating patients.
- We saw that known patient allergies were recorded in patient records; however we saw that when allergies had been identified, patients were not given a red wrist band wear to assist staff in easily identifying patients with allergies. There had been one reported incident in the last 12 months where a patient had been administered a medication they had an allergy.
- We observed and saw in patient records that early warning scores were used to monitor patients and identify when patients were deteriorating. These were monitored regularly. There was a process in place to escalate any patient who was identified as deteriorating.
- There was a tracking screen in the nurse station that all staff could access, which showed each patient's status.
- We saw no evidence of rapid assessment and treat (RAT) processes as we inspected the department although there was a rapid access area for patients who had been referred to the department by their GP.

- We looked at 38 sets of patient notes. We found that risk assessments such as, nutrition, personal care and falls assessments were documented as having been carried out in two sets.

Nursing staffing

- Information from the trust showed that there were 68 nursing staff employed to work in the A&E department. This consisted of 11 health care assistants, one health care support worker, 29 staff nurses, 16 charge nurses, one nurse manager, four specialist nurse practitioners and five associate practitioners.
- Within the paediatric A&E department, there was always one qualified children's nurse, plus either a play specialist, or a health care assistant and a doctor with a special interest in paediatrics.
- The department management team we spoke with told us that staffing levels were reviewed every six months and that a review was currently underway to ensure that there were sufficient staff with the correct skill levels deployed by the department. The department used the nationally recognised 'Safer nursing care' tool.
- Nurse actual and expected staffing levels were displayed in the department and updated on a daily basis. We looked at the rotas for nursing staffing. for the previous six weeks. We found that although there were some gaps in rotas, these were not excessive and nursing cover in the department was at acceptable levels however we noted that the way staff were deployed meant that there was one nurse routinely allocated to the three beds in the resuscitation area. When these beds were in use, nursing staff had to be moved from elsewhere in the department to assist.
- We observed nursing handovers and board rounds and saw that staff effectively communicated the presenting symptoms and care needs of patients to colleagues starting the new shift.
- There were qualified members of the nursing team who worked in advanced roles as emergency nurse practitioners, treating patients with minor injuries, and advanced nurse practitioners who worked with more seriously ill patients in the majors and resuscitation areas.
- The manager of the department told us that there were currently 5.7 WTE (whole time equivalent) band five vacancies, one current band six vacancy and one pending band six vacancy. Recruitment was underway and four band five nurses had already been recruited to fill the vacancies.
- Current vacancies were being managed using internal bank staff and some agency staff. Only a limited number of agencies were approved and only regular agency staff were used. This was to ensure that all staff working in the department were familiar with the way the department worked.
- Between October 2013 and March 2015 the average agency use per month was 3.8%. Agency use peaked at 5.9% in February 2015.
- The nursing manager told us there was an induction process in place for agency staff and that only a limited number of agencies were used by the department. This was to ensure that only staff with the necessary skills were used by the department. We saw that there was a local induction in place for all new staff including agency staff.
- Newly qualified staff were given preceptorship (mentoring and support) and newly employed staff shadowed existing staff for two weeks prior to being counted as a member of the team for staffing purposes.
- We had some concerns about nursing leadership capacity in the department. This was because there was only one band seven employed to manage the department clinically and one band eight nurse to operationally manage the department. This meant that there were times when the department was being led by a band six sister.
- According to information provided to us by the trust, there was a nursing staff turnover rate of 21% between April 2014 and March 2015.

Medical staffing

- At the time of the inspection, were 11.2 WTE consultants employed by the trust. There was one vacancy for a consultant with a special interest in paediatrics. There were two junior doctor vacancies in the department. These were being covered by existing staff.
- The average locum use in the department was 5.2% between October 2013 and March 2015. Locum use peaked at 16.2% in July 2014.
- We spoke with both senior and junior medical staff about the medical cover provided in the department. All staff told us that consultant cover was in place between 8am and 10pm and that if advice or guidance from

consultants was needed outside of these hours, it was readily available via the on call rota. Staff told us that consultants often worked outside of the hours rostered to them when the department was busy, to support their colleagues.

- We saw that there was sufficient medical staff in the department to manage the number of cases in the department. We discussed the use of locum staff with the clinical director and other departmental managers. They told us that only a select number of agencies were used and regular locums were selected whenever possible. Additionally, before a locum was able to work unsupervised in the department, they were assessed by a senior clinician to ensure that they were competent.
- We observed three medical handovers take place. Each patient was discussed in detail, along with future plans and tests the patients required. The handovers were informative.
- The department ensured that junior doctor trainees were supervised and able to access further training and take study leave. Junior doctors we spoke with told us they were supported to access the training they needed to progress in their careers.
- Feedback on performance to junior doctors was variable with some receiving occasional feedback and others receiving feedback only if their performance needed to improve.
- All staff we spoke with told us that the department was supportive of their developmental needs.

Major incident awareness and training

- There were major incident plans in place within the department. Business continuity plans were in place to ensure the department continued to function. We looked at the major incident policy. This was detailed and contained information about roles and responsibilities of staff within the trust.
- The department took part in regular mock major incident exercises and had been involved in one within the last four months. Most staff we spoke with had undergone major incident training and were familiar with the techniques needed on such occasions. Medical staff we spoke with told us that patients with chemical burns attended the department occasionally but that any hazardous materials would be dealt with at the site of the incident. They were confident in their capacity to deal with major incidents.
- The department had the equipment it needed to deal with major incidents such as hazardous material suits. High visibility suits and tents were available in the event of an incident.
- We spoke with both staff in the department and security staff about whether there was a protocol in place if the air ambulance attended the hospital. Staff in the department told us that security staff were responsible for ensuring that the air ambulance landed safely. Security staff we spoke with were unsure of the protocol to follow if the air ambulance was due to attend.
- From our observations, we saw that it would be very difficult to lock down the department for security reasons in the case of a major incident. We requested a copy of the 'lock down' policy for the department. There was no specific policy for the department however the generic lockdown policy detailed staff roles and responsibilities such as how the lock down should be commenced and how it should be carried out.

Are urgent and emergency services effective?

(for example, treatment is effective)

Requires improvement

We rated the effectiveness of the department as requires improvement.

Staff underwent annual appraisal although 17% of staff were recorded by the trust as red or amber rated in relation to being overdue for appraisal. Staff had their competencies checked regularly however some staff with limited triage experience were triaging patients and we had concerns about their competency to do so. Additionally, a number of medical staff were not up to date with their basic and advanced adult and paediatric life support training. Staff understood their responsibilities in relation to taking consent from patients. Staff additionally understood the principles of the Mental Capacity Act 2005 and to assess patient capacity however this again was not well documented.

There were policies and procedures in place and these were evidence based. Audits, such as for the College of Emergency Medicine (CEM) took place to ensure that staff were following relevant clinical pathways. Staff were able to

access information about clinical guidelines. Information about patients such as test results were readily accessible. The trust was taking part in local and national audits and monitoring patient outcomes. However, trauma patients had a slightly elevated risk of mortality than at comparable trusts nationally.

Pain relief was offered to patients on arrival at the department and regularly during the duration of their attendance at the department although this was not always well documented. Patient and relative nutrition and hydration needs were managed and we saw patients being offered drinks and food whilst we were inspecting the department. Patients also confirmed that they had been offered food and drinks when they had attended previously. There was evidence of multi-disciplinary working throughout the department and the department offered a full seven day service.

Evidence-based care and treatment

- There was a wide range of departmental policies and guidelines for the treatment of both children and adults.
- Departmental policies were based upon NICE (national institute for health and clinical excellence) and Royal College guidelines..
- We saw evidence that the department followed NICE guidance for a number of conditions such as sepsis, head injury and stroke. We saw examples of the management of sepsis done really well and patients with suspected strokes were sent quickly for diagnostic tests. We found that the process for recording patients with head injuries was not as robust as it could be.
- Care was provided in line with 'Clinical Standards for Emergency Departments' guidelines and there were audits in place to ensure compliance.
- We looked at the documentation used for patients with suspected fractured neck of femur. We found that the documentation template did not fully reflect best practice in clinical pathway documentation for this condition.
- Local audit activity took place within the department to measure staff compliance with departmental guidelines. For example, we saw that an audit of time to CT for major trauma in January 2015 had led to education sessions for staff and improved working with the radiology department to improve times. A re-audit was planned but was yet to take place.

Pain relief

- CQC's national A&E survey 2014 showed that the trust performed 'about the same' as other similar trusts for the time patients waited to receive pain medication after requesting it.
- The trust performed 'about the same' as other similar trusts when patients were asked whether staff did everything they could to control people's pain in the same survey.
- We saw that patients were being asked if they required pain relief as part of the triage process however it was not documented if patients refused. Patients were checked regularly to see whether they needed further pain relief.
- We saw nurses giving patients pain relief such as paracetamol and ibuprofen using PGDs.
- When we looked at the notes of children visiting the department, we found that pain scores were not always recorded despite some children attending with injuries.

Nutrition and hydration

- CQC's national A&E survey 2014 showed that the trust performed 'about the same' as other similar trusts for the ability of patients to access food and drinks whilst in the A&E Department.
- When we looked at the records of 14 patients, we found that eating and drinking needs had not been documented as assessed in any of the records. This meant that people who were vulnerable, or who had specific dietary needs had not been identified.
- Staff told us, as we saw that there were food packs available for patients in the department. One patient told us they had been given breakfast cereal whilst waiting in the department. Sandwiches and drinks were available to patients and there were vending machines present which relatives and carers could access.
- We overheard staff asking patients if they wanted drinks or snacks.
- On the first day of our inspection we noted that there was a trolley with tea, coffee and small packets of biscuits available for patients; however the trolley was not present on the subsequent days of our inspection.

Patient outcomes

- The trust had a better than the England average rate for unplanned re-attendance at A&E within seven days at approximately 5% compared to the England average of 7.2%.

- A&E medical staff carried out CEM audits. Audits included consultant sign-off. The department scored better than the England average for three of the eight outcomes in the consultant sign off audit. CEM audits were carried out for asthma in children, paracetamol overdose and severe sepsis and septic shock. We saw action plans for these audits which showed that actions had been completed. We saw that recommendations from the sepsis audit had been implemented, for example the use of the 'Sepsis 6' stickers had been relaunched. We saw them in use in patient records. The department had also take part in the mental health (care in emergency departments), older people (care in emergency departments) and fitting child (care in emergency departments) audits. Results of these were yet to be received.
- The department had three CQUIN (Commissioning for quality and innovation) targets for 2014/2015. These were the Friends and Family Test (achieved), Assessment of Frail Elderly which was achieved two of four quarters and Ambulance Handover which was achieved three of four quarters of the year.
- The department had three CQUIN targets for 2015/2016. These were for sepsis, increasing the number of patients whose admission is prevented by accident and emergency and reducing the number of multiple attenders to the department. Results will be collated annually for these indicators.
- Results of the 2014 A&E survey showed that the department performed better than expected in two sections: timely test results and explanations of test results. Results were as expected in 32 questions. Only one question was worse than expected: information about how long patients would wait to be examined. During the inspection we saw that waiting times were not displayed in the waiting area. When we asked reception staff, they were happy to tell us waiting times, but times were not routinely displayed.
- According to Trauma Audit Research Network (TARN) information, the trust was performing slightly worse than the England average with 1.3 additional deaths of trauma patients per 100 patients based on data from January 1st 2012 to June 30th 2015. There had been 391 trauma patients during this time.

Competent staff

- According to the trust dashboard, 9% of staff who worked in A&E were rated as red for non-compliance of appraisals. The trust dashboard showed that 8% of staff were rated as amber for non-compliance of appraisals. However staff told us they had regular annual appraisals.
- We spoke with staff about whether they were able to access clinical supervision. Staff told us that clinical supervision didn't take place formally however staff felt well supported and able to discuss clinical issues openly with colleagues and managers.
- We saw evidence that not all staff were up to date with basic or advanced life support and advanced paediatric life support training. For example, we saw that thirteen medical staff and six nursing staff were overdue an update of paediatric basic life support training. Nine medical staff were overdue an update of advanced life support training. However, we witnessed staff putting life support skills into practice effectively.
- Healthcare assistants performed advanced roles such as taking blood, and also had the opportunity to train as emergency department assistants who could put on plaster casts and take electrocardiograms among other duties.
- Regular simulation scenarios were undertaken in the department by medical and nursing staff. The management of the scenarios was critically analysed after the event and feedback was given to staff as a way to improve future ways of working.
- Newly qualified staff were given six weeks preceptorship by qualified mentors. Thirteen staff in the department were mentors.
- At the time of the inspection we saw that a relatively inexperienced children's nurse (qualified six months) was the only nurse in the paediatric department and was assessing paediatric patients without visible supervision. We discussed this with the trust who told us that the nurse had good experience and had undergone triage training as part of their induction. We felt that there was an increased risk to patients by using a relatively inexperienced nurse to triage patients.
- Staff competencies were informally monitored throughout the year by senior members of staff and managers told us that action was taken to address any concerns about staff competencies. This applied to both medical and nursing staff.
- All staff were part of the revalidation scheme and we identified no concerns about compliance within the department.

Urgent and emergency services

Multidisciplinary working

- The A&E team worked effectively with other specialty teams within the trust. We observed specialty teams composed of physicians and surgeons working in the department. This included the prompt arrival of the paediatric crash team in the resuscitation area following the admission of a baby.
- There was very good access to psychiatry clinicians within the department with 24 hour access to psychiatric liaison staff who were situated within the department.
- There was a substance and alcohol misuse liaison team available to support patients and staff treating them.
- Allied health professionals were based in the department. This meant that patients who needed therapy input or assessment prior to discharge could be seen quickly and efficiently.
- There were local pathways in place, written in conjunction with local GPs to ensure that unnecessary attendances and admissions to the department were avoided.
- We saw that medical and nursing staff worked well together and communicated clearly and effectively about patients.

Seven-day services

- The A&E department offered a seven-day service, with consultant cover in the department for 14 hours a day. There was also on-call consultant cover, including during the ten hours when there was no consultant in the department.
- There was full 24 hour seven day access to diagnostic and screening tests.

Access to information

- Staff were able to access the patient information using the electronic system EDIS and using paper records. This included information such as previous clinic letters, test results and x-rays.
- Clinical guidelines and policies were available via the trust intranet and also via a system called the Tree of knowledge. We found that some guidance on the intranet was in need of updating however we were informed that this process was underway throughout the trust.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- The department had a specially designed form to document whether patients had capacity. However we found that this was rarely used when it was appropriate to do so. Clinicians told us they would only use the form to assess capacity to make specific decisions.
- We spoke with staff about the Mental Capacity Act (MCA) 2005 and deprivation of liberty safeguards. Staff understood the basic principles of the Act and were able to explain how the principles worked in practice in the department.
- We looked at the records of 38 people who attended the department during our inspection. We found no evidence in records of patient capacity being assessed, despite a number of patients being diagnosed with advanced dementia. For example, we saw a patient, supported by a carer attend with advanced dementia and a suspected fracture and there was no evidence of a capacity assessment being carried out.
- MCA and DoLs training were incorporated in the safeguarding vulnerable adults level one training. Training figures showed compliance was at 93% for this.
- Staff we spoke with understood the need to obtain consent from patients to carry out tests and treatments. Staff told us that they accepted implied consent as the patient agreeing to a procedure and we saw evidence of staff explaining procedures to patients and patients agreeing to them. Consent training for staff was at 98%.

Are urgent and emergency services caring?

Good

The care given to patients by the department was good. Privacy and dignity were maintained and people were dealt with in a kind and compassionate way. People were involved in decisions about their care and emotional support was given to patients and family members during difficult situations.

Compassionate care

- During our time in the A&E department, we saw patients and relatives being dealt with in a compassionate manner.
- All of the patients and relatives we spoke with told us that staff behaved in a kind and compassionate way towards them.

Urgent and emergency services

- Parents of children told us that staff were understanding of their concerns and showed empathy towards them and their children.
- Results from the friends and family test (FFT) showed that 88% of patients would recommend this department to their friends or family. This figure had steadily dropped since January 2014.
- The department scored 'about the same as other trusts' in the majority of the 2014 Accident and Emergency survey. The trust scored 'worse than other trusts' for people being told how long they would have to wait to be examined and 'better than other trusts' for being given their test results before leaving the department and for being given an explanation of their results.
- The A&E department took part in the national Friends and Family test. The results showed that the trust scored consistently better than the England average between December 2013 and November 2014.
- The response rate for April 2015 was 0.6%. The response rate for May 2015 was 9.9%. This was compared to the England average response rate of 14.1%
- Of those who responded, 90% said they recommended the department. This is slightly better than the England average of 88.3%. 3% said they would not recommend the department. This is slightly better than the England average of 6%.

Understanding and involvement of patients and those close to them

- We observed staff explaining to patients their diagnoses and treatment options in language and terms that were appropriate and easy to understand. This was done in a very calm and sensitive way. Patients were asked if it was acceptable to share information with family members.
- We observed that triage of patients did not involve relatives and patients were not asked if they wished a family member present with them.
- Patients and relatives told us that staff were responsive to their questions and made sure they understood their care or treatment pathways and next steps.

Emotional support

- We observed staff talking with patients and relatives in a calming way and offering reassurance to both concerned patients and their family members.
- Patients told us that they were offered support by staff and informed of support services available to them if required.
- Staff were observed delivering bad news in a sensitive and compassionate manner.

Are urgent and emergency services responsive to people's needs?
(for example, to feedback?)

Good

We rated the responsiveness of the Accident and Emergency department as good.

The department was working to introduce new services to meet the needs of local people, for example by having GPs based in the department on weekends. Patients who visited the department had their individual needs met. Interpreters were available and there were facilities available to assist patients with disabilities or specific needs.

Achievement of the national four hour waiting time target had improved since March 2015 after a slight dip in Quarter 4 2014/15 and most patients were discharged within three hours of admission. The trust was performing better than the England average for a number of other performance measures relating to the flow of patients. There were however some delays in the triage of patients which had associated risks. Patient complaints were managed in line with trust policy and feedback was given to staff. Lessons were learned and where applicable, practice was changed to minimise the likelihood of recurrence.

Service planning and delivery to meet the needs of local people

- The department had acknowledged the mental health needs of the population and had 24 hour access to mental health services, with mental health staff based in the department.
- The management of the department were aware of the increasing demands on the department and were working to introduce new services to manage demand, for example by having GPs based in the department on weekends.

- Managers were aware of the type of patients who attended the department and the potential major incidents which could occur locally and had ensured that the department had the necessary equipment and trained staff to manage such situations.
- Recent reconfiguration of services managed by the trust meant that some services had been consolidated on one site. This meant that some patients had to travel a significant distance to access the department. The trust had tried to manage the situation by offering transport and alternative services such as a shuttle bus to assist with access. .

Meeting people's individual needs

- The waiting room and triage rooms were large and spacious. This meant that the department was easily accessible to patients who used wheelchairs. Additionally there were dedicated disabled toilets available.
- On average, 25% of patients that attended the department were under the age of 17. There was a dedicated paediatric A&E department with age appropriate décor in the waiting room and treatment rooms. This was open 24 hours a day and staffed by paediatric qualified nursing staff and doctors at all times. This meant that young people were away from the adult waiting and treatment rooms.
- The paediatric department was in the process of creating a waiting area for adolescents with age appropriate décor.
- There were facilities such as beds and wheelchairs for bariatric patients.
- The trust had access to interpreting services for people whose first language was not English. Staff told us that in an emergency situation they may use a family member in the very first instance, but would try to access an interpreter as quickly as possible. The trust could also access telephone interpreters if necessary.
- Most patient information was available in different formats such as large print, audio, CD, braille and languages other than English on request.
- There were private areas for relatives to wait whilst patients were being treated and there was a relatives' room where people who were recently bereaved were given bad news. They could wait in privacy and also view the recently deceased. The room was comfortable and tastefully decorated. There were advice leaflets available for relatives.
- The trust had a dementia strategy and within the department, there were designated dementia leads for nurses and doctors.
- The staff we spoke with about patients living with dementia, or a learning disability all told us that they would treat patients as individuals but would try to find out about them in order to make a decision about whether they needed any extra support such as to be seated in a private area. Staff told us that whenever possible, people with dementia or a learning disability would be seen as quickly as possible in order to minimise distress for the patient.
- Some patients with learning disabilities had patient passports. When these were presented at the department by the patient or carer, staff used the information within to assist them in making decisions about patient needs and wishes.
- The records of patients living with dementia or a learning disability were marked using a flower sticker. Alerts were also put on to the electronic record system to alert staff if patients had specific needs. The electronic records system had a built in alert system which highlighted any patients attending the department who were at risk of self-harm, or harming others. This made sure that staff were aware of safety risks to patients and to themselves. Security staff were called to the department when necessary, for the safety of patients and staff.
- There was no information readily available of visible to patients about expected waiting times. This meant that patients did not know how long they could expect to be in the department. A number of patients we spoke with told us that an expected waiting time would be helpful to them and would keep them informed.
- There was 24 hour access to Chaplaincy services for patients and relatives of all faiths.
- Patients with purely mental health needs often waited in the relative's room if this was vacant. We noted that there were a number of ligature risks in the room.

Access and flow

- Achievement of the national four hour waiting time target had improved since March 2015 after a slight dip in Quarter 4 2014/15 and most patients were discharged within three hours of admission.. The percentage of

admissions via A&E waiting between four and 12 hours was consistently better than the England average between March 2013 and January 2015 at approximately 0.5%.

- The department had a patient flow facilitator who worked with other departments in the hospital such as the emergency admissions unit, wards and bed managers to locate vacant bed and ensure that patients were moved to appropriate wards as soon as it was safe to do so. At the time of the inspection, this was being trialled day and night. Staff we spoke with thought that this was a valuable and useful service.
- The department had no black breaches. A black breach is when a patient waits more than 60 minutes to be handed over from the ambulance crew to the hospital staff. Between April 2014 and March 2015 a total of 27 patients waited over 30 minutes to be formally handed over to the department. Ambulance crews we spoke with told us that they had no concerns about the length of time it took to hand over patients to this department. They were complimentary about the system the department had in place to handover information about patients to clinical staff.
- There was a link to the ambulance trust that showed how many patients were on their way to the hospital along with brief details of the presenting condition. This meant that the department could be prepared for their arrival.
- During our inspection we observed the department deal with a call from the ambulance trust informing them of the pending arrival of a very sick child. The department had a process in place for ensuring that staff with the relevant skills were present in the department before the baby arrived. This included making sure that colleagues from other departments were also present.
- We identified some concerns about the way ambulance handover times were recorded. We noted at least four occasions when ambulance staff were yet to check the patient in to the department but department staff had recorded that handover was complete. In one case, the patient was still in the ambulance. We discussed this with the department manager who told us that formal handover was calculated as the time the patient was moved from the ambulance trolley to a hospital chair or trolley. They told us that ambulance staff chose to complete the handover of patient details at the reception and make sure the patient was registered on the system, but that this could be done by hospital staff.
- The department was on the whole better than the England average for patients leaving the department before being seen with an average of 2.2% compared to the England average of 2.5%. The trust had a target of 5% therefore the department was achieving the trust target.
- Just over 71% of patients were discharged from the department within three hours of admission. 51% of patients were discharged from the department within two hours and 23% of patients were discharged within one hour. The trust did not meet the government target of 95% of patients being seen within four hours in June 2014, November and December 2014, January, February and March 2015. This was in line with the England average.
- The department was piloting the use of General Practitioners (GPs) at the weekend. This meant that patients who did not need to be seen by accident and emergency staff could be seen by a more appropriate clinician. Staff told us that the use of GPs in the department freed up their time to treat patients who actually needed to see Accident and Emergency staff.
- The department had a target of 5% for the percentage of patients who re-attended the department unplanned. Between April 2014 and March 2015, this target was met for seven months. The target was breached in May, June, October, November and December 2014.
- We observed the length of time patients waited to be triaged. We also asked reception staff about the triage waiting time. The triage waiting time was consistently longer than an hour for walk in patients. This meant that patients often waited for longer than an hour before a decision was made about which area of the department was most appropriate to treat them. There was a risk that poorly patients could deteriorate significantly during this time. We saw an example of when this happened and when a patient with a time critical condition was not seen in a timely manner.
- The department had a target that all patients with fractured neck of femur (broken hip) should be admitted within two hours. This was a CEM standard. They had failed to meet this target consistently between April 2014 and March 2015. The percentage of patients who met the target varied between 36% and 67%.
- Patients waiting more than 4 hours were not routinely offered a bed and were left on a trolley unless they had specific needs such as high risk of pressure sores.

Urgent and emergency services

Learning from complaints and concerns

- Patients and relatives we spoke with were confident about how to make a complaint to the trust although none of the people we spoke with had complained about the department.
- There was information about how to raise concerns about the department or the trust as a whole on display in the department and there were leaflets available for patients to take away with them.
- Staff were able to describe to us the action they would take if a patient or relative complained to them.
- There were 136 complaints received about the Accident and Emergency department between June 2014 and June 2015. Two were related to A&E admissions, 42 related to triage, 10 related to attitude, 28 related to diagnosis, 25 related to communication, 11 related to discharge and 19 related to care of elderly, disabled or vulnerable patients. There was evidence that complaints had been acknowledged and responded to in line with the trust complaints policy.

Are urgent and emergency services well-led?

Requires improvement

We rated well-led as requires improvement. Senior nursing leadership capacity was limited to one band seven and one band eight nurse supported by a team of band six and band five nurses. Although there was a competency framework in place, we were not assured about the level of leadership capacity. Additionally we had concerns about risk management and the lack of evidence that risks were being managed in a timely way specifically through the risk register. The trust was aware of the need to review risk register management and had revised the risk management strategy; however the action plan had not been implemented at the time of inspection.

Staff we spoke with felt they were well-led at departmental and trust level. Staff were able to take part in national and local staff surveys and felt that they could express their opinions and concerns about the department to their managers. We found the department had a positive and supportive team working focussed culture. There were processes in place to manage governance and measure quality; however these were not multidisciplinary in nature.

The department was working on a revised strategy and looking at ways to manage demand. This had led to some innovative practice such as the introduction of GP staff to work within the department on weekends.

Vision and strategy for this service

- The department had a strategy in place which was in the process of being revised due to changes in future service configurations.
- Managers in the department were aware of the increasing demands on the department and the increasing number of patients accessing the accident and emergency department. Work was underway to look at how increased demand could be managed and how the department will grow to meet future patient needs.
- Staff we spoke with were aware of the future plans for the department and were aware that work was ongoing to decide how the department would develop.

Governance, risk management and quality measurement

- The department had monthly patient safety meetings that reviewed complaints and compliments, incidents, serious untoward incidents including the summary report, claims, application of duty of candour and clinical audit outcomes. These meetings were generally attended by eight consultants, two matrons, the patient safety lead, the clinical director and general manager. The clinical audit meetings were attended by medical staff and the senior clinical matron and updates were circulated to nursing staff. The directorate meetings also included governance issues as well as operational topics. The minutes of these meetings did not demonstrate a regular review of the departmental risk register.
- We looked at the risk register sent to us by the department. Risks were graded and actions taken were reported upon. There were 46 risks recorded. We found that some risks had been on the register since 2001 and remained as moderate risks. Some risks such as the robustness of business continuity plans remained as moderate risks on the register. It was unclear why the risk remained moderate. It was also identified in January 2011 that the department was not adequately prepared to respond to a chemical incident. The latest review of this risk was in July 2014 when the risk remained moderate, suggesting that the department

was still not adequately prepared to deal with a chemical incident. Some risks remained on the risk register despite being resolved; for example, relating to pager use during major incidents.
- There was a system in place for assessing new NICE and other clinical guidance and ensuring that staff were aware of any changes to clinical practice as a result. NICE guidance was discussed at monthly audit meetings. Any urgent alerts were discussed at daily safety huddles.
- The department took part in national CEM audits and other locally agreed audits of clinical practice. We saw action plans and evidence of changes implemented as a result of audits, for example, amended documentation and improved record keeping.
- Staff from the department attended the trust wide morbidity and mortality meetings.
- The department produced a monthly dashboard which clearly showed the department's performance against national and local targets.

Leadership of service

- We found that the leadership in the department needed to be strengthened. Senior nursing leadership capacity was limited to one band seven and one band eight nurse supported by a team of band six and band five nurses. Although there was a competency framework in place, we were not assured about the level of leadership capacity. This was an issue that was recognised by the trust and additional general manager capacity had been added during the past year.
- We saw that medical leadership was effective with clear lines of responsibility. The department was headed by a triumvirate which consisted of a general manager, a clinical director and a nursing manager.
- Staff told us that members of the executive team, other than the medical director who still worked in the department occasionally, rarely visited the department. Staff felt that their hard work was rarely acknowledged to them.
- Nursing staff told us that they felt well led at a local level and that they had no concerns with their line managers. They felt that they could raise concerns and be confident that they would be resolved whenever possible.
- We saw evidence from meeting minutes that nursing values (the 'six c's') were discussed with staff on a regular basis.

Culture within the service

- Staff told us that there was an open and supportive culture within the department.
- Staff told us that morale in the department had improved recently with the appointment of new senior staff. Comments included, "There is more of a patient focus rather than a target focus now" and "Staff feel that their welfare is important too and if we are unwell and come to work, managers will tell us to go home".
- We had no concerns that there was a bullying culture in the department. Staff felt supported and were supportive of each other. We saw and were told that staff had very good professional relationships.
- Staff told us that they were treated as equals, no matter what their role or experience. All staff were encouraged to contribute to 10 minute teaching sessions which happened on a daily basis.

Staff engagement

- We saw that regular staff meetings took place every month for both medical and nursing staff. Additionally, daily safety huddles, board rounds and ten minute teaching sessions took place every day. Staff were able to contribute open and honestly to these sessions.
- The national staff survey of 2014 showed that the trust as a whole scored better than other similar trusts for staff working extra hours, staff witnessing or experiencing bullying or harassment and staff witnessing potentially harmful errors or near misses. There were no specific results for the accident and emergency department.
- The national staff 2014 survey showed that the trust as a whole was performing worse than other similar trusts for staff thinking their role made a difference to patients, effective team working, receipt of health and safety training, staff reporting errors, near misses or incidents witnessed, staff feeling pressure to attend work when unwell, staff motivation, staff receiving equality and diversity training in the last year and overall engagement. There were no specific results for the accident and emergency department.

Innovation, improvement and sustainability

- The department had introduced GPs to the department on weekends as a way of ensuring that patients were seen quickly and by the most appropriate clinician.

Urgent and emergency services

- There was a trial using the patient flow facilitator 24 hours a day to ensure that during busy times, patient flow was managed and patients avoided waiting in the department until a bed was found for them elsewhere in the hospital.
- All staff were aware that the department was too small and that the configuration of the physical environment was not ideal. Since confirmation had been received that a new hospital was not to be built in the foreseeable future, managers were in the early stages of looking at how the department would be improved to meet future capacity demands.

Medical care (including older people's care)

Safe	Good
Effective	Requires improvement
Caring	Good
Responsive	Good
Well-led	Requires improvement
Overall	Requires improvement

Information about the service

The University Hospital of North Tees in Stockton on Tees provides a range of medical care services, including older peoples care, and is managed by the In-Hospital Care directorate. There were 12 medical wards, including ambulatory care, emergency assessment unit (EAU) and rapid access unit (RAU). There were a number of different medical specialities provided, such as general medicine, care of the elderly, cardiology, respiratory medicine, gastroenterology and stroke care. In 2013-2014 there were 30,000 medical admissions to the trust of which 58% were emergency admissions, 2% were elective admissions and 40% were day case admissions.

We looked at 14 care records and prescription cards. We spoke with 31 patients and relatives and 108 staff, including doctors, nurses, therapists, pharmacists and mangers. We visited 12 wards and endoscopy day unit, carried out observations on the areas we visited. Before the inspection, we reviewed performance information from and about the trust.

Summary of findings

We rated medical care services as good for safe, caring and responsive and requires improvement for effective and well-led.

Areas of concern included management of risk registers, management of clinical policies and the continuing worse than expected performance related to mortality ratio. Hospital Standardised Mortality Ratio (HSMR) compares the number of deaths in a trust with the number expected given age and sex distribution. HSMR adjusts for a number of other factors including deprivation, palliative care and case mix. HSMRs usually expressed using '100' as the expected figure based on national rates. In 2014/15 the Trust had an increased HSMR of 124.5 (year to May 2015); this was higher than expected. The Summary Hospital-level Mortality Indicator (SHMI) was 123.5 (year to May 2015); the trust was among the 11 worst performing trusts in England for mortality performance. The trust had implemented plans to improve the trust position in both indicators and been open to expert scrutiny.

Systems were in place to report incidents, analysis and feedback was provided to staff. Wards monitored safety and harm free care and results were positive, overall. Wards were clean and staff adhered to infection control principles, however, we did observe some doors left open on side-rooms where patients were in isolation. Some of the ward areas were cluttered and cramped. Patients' records and observations were recorded appropriately and concerns were escalated in

Medical care (including older people's care)

accordance with the trust guidance. The trust had highlighted the high number of nursing vacancies as a concern and plans were in place to improve this, staffing was reviewed on a day by day and shift by shift basis, using agency staff as required. Attendance at mandatory training and safeguarding was good in all specialities.

Almost all patients and relatives told us that they or their relatives had been treated with compassion and that staff were polite and respectful. Patients were aware of what treatment they were having and understood the reasons for this and, in many cases, had been involved in the decisions. The trust had prioritised and developed a number of initiatives to improve the care of people living with dementia, including the use of therapeutic volunteer workers.

The In-Hospital care directorate had a clear vision and strategy; we spoke with staff who demonstrated pride and compassion in the care that they provided. Medical and nursing staff told us there was a positive cultural and management genuinely listened about issues. At the time of the inspection 88% of staff in the In-Hospital care directorate had received an annual appraisal. The trust was proactive in planning discharges and utilised step down wards to manage those medically fit, but not therapy fit for discharge.

Are medical care services safe?

Good

Services were safe and people were protected from harm, learning was demonstrated following a never event and processes were being put in place to mitigate the risk of it happening again. Staff informed us they were actively encouraged to report incidents, including grade one pressure ulcers. During our inspection we were provided with samples of the Duty of Candour in action.

The wards we inspected were clean and infection control policies were adhered to, however, we did observe doors left open on side rooms where patients were being barrier nursed. There were suitable arrangements for the safe disposal of waste. We observed that some wards were cramped; as a result the emergency resuscitation trolley for the Haematology day unit was kept through two doors in the discharge lounge.

We reviewed patient care records, these contained standard risk assessments and also a standardised approach to goal setting and care planning utilising elements of care. The adult safeguarding team had a visible presence on the wards, and supported staff in strategy meetings. The adult safeguarding pathway was displayed on all wards we visited.

The In-Hospital Care directorate had 33 whole time equivalent (wte) nursing vacancies. There was a trust wide recruitment strategy which included an adaptation programme for overseas nurses who resided in the UK and also planned visits to the Philippines, there were also rolling recruitment adverts. The Trust used an evidence based acuity tool to calculate ward establishment, additionally staffing was discussed daily and nurses and health care assistants were flexed to provide safer staffing levels across the directorate.

Incidents

- One Never Event was reported in March 2015. Never Events were defined at that time as serious, largely preventable patient safety incidents that should not occur if the available preventative measures have been implemented. This event was categorised as a wrong

site surgery. Learning was shared by using ward based simulations and led to the development of an adapted World Health Organisation (WHO) safety checklist for medical procedures.

- A policy was in place for the reporting and investigation of incidents inclusive of Never Event reporting requirements and staff were aware of the policy. Incidents were reported electronically using an online reporting system. Between December 2014 and March 2015 there were 930 incidents reported by the In-Hospital Care directorate. Of these 24% (224) were attributed to patient falls.
- Strategic Executive Information System (StEIS) reported 28 serious incidents between 1 May 2014 and 30 April 2015. The most frequent subject was slips trips and falls 68% (number:19). We saw evidence of learning from incidents, such as fall sensors in high risk areas. We were told that 1:1 supervision within a close observation area was in place for at risk patients, however this was not observed during inspection.
- Staff at all levels informed us they were actively encouraged to report incidents including grade one pressure ulcers. They were confident about reporting incidents, near misses and poor practices. Staff were able to describe recent incidents and clearly out lined actions that had been taken as a result of investigations of incidents to prevent recurrence.
- We reviewed medical executive team meeting minutes and mortality was discussed as a specific agenda item in one of the papers, however, we reviewed further evidence, which showed discussions on mortality and morbidity was discussed at all meetings through the directorate. The trust also held weekly morbidity and mortality meetings to review the week's cases from the previous week
- During inspection we were told of examples of duty of candour. Staff reported using duty of candour to inform patients and their families about incidents, processes being used to investigate them and improvements that were implemented to prevent a recurrence.

Safety thermometer

- The In-Hospital Care directorate was managing patient risks such as falls, pressure ulcers, blood clots, and catheter acquired urinary infections, which are highlighted by the NHS Safety Thermometer assessment tool. The NHS Safety Thermometer is a tool designed to be used by frontline healthcare professionals to measure a snapshot of these harms once a month.
- The trust monitored these indicators and displayed information on the ward performance boards; throughout our inspection all boards we observed were up to date to the previous month and current ward performance. Staff told us that individual ward performance was discussed regularly at staff meetings. Minutes of staff meetings we reviewed confirmed this.
- The results between May 2014 and May 2015 fluctuate between highs of harm free care on some wards to lows of 64% on ward 42 in January 2015. This meant that or is it 36% of patients on ward 42, at the time the thermometer was taken had suffered some sort of harm (e.g., fall, pressure ulcer, blood clot or catheter acquired infection).

Cleanliness, infection control and hygiene

- The wards we inspected were visibly clean. There were cleaning schedules in place and levels of cleanliness were audited regularly.
- Hand towel and soap dispensers were adequately stocked. There was a sufficient number of hand wash sinks and hand gels.
- The hospital infection rates for Clostridium difficile (C.diff), including the wards within the In-Hospital Care Directorate, had been better the England average, with only 28 cases reported trust wide between May 2014 to May 2015. Methicillin Resistant Staphylococcus Aureus (MRSA) infection rates had been better than the England average since May 2014 with only one reported case.
- Staff were aware of current infection prevention and control guidelines. We observed staff following good hand hygiene practice on all of the wards we visited. We observed patients nursed in isolation with loose stool, but following stool sample had no infection.
- On Ward 37 universal infection prevention and control procedures were not always followed as we observed doors left open on side rooms where patients were barrier nursed. We also reviewed patient toileting arrangements and we observed faeces on a toilet bowl, which had not been cleaned by the time we inspected. We also observed paper towels on the floor which were not picked up by staff, however when we returned to the ward this had been addressed.

- There were suitable arrangements for the safe disposal of waste. We saw that used linen that presented an infection risk was segregated and managed appropriately. Clinical and domestic waste was segregated in colour-coded bags and managed appropriately. Sharps such as needles and blades were disposed of in approved receptacles.

Environment and equipment

- Staff on all wards told us that equipment including falls sensors was readily available and any faulty equipment was either replaced or repaired promptly.
- We checked the resuscitation equipment on all of the wards we visited and found that the resuscitation trolley on Ward 41 was not always checked daily.
- We reviewed a sample of equipment on each ward we visited and not all equipment had a valid Portable Appliance Test (PAT) sticker on them, these included electronic thermometers on Ward 42 and electronic blood pressure monitoring on Ward 40. Full PAT testing documentation was reviewed and we were assured that the trust had robust systems in place to monitor equipment. Staff told us that the medical devices department coordinated monitoring of equipment and calibration of scales and this was done yearly.
- During our inspection we noted that the conservatory attached to the discharge lounge was accessed through a fire door, however, there was no handle on this door to return to the lounge as required, hence the door needed to remain open. We highlighted this as a risk during our inspection and the fire warden was called to review.
- The emergency resuscitation trolley for the haematology ward was kept on the discharge lounge and was accessed through two doors, checks on this equipment were completed daily, however, there was not suitable space for the trolley to be kept on the haematology ward. It was found that the haematology ward was cramped and our expert by experience found it difficult to negotiate the area when interviewing patients.
- We noted on Ward 37 that patient toilets had no signage on the doors to state they were engaged to those wishing to enter.

Medicines

- The hospital used a comprehensive prescription and medication administration record chart for patients which facilitated the safe administration of medicines, however, compliance in completing the records varied. We reviewed 14 medication charts during our inspection, the majority were completed appropriately, however, we noted inconsistency in the codes used to omit doses, which did not follow trust policy, exact times of doses were not always documented. Medicines interventions by a pharmacist were recorded on the prescription charts to help guide staff in the safe administration of medicines.
- Controlled drugs were stored and managed appropriately.
- Drugs stored in fridges were in date, however, they were disorganised and patient take home medications were stored together with ward stocks.
- We observed drug rounds, however, the approach to managing the drug round varied across the wards. The drugs trolley on Ward 41 was clearly labelled "Do Not Disturb" to ensure the round was not interrupted. We observed staff supporting patients to take their medications as directed.

Records

- During our inspection we reviewed 19 sets of patient records. The trust used standard nursing care records across In-Hospital Care directorate with the exception of Ward 41, where they used specific stroke documentation in line with the standardised documentation. Nursing records were comprehensive, current and easy to navigate and contained all the information required to support the delivery of safe care.
- The nursing documentation contained a range of risk assessments covering the major risks for patients. The standardised risk assessments covered risks such as tissue damage, risks of falls and use of bed rails. These had usually been updated when required. Alongside the risk assessment, the trust developed 'Elements of Care' to support a standardised approach to care planning, however, there was also scope to personalise these.
- We reviewed 19 sets of medical and allied health professional records on four wards and found them to be accurate, legible, signed and dated, easy to follow and gave a clear plan and record of the patient's care and treatment. It was noted that on one patient record that there was no indication the patient required a communication tool; however, we were informed of this by a ward doctor.

Medical care (including older people's care)

Safeguarding

- There was a system in place for raising safeguarding concerns. Staff were aware of the process and could explain what was meant by abuse and neglect. This process was supported by staff training.
- The adult safeguarding team had a visible presence on wards as the team undertook a walk round three to four times a week. We were informed that this enabled the team to pick up supervision needs and any developing issues. The adult safeguarding team also supported staff during strategy meetings
- All frontline staff we spoke with had received safeguarding training and were aware of their individual responsibilities regarding the safeguarding of both children and vulnerable adults. All wards we visited had an adult safeguarding pathway displayed in the ward area.

Mandatory training

- Levels of mandatory training within the In-Hospital Care directorate were positive, with very few areas where training levels were below the target for example resuscitation training. We were told that simulation training was currently being rolled out in the ward areas; however, this was dependant on capacity within the ward and patient numbers.
- It was noted that resuscitation training for the In-Hospital Care directorate was at 52%; we saw no plans in place to improve this position.

Assessing and responding to patient risk

- Staff within the medical division used the National Early Warning Score (NEWS) which was designed to identify patients whose condition was deteriorating. Staff were prompted when to call for appropriate support. The chart incorporated a clear escalation policy and gave guidance about ensuring timely intervention by appropriately trained personnel. We found that that staff understood the tool and escalated changes in the patient's condition appropriately.
- We found that the response provided by medical staff to a patient whose condition was deteriorating was timely and effective. For example, all patients admitted through the EAU were reviewed by a consultant within 14 hours of admission.
- Patients admitted with suspected stroke (who were identified as having facial palsy and arm weakness) were reviewed by senior nursing staff following the stroke pathway and admitted to the stroke ward via the scan department, to ensure patients were assessed and treated in a timely manner.
- Medical staff were supported out of hours, by an intensive care unit (ITU) outreach team of nurse specialists. Medical and nursing staff spoke positively about the outreach team and the timeliness of their response.

Nursing staffing

- The trust used an evidence based acuity tool to calculate nursing establishment at ward level. Additionally nursing staffing levels were reviewed throughout the In-Hospital care directorate twice each year. Staffing levels had been assessed using a validated acuity tool. There were minimum staffing levels set for medical wards throughout the hospital. Planned and actual staffing numbers were displayed on every ward we visited and in all cases during our inspection planned and actual staffing levels were safe. We reviewed the 2015 workforce analysis report which identified registered nursing vacancies of 33 whole time equivalent (wte). There was a trust wide recruitment strategy which included an adaptation programme for overseas nurses who resided in the UK and also planned visits to the Philippines, there were also rolling recruitment adverts.
- Staffing risks were mitigated by a daily staffing meeting, which ensured that all wards were staff staffed and supported; this involved flexing staff across the directorate as required.
- The trust did not operate a nurse bank, and supported vacant shifts on a daily basis through NHS Professionals (NHSP). Staff informed us that staff rostered from NHSP could cancel shifts with little notice; this was fed back to NHSP and incident forms submitted. Between April 2014 and March 2015, nurse agency use was found to be 9% across the directorate, however, some areas had higher use of agency nurse staff. For example Ward 42 had an agency use of 15% for the overall year, however, between, October 2014 and January 2014 Ward 37 had an average agency use of 28%

Medical care (including older people's care)

- The In-Hospital Care directorate employed 14 wte 1:1 band one support workers to support the programme of falls reduction; these were non-clinical staff whose role was to protect patients from harming themselves or others and to observe the patient's behaviour.
- Nursing handovers were supported by the electronic bed management system, patient progress was documented on to the system and this was then printed for nurse information sheets. At the end of each shift this was then disposed of in confidential waste.
- Staffing on the respiratory wards (24 and 25) had been acknowledged by the directorate as requiring additional resource due to the number of patients who met the criteria for Non Invasive Ventilation Level One care. Staff informed us that staffing ratios were one registered nurse to two patients in the high intensity monitoring bay. This was in line with trust policy and national guidance and at the time of inspection we observed this policy being followed.
- We were informed by staff that Ward 37 experienced high levels of staff shortages throughout the winter months; this resulted in a significant number of different agency staff who were unfamiliar with the ward surroundings and requiring support and affecting patient safety. This was escalated to the executive team and agency nurses were block booked to mitigate the risk.
- Agency staff were orientated to the ward environment and supported locally. The trust had an arrangement with NHS professionals (NHSP) to ensure their staff were appropriately trained.

Medical staffing

- The trust acknowledged that senior medical staffing was a concern, however, reported there was a regional shortage of senior positions, and had plans in place to support recruitment and retention of staff. The ratio of consultants to other medical staff was worse than the England average. There were 159 wte medical staff within the In-Hospital Care directorate of which 28% were consultant posts, which was worse than the England average of 33%. Middle career and registrar groups were again below the England average; however there were 36% junior doctors compared to 22% nationally.
- There was appropriate consultant cover, which included cardiologist of the week, gastroenterologist of the week, gastrointestinal bleed consultant of the week and stroke physician of the week, all 24hours a day (7 days per week).
- Consultants were onsite from 8am to 9pm, seven days a week. No consultants were routinely on site over night, but cover was provided by an on call system.
- Handovers were both verbal and electronic using the integrated bed management system. During inspection we observed medical handover on Emergency Assessment Unit (EAU); this was attended by consultant's speciality trainees and junior doctors. Staff reported that this was undertaken seven days a week.
- During our inspection we met with the executive team for In-Hospital Care directorate who advised that medical recruitment was a directorate priority. The directorate used locums to backfill positions. For example; there was one substantive consultant in haematology and two locum consultants. Data provided by the trust showed that the locum usage in the directorate between April 2014 and March 2015 was 9.4%

Major incident awareness and training

- There was a major incident plan in place and staff we spoke with were aware of this.
- The trust and regional partners had escalation/resilient plans which were enacted when required for example bed capacity was reduced the North East Escalation Plan (NEEP) this is graded one (normal) to four (severe pressure), During our inspection the trust was at a NEEP level 3 (increased pressure).

Are medical care services effective?

Requires improvement

We rated medical services as requires improvement for effective.

Hospital Standardised Mortality Ratio (HSMR) compares the number of deaths in a trust with the number expected given age and sex distribution. HSMR adjusts for a number of other contextual factors and is usually expressed using '100' as the expected figure based on national rates. In 2014/15 the Trust had an increased HSMR of 124.5 (year to May 2015); this was higher than

expected. The Summary Hospital-level Mortality Indicator (SHMI) is the ratio between the actual number of patients who die following hospitalisation at the trust and the number that would be expected to die on the basis of average England figures, given the characteristics of the patients treated there. The SHMI was 123.5 (year to May 2015) which remains higher than expected; the trust was reported in July 2015 (health and Social Care Information Centre) as among the 11 worst performing trusts in England for mortality performance. The trust had implemented action plans to improve the trust position in both indicators and was open to expert scrutiny.

Staff were aware of the local policies and procedures. We reviewed policies during our inspection, however, of the 53 policies we reviewed electronically 25% (13) were within date and 30% (16) had not been approved. Audits were undertaken to monitor compliance with guidance. Pain relief, nutrition and hydration needs were met. At the time of inspection 88% of staff in the In-Hospital Care directorate had had an appraisal. The hospital had a co-ordinated system for medical handovers. We saw evidence of good multidisciplinary (MDT) working across the directorate in particular on the stroke ward and the step down ward.

Evidence-based care and treatment

- Staff used a combination of National Institute for Health and Care Excellence (NICE), and Royal Colleges' guidelines to determine the treatment they provided. Local policies were written in line with this and had been updated periodically, as required; however, the In-Hospital care directorate policies were available on the Trust intranet site. We reviewed policies during our inspection, however, of the 53 policies we reviewed electronically 25% (13) were within date and 30% (16) had not been approved. We were advised that the policies has been transferred the week before our inspection to a new intranet page.
- Specific local audits were undertaken within each of the medical specialities, relevant to the care and treatment provided within the speciality. In addition, more general audits were undertaken across the In-Hospital Care directorate. These included infection control and documentation audits we observed action plans as a result of these audits.
- The endoscopy unit had a Joint Advisory Group (JAG) accreditation. JAG accreditation is the formal recognition that an endoscopy service has demonstrated that it has the competence to deliver against the measures in the endoscopy Global Rating Scale standards.
- Staff informed us that that NICE guidance was followed in relation to sedation of the agitated patient, as there was no trust policy available for this.
- There were specific care pathways for certain conditions in order to standardise and improve the care for patients. For example, care pathways were used for the care of patients with stroke and the assessment of thrombolysis.

Pain relief

- Pain relief was provided as prescribed and there were systems in place to make sure additional pain relief could be accessed via medical staff if required.
- Patient records indicated that pain relief was incorporated into their elements of care, this supported the management of people's pain and checks were recorded as required.
- Patients told us they were asked about their pain and if they required any pain relief. Patients we spoke with had no concerns about how their pain was managed.

Nutrition and hydration

- Patients were assessed regarding their nutritional needs using the Malnutrition Universal Screening Tool (MUST), patient weights were recorded twice weekly. This was corroborated in the notes that we observed. We were informed if a patient's height was unable to be recorded conventionally; height was estimated using ulnar measurement.
- We observed completed fluid balance charts; however, we observed one chart that had 700mls of fluid intake in a 24hr period, which is below the daily recommended fluid intake.
- Relatives were encouraged to support their family members during mealtimes. This was especially the case on ward 41 when the patient was coming close to discharge.
- We observed red trays for at risk patients who required support with feeding and also coloured plates and bowls for patients living with dementia.
- We were told how ward staff met with the catering department to improve the quality of the pureed and fortified foods; we were told that "carrot's now look like carrots",

- Seven patients we spoke with reported the food provided during their stay was satisfactory; these patients valued the opportunity to choose the size of their meal.

Patient outcomes

- Hospital Standardised Mortality Ratio (HSMR) compares the number of deaths in a trust with the number expected given age and sex distribution. HSMR adjusts for a number of other factors including deprivation, palliative care and case mix. HSMRs usually expressed using '100' as the expected figure based on national rates. In 2014/15 the Trust had an increased HSMR of 124.5 (year to May 2015); this was higher than expected. The Summary Hospital-level Mortality Indicator (SHMI) was 123.5 (year to May 2015); the trust was among the 11 worst performing trusts in England for mortality performance. The trust had implemented plans to improve the trust position in both indicators. For example, the trust had introduced centralised weekly mortality and morbidity meetings incorporating palliative care input and led by the deputy medical director. The review group used a national mortality assessment tool; this enabled consistency in the way in which each case was evaluated and discussed. In addition, clinicians were working with the coding department and there was a dedicated clinical lead in medical services.
- In the Sentinel Stroke National Audit Programme (SSNAP) audit, the trust had shown mixed results with several areas showing improvement and the stroke unit and specialist assessments performing consistently well. However, scanning and speech and language therapy scored consistently poorly with the SNAPP level for both patient centred key indicators (KI) levels and team-centred KI levels performing towards the bottom of the scale. The overall SSNAP level for the trust is D. The trust's team-centred stroke unit score is consistently high.
- There was an acute stroke integrated care pathway and record in place for patients. Patients were admitted directly to the ward and if required senior nursing staff attended the Accident and Emergency department to triage a patient with suspected stroke, in order to reduce any delay in scanning and thrombolysis..
- In the heart failure audit, three out of four In-Hospital care indicators and five out of seven discharge indicators were better the England average.
- Performance in the national diabetes inpatient audit (NaDIA) September 2013 indicated that out of the 21 indicators the hospital was better that the England median average in 13 areas and worse than the England median in six, there was no data available with regard to foot risk assessments after 24 hours and percentage of renal replacement therapy.
- Two out of three non-ST-Segment-Elevation Myocardial Infarction (nSTEMI) indicators were worse than the England average for University Hospital North Tees. There had been a large drop in the percentage of patients admitted to a cardiac unit or ward from above average in 2012/13 at 82.9% to below average in 2013/14 at 50.5%.
- The standardised relative risk of re-admission rate for both elective and non-elective episodes was comparable or better than the standardised England average with the exception of elective Clinical Haematology at University Hospital of North Tees.
- The average length of stay for elective admissions in the University Hospital of North Tees was equal to the England average at four days. The average length of stay in General Medicine was three days; this was better than the England average of five days, but Clinical Haematology had an average length of stay of seven days which was worse that the England average of six days. The average length of stay in respiratory medicine was equal to the England average at four days.
- The average length of stay for non-elective admissions in the University Hospital of North Tees was 6 days, this was better than the England average of nine days. The average length of stay in General medicine was equal to the England average of six days, however, average length of stay in clinical haematology the was 7 days and cardiology was eight days these were both worse than the England average of six days.
- Standardised relative readmission rates for elective medical patients in the University Hospital of North Tees ran worse than the England average (100) for clinical oncology (117), clinical haematology (124) and general medicine (102). For non-elective patients, standardised relative readmission rates ran worse than the England average (100) for general medicine (102) and better than the England average for clinical Haematology (67) and clinical oncology (72).

Competent staff

- We reviewed appraisal data provided by the trust; at the time of the inspection 88% of staff had received an appraisal within the last 12 months.
- Figures from the 2014 NHS staff survey indicated that 70% of staff in the medical divisions had in the last 12 months, had an appraisal. The same survey identified that 81% of staff had received job-relevant training, learning or development in the last 12 months.
- Student nurses told us they were supported by a university educator; they also told us they received good support from their ward based mentors and received a good balance of practical skills and theoretical knowledge. All students had been through a 360 degree feedback process whilst on the wards to appraise their performance, this included feedback from staff, patients and their relatives.
- Allied health professionals and support staff who spoke with us reported they were supported to participate in external training relevant to their role.
- Junior doctors we spoke with felt supported through their induction programme, we were told that there was lots of teaching in the In-Hospital care directorates with one session per week core medical training
- Some non-registered staff told us there were opportunities for development. We were given examples of staff being supported with the leadership programme and feeling that this empowered them to bring about positive change in their own work place.

Multidisciplinary working

- Multidisciplinary teams (MDTs) worked well together to ensure coordinated care for patients. From our observations and discussions with members of the multi-disciplinary team, we saw that staff across all disciplines genuinely respected and valued the work of other members of the team.
- On Wards 41 (stroke ward) and 37 (step down ward) we observed integrated MDT working, occupational therapists and physiotherapists based on the wards and working alongside nursing and medical professions. We spoke with health care assistants (HCAs) who were encouraged to work alongside the allied health professionals. The rationale for this was to share areas of good practice and provide consistency of support for the patients.
- Therapy staff we spoke with said they felt a valued part of the MDT.
- Staff told us that referral between specialist teams was usually seamless, however, not all teams used the same process, for example some teams accepted telephone referrals and others accepted referrals via emails. This could cause confusion amongst staff.
- Transfers from the acute setting in North Tees and Holdforth Unit were led by a consultant geriatrician, who we were told assessed the suitability of patients for transfer.
- The Trust worked with three local authorities and we were told that relationships between the Trust and adult social care departments were good.
- Staff we spoke with informed us that they were supported by the specialist psychiatric nurse. We were able to corroborate this as we observed outcomes of reviews and evidence in patient notes.

Seven-day services

- Consultant cover was available Monday to Friday on all the medical and care of elderly wards where daily ward rounds took place.
- Seven day cover was provided on the EAU, where consultants worked 8am to 9pm. Specialist registrars provided overnight cover and consultants were available on an on call rota.
- The trust has implemented a consultant of the week initiative and this included gastroenterologist and cardiologist of the week. Additionally the trust had a consultant on call for gastrointestinal bleeds 365 days per year and access to stroke and transient ischaemic attack services.
- Ward rounds took place several times a day on EAU, this process included the patient flow team.
- Staff we spoke with informed us there was access to on call physiotherapists, radiology, chaplaincy and catering services.
- A critical care outreach team provided 24 hour support for the deteriorating patient.
- The patient flow team provided site cover 24 hours a day and 7 days a week with non-clinical bed managers supporting 10.00am to 10.30pm.

Access to information

- Doctors told us they received test results and information in a prompt timeframe.

- Guidelines were stored on the trust intranet pages, however, doctors informed us that the trust guidelines were difficult to find and use. Additionally they were in need of review and updating.
- The adult safeguarding pathway was displayed in all wards we visited.
- We were shown handover sheets which had been generated by the electronic bed management system; they contained detailed and thorough information.
- Information was communicated throughout the In-Hospital care directorate through monthly bulletins, each patient had an information board at the head of the bed, this was updated each shift. This detailed the patients' consultant and nurse responsible for their care during that shift.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- Patients were asked for their consent to procedures appropriately and correctly. We saw staff obtaining verbal consent when helping patients with personal care
- We reviewed three Deprivation of Liberty Safeguards (DOLS) urgent and standard authorisation forms which had been completed to a high standard by the ward matron supported by the safeguarding lead nurse. A capacity assessment had been undertaken appropriately, a best interests form completed and a referral made to the mental health team. The forms had been countersigned by an appropriate individual.
- We reviewed records that showed every time a DOLS application was completed by staff, an incident was recorded on the Electronic reporting system.
- We were informed that all Mental Capacity Act (MCA) assessments should be shared with the Safeguarding team.
- We reviewed MCA documentation in six health care records; these were found to be not fully completed in where families had not signed the forms to confirm consent, there was no indication of whether this was because there was no family member to do so. At the time of our inspection there were no formal processes to audit MCA and best interests assessments.
- MCA and DoLS training was included within the adult safeguarding training. Training records showed that 94% of staff had been trained. We were informed by leads that plans were in place to recruit ward champions and ward managers to undertake additional training in MCA assessments, whilst being supported by the safeguarding team.

Are medical care services caring?

Good

Almost all patients and relatives told us that they or their relatives had been treated with compassion and that staff were polite and respectful. The percentage of patients who would recommend the services was consistent with or higher than the national average in December 2014 according to the friends and family test results. The trust performed about the same as other trusts in relevant questions in the 2014 CQC inpatient survey. Patients we spoke with were aware of what treatment they were having and understood the reasons for this and, in many cases, had been involved in the decisions made about their care.

Compassionate care

- We observed all staff talking about patients during the huddles and MDT meetings with care, respect and compassion.
- The NHS Friends and Family test results (FFT) results between December 2013 and November 2014 indicted the response rate was worse than the England average (29.1% compared to England average of 30.1%). The percentage of patients who would recommend the services was consistent with, or better than, the national average during this time.
- Senior Managers told us they found the FFT results useful, it helped them to make local improvements.
- We spoke with 29 patients during our inspection; all were very complimentary of the care they received: A patient and their family on Ward 42 summed up their care as "Marvellous". Patients on Ward 24 told us the care was "very good, the staff are absolutely wonderful, they will do anything for you. Patients on Ward 41 were very positive about all aspects of their care saying "I feel very safe here. The staff are all very good and it's a nice atmosphere". A day case patient in endoscopy told us that "staff made what was originally a very nervy

experience so welcoming and human; they are on the ball here." A patient and their family approached us in a corridor to tell us they had been treated wonderfully since she had been there.
- The trust performed around the same as other trusts in relevant questions in the 2014 CQC inpatient survey such as nurses answering questions in a way patients could understand.
- The 2014 National Cancer Patient Experiences Survey results showed that 93% of respondents rated their care excellent or very good compared to the England average of 89%. Of the 70 questions, 32 responses rated the trust as within the top 20% of trusts nationally.

Understanding and involvement of patients and those close to them

- Patients and relatives said they felt involved in their care.
- They told us they had sufficient opportunities to speak with the consultant and other members of the multi-disciplinary team looking after them about their treatment goals. This enabled patients to make decisions about and be involved in their care.
- Patients told us that if they did not understand any aspects of their care that the medical, nursing or allied health professional staff would explain to them in a way that they could understand.

Emotional support

- We were informed by staff that there were a number of therapeutic volunteers who provided support to patients, especially those living with dementia, however, the volunteers attend the wards during the afternoons, however, staff informed us volunteer support would be more valuable in the morning when the ward area is exceptionally busy. During our inspection we did not observe any volunteer on the ward.
- Almost all patients said they felt supported by staff. Patients and staff spoke positively about their input, for example, we spoke with and observed the dementia specialist nurse who supported patients and their families.
- The psychiatric specialist nurse provided support for patients identified with low mood, we observed observations in the notes and support plans.

Are medical care services responsive?

Good

There were good links with commissioners and other providers, including the ambulance service during the planning and delivery of services. There were processes in place to ensure most patients were cared for in the right place at the right time. Patient flow was a priority and this was proactively managed by the patient flow team. We were advised that patients moves during an admission were monitored using the trust electronic ward board system. The trust used a discharge lounge to maintain flow of admissions and discharges. The trust responded to the winter pressure and increasing numbers of medical boarders, by splitting a surgical ward and using half of the beds as medical beds.

Six weeks prior to our inspection the department introduced a new stroke pathway where patients were reviewed by senior nursing staff from the stroke ward, all assessments were completed and patients were scanned in a more timely manner, Thrombolysis assessments were also completed if appropriate. We were advised work was being undertaken for consultants to review scans at home to streamline the process.

Service planning and delivery to meet the needs of local people

- There were good links with commissioners and other providers, including the ambulance service, during the planning and delivery of services.
- Extended visiting hours had been introduced, this allowed for greater access and support from family and friends.
- Staff we spoke with told us the trust implemented a system of escalation and step down beds to support the needs of patients close to discharge.
- There was a range of clinical nurse specialists at the trust including, alcohol, oncology, Parkinson Disease, anti-coagulation, dementia diabetes, chronic obstructive pulmonary disease, haematology, gastroenterology, cardiac, rheumatology and eating disorders.

Access and flow

- All staff and leads we spoke with identified patient flow as a directorate priority; this was proactively managed

by the patient flow team. This team monitored capacity, demand and appropriate escalation in line with trust policy. The patient flow team had a 24 hour presence in the trust and consisted of a team of; a patient flow manager and nine Senior Clinical Matron Out of Hours (SCHMO) and non-clinical bed managers. The team met three times a day to monitor the flow of patients in the trust, this role is led from a resilience command and control room based in the EAU.

- We were advised that patients should not be moved multiple times during an admission. We reviewed trust wide data which identified 8% of inpatients had one inpatient move, 1% of patients experienced two inpatient moves in 2014/15. Leads informed us that if a patient was required to move wards, those who had already been moved would be avoided.
- We were informed that patients should not be moved after 10pm. We reviewed data which identified 22% of patient moves in the In-Hospital Care directorate occurred between 10pm and 7.59am and this accounted for 2% of all emergency admissions to the In-Hospital Care directorate.
- Patients identified safe for discharge were moved from the base ward to the discharge lounge, this released beds on base wards whilst patients waited for take home medications and transport.
- The discharge lounge was open 9am to 6pm; however, staff told us that it was open until the last patient went home. Between April 2015 and June 2015 there was 1044 patients admitted to the discharge lounge, of these four patients were readmitted to their base ward. The average length of stay in the discharge lounge was 1 hour 39 minutes with the shortest stay recorded as one minute and the longest recorded stay as 7hrs 15minutes.
- The discharge lounge was also used by specialist nurses for procedures where patients would not need to be admitted overnight. For example patients requiring a paracentesis (drainage of fluid from a body cavity). The patients were cared for in a side room and the specialist nurse would stay with the patient, which would not take staff away from the running of the discharge lounge.
- The nurse practitioner led Rapid Assessment Unit (RAU) was open 8am – 8pm. Patients were triaged within 20 minutes; medication prescribed and diagnostics ordered. Patients were directed through to the ambulatory care unit or the emergency assessment unit (EAU).
- The EAU was a 42 bedded unit with consultant cover 8am – 8pm. The length of stay was reported as being 24-48 hours; however, due to the number of side rooms and capacity for beds within the hospital, some patients had stayed on the unit longer.
- The trust operated step down rehabilitation wards for patients identified as medically fit for discharge but who required further rehabilitation. Ward 37 had therapy staff based on the ward coordinating discharges to the community for patients who required continuing healthcare.
- The In-Hospital care directorate referral to treatment time (RTT) for elective care was consistent. Data provided by the trust identified that the 97.9% of cardiology patients and 100% of gastroenterology, general medicine, rheumatology and geriatric medicine referrals met the standard.
- We reviewed the cancer two week wait data; a target had been set at 93% of patients seen in 2 weeks. Between April 2014 and March 2015 an average 94% of patients were seen within the required 2 weeks.
- We asked the trust about the number of medical outliers; this is where a medical patient is placed on a ward not specified for medical care, for example a surgical ward. We were advised that six months prior to our inspection the trust made the decision to split Ward 28 (a urology ward) into a mixed medical and surgery ward to reduce the pressure on medical beds. We were advised that the surgical nursing staff were not provided with additional training to care for the needs of medical patients.
- At the time of our inspection, we were told of 19 medical boarders. This included 14 on Ward 28, three on Ward 31, one on Ward 30 and one on Ward 32. We were advised that a list of boarders was produced every morning and the appropriate medical team would review the patients and were responsible for their care.
- The trust also advised us that Ward 39 was opened specifically to support capacity during the winter pressures. At the time of our inspection this ward was closed.

Meeting people's individual needs

- The trust operated a system of virtual wards. These were described and observed as wards or groups of patients which had similar characteristics. For example the

dementia specialist nurse had a virtual ward of patients assigned which had patients formally diagnosed with dementia and along with those who showed possible signs of dementia but with no formal diagnosis.
- We were told that 1:1 supervision or nursing within a close observation area for at risk patients was provided; however this was not available to observe during inspection.
- The dementia strategy supported the specific needs of patients. The person centred tool "All about me" was offered to all families. The dementia specialist nurse had implemented the "grab bag" which had activities; all 1:1 staff had been trained in how to use them.
- We were also informed of a project working with Hartlepool Council where the details of all clients with learning disabilities had been shared with the trust, when a client with learning disabilities is admitted to the hospital an alert is generated and they are admitted a virtual ward. This ensured that all the trust was able to respond the in an appropriate and timely manner.
- Staff we spoke with were able to use language line if interpreting services were required.
- Access to information was good for patients and their families. We saw examples of comprehensive information for patients regarding the management of their health conditions.
- We were informed that six weeks prior to our inspection, a new stroke pathway was introduced where patients were reviewed by senior nursing staff from the stroke ward, all assessments were completed and patients were scanned in a more timely manner, Thrombolysis assessments were also completed if appropriate. We were advised work was being undertaken for consultants to review scans remotely to streamline the process. At the time of our inspection there was no formal SSNAP data to evidence improvements in the pathway.
- Recent dashboard results were displayed on wards we visited; real time patient feedback on one ward was 44 compliments and no complaints April to June 2015.

Learning from complaints and concerns

- Every ward we visited had information on how to make a complaint prominently displayed.
- We were told that all complaints were discussed during monthly ward meetings and learning from complaints was discussed during this time, this information was corroborated when we reviewed minutes from meetings.
- Staff followed the trust's complaints policy and provided examples of when they would resolve concerns locally such as complaints about ward moves, treatment plans or lost property or how to escalate more serious concerns when required.
- Each ward board we observed had details of the number of complaints and compliments received in the year to date from April 2015 and the previous month.
- The specialty had received 103 complaints in the last 12 months. The main themes were poor communication and delays in being seen. We saw that these had been responded to and action taken where possible to prevent further complaints.

Are medical care services well-led?

Requires improvement

We rated well-led as requires improvement based on concerns around risk management and governance. The In-Hospital Care directorate risk register contained 208 risks, many of which were duplicated; the risk register did not reflect the risks currently faced by the directorate. There was a lack of evidence that risks were not dealt with in a timely way. We found that 75% of policies were not in date and 30% had not been approved which meant there was a lack of assurance that care and treatment reflected current evidence based practice.

The In-Hospital Care directorate had a clear vision and strategy; we spoke with staff who demonstrated pride and compassion in the care that they provided. Consultants told us there was a positive cultural and management genuinely listened to consultants and medical staff about issues such as: recruitment, training and improvements for medical patients. Junior doctors reported that they were well supported by senior colleagues.

Vision and strategy for this service

Medical care (including older people's care)

- There was a clear vision for the service and how it would function through an integrated health economy. Staff we spoke with were aware of the corporate vision of the trust.
- Some wards had their own 'philosophy of care', identifying what they achieved well and areas for development on the ward. Two staff we spoke with on these wards knew of their ward vision.
- Individual staff spoke with pride and compassion about what they thought good care looked like and how they demonstrated this on a daily basis.

Governance, risk management and quality measurement

- We reviewed the In-Hospital Care directorate risk register, which contained 208 risks in total. There were no current high risk items on the register as some had been downgraded following review, however there was a lack of evidence of consistent treatment of risks or of risks being removed once actions were complete and the risk was judged as mitigated. For example the correct use of emergency suction equipment was initially categorised as high risk, however, this risk had been reviewed was downgraded to moderate risk, on further inspection there were 16 risks associated with suction equipment and with the majority (12) sharing the same title "Correct use of emergency suction equipment". Much of the information around the risks was repeated.
- We reviewed 53 policies and guidelines which were available on the intranet we found that 75% (37) of local policies were not in date and were not highlighted as under review. Additionally 30% (16) had not been approved.
- Medicine performance was recorded electronically and shared throughout the directorate. We reviewed medical executive meeting minutes which included discussion of governance but did not include regular review of the directorate risk register.
- Reporting incidents was imbedded across the In-Hospital Care directorate front line staff, and we saw evidence of staff receiving feedback on individual incidents they had raised.
- Staff we spoke with were actively encouraged to report incidents for example on ward 41 staff reported grade one pressure sores
- The quality of care was measured using nursing performance dashboards at ward and directorate level, we observed these on all wards we visited.
- We reviewed evidence of the In-Hospital Care directorate undertaking both local and national audits, and related action plans. For example infection protection audits and environment.

Leadership of service

- We had concerns about leadership related to governance and the management of the risk register and of clinical policies. The majority of policies were out of date and the risk register required review to ensure that it was relevant and effective.
- Medical and nursing staff were positive about their local leadership and felt that managers communicated well and were visible.
- Staff reported that they felt that they could raise concerns and be confident that they would be resolved whenever possible.

Culture within the service

- Many staff spoke enthusiastically about their work. They described how they loved their work, and how proud they were to work at the trust.
- In general, we found the culture of care delivered by staff across all medical services was dedicated, compassionate and strongly supported at divisional and ward level.
- Consultants told us there was a positive cultural and management genuinely listened to consultants and medical staff about issues such as: recruitment, training and improvements for medical patients. Junior doctors reported that they were well supported by senior colleagues.

Public engagement

- The percentage of patients who completed the NHS Friends and Family test across all medical services in June 2015 was 50% this was better than the England average for that month, at 27%. This test measured patients who were likely or extremely likely to recommend the trust. The results showed between April 2015 and June 2015 the average score was 96%.

Staff engagement

- The trust, including the In-Hospital care directorate scored 3.6 out of 5 for staff engagement used within the

NHS staff survey in 2014, this remained unchanged from the previous survey in 2013 and was below the England average of 3.7, although the score is improved from 2013. There was no information specifically for the directorate.

- Staff we spoke with told us that there were involved in developing their own ward philosophy, it was reported that this helped them to feel valued as part of the team, and developing the vision together.

Innovation, improvement and sustainability

- The stroke pathway was developing the use of telemedicine to enable on call consultants to review scans at home; we were informed that this would reduce the time between review and treatment choice, decision.
- The patient flow team resilience command and control centre was the central point where patient flow was discussed, this system was developed in 2011.

Surgery

Safe	Good
Effective	Good
Caring	Good
Responsive	Good
Well-led	Good
Overall	Good

Information about the service

The University Hospital of North Tees provides a range of surgical services for the population of County Durham and the immediate surrounding area and is also servicing the population of the North East of England. The hospital provides elective and non-elective treatments for ear, nose and throat surgery, colorectal surgery, breast surgery, trauma and orthopaedics, urology, and ophthalmology.

During this inspection we visited the following surgical wards: Ward 28, Ward 31 and Ward 32 as well as the Emergency Assessment Unit. We visited all theatres and recovery areas on site and observed care being given and surgical procedures being undertaken.

We spoke with 48 patients and relatives and 22 members of staff. We observed care and treatment and looked at care records for 18 people.

Summary of findings

We rated surgery services to be good for safe, effective, caring, responsive and well-led.

Staff were aware and familiar with the process for reporting and investigating incidents using the trust's reporting system. Staff told us feedback on reported incidents was given and felt they were appropriately supported. A training suite had been set up to simulate procedures within surgery and enabled staff to practice and upskill in a safe environment. Care records showed risk assessments were being appropriately completed for all patients on admission to the hospital. Infection control information was visible in all ward and patient areas. Monthly cleanliness audits were undertaken and results were displayed through the Nursing Dashboard in ward areas.

Staffing levels for wards were calculated using a recognised tool and trust 'template'. We reviewed the nurse staffing levels on all wards visited and within theatres and found that levels were compliant with the required establishment and skill mix. We reviewed patient records and saw medical patients had been placed on surgical wards ('boarders') when beds were not available on medical wards. Although medical 'boarders' were under the care of medical clinicians, surgical staff told us they did not feel able to provide the same level of care to medical patients.

We observed patients being treated with compassion, dignity and respect throughout our inspection at this

hospital. We saw ward managers and matrons were available on the wards so that relatives and patients could speak with them. We saw information leaflets and posters available for patients explaining their procedure and after care arrangements. Patients were able to access counselling services and the mental health team. Therapists worked closely with the nursing teams on the wards and staff told us they had good access to physiotherapists, occupational therapists and speech and language therapists.

The service was responsive to the needs of patients living with dementia and learning disabilities. All wards had dementia champions as well as a learning disability liaison nurse. There was access to an independent mental capacity advocate (IMCA) for when best interest decision meetings were required. Complaints were handled in line with the trust policy and were discussed at monthly staff meetings where training needs and learning was identified as appropriate.

Senior managers had a clear vision and strategy for the division and staff were able to repeat this vision and discuss its meaning with us during individual interviews. Joint clinical governance and directorate meetings were held each month. The directorate risk register was updated following these meetings and we saw that action plans were monitored across the division. Records for 2014 showed that staff across all wards in surgery and theatres had received an appraisal or had an appraisal planned. Staff said speciality managers were available, visible within the division and approachable; leadership of the service was good.

Are surgery services safe?

Good

We rated surgery services as good.

Staff were aware and familiar with the process for reporting and investigating incidents using the trust's electronic reporting system and feedback was given. All patients at risk of pressure damage had management plans in place. Care records showed risk assessments were being appropriately completed for all patients on admission to the hospital and an early warning scoring system was used for the management of deteriorating patients. We observed theatre staff practiced the 'Five Steps to Safer Surgery, World Health Organisation (WHO) and the checklist had been reformulated to improve compliance.

NHS safety thermometer information included information about all new harms, falls with harm, and new pressure ulcers and was displayed on boards on all areas visited. Wards and patient areas were clean and monthly cleanliness audits were undertaken. The introduction of ward rounds with one of the trust's microbiologist had been introduced to focus on infection and antibiotic issues.

Mental capacity assessments were undertaken and consent, Mental Capacity Act (MCA) and Deprivation of Liberty Safeguards (DoLS) training was delivered as part of staff induction. Staff were aware of the safeguarding policies and procedures and had received training. The Emergency Admissions Unit had introduced days dedicated to the completion of training modules. The development of Advanced Nurse Practitioners had enabled patients to be consented in a timely manner and MCA and DoLS assessments were included in risk assessments.

Staffing levels for wards were calculated using a recognised tool and trust 'template'. We reviewed the nurse staffing levels on all wards visited and within theatres and found that levels were compliant with the required establishment and skill mix. Surgical consultants from all specialities were on call for a 24-hour period and arrangements were in place for effective handovers. Difficulties in the recruitment of junior doctors had been covered through the use of locum medical staffing and the development of advanced nurse practitioners.

Incidents

- Staff were aware and familiar with the process for reporting and investigating incidents, near misses and accidents using the trust electronic systems including those with Duty of Candour concerns. Staff told us feedback on reported incidents was given and felt they were appropriately supported.
- No never events and 17 serious incidents within surgery had been reported at this trust between May 2014 and April 2015. The reporting of serious incidents was in line with that expected for the size of the hospital; four of these incidents related to a Grade 3 pressure ulcer.
- Risks identified as a result of incidents were added to the risk register, monitored by an identified 'risk handler' and discussed at the monthly senior management meeting.
- Mortality and morbidity meetings were held monthly in all relevant specialities and unplanned returns to theatre were discussed to identify causes and facilitate learning.
- The directorate had identified improvements to the reporting of incidents resulting in an unplanned return to theatre. Eight cases of unplanned return to theatre had not been reported through the trust electronic system between January 2015 and March 2015.
- A process had been put in place to discuss unplanned returns to theatre at the monthly Morbidity & Mortality meeting and to undertake a review of the electronic reporting system. Unreported cases were then reported retrospectively to ensure appropriate investigation.
- All relevant staff participated in mortality case note reviews and reflective practice. .

Duty of Candour

- We saw that information about duty of candour was displayed on the staff intranet.
- Staff we spoke with were aware of their responsibilities under the duty of candour requirements Safety thermometer

Safety Thermometer

- The trust used the NHS Safety Thermometer which is an improvement tool for measuring, monitoring and analysing patient harms and 'harm free' care. Performance was monitored through the senior sisters meetings and communicated to the wards and departments.
- Safety thermometer information included information about all new harms, falls with harm, and new pressure ulcers and was displayed on boards on all wards and theatre areas visited. There were no falls, or urinary tract infections during 2014/15 reported via the safety thermometer for Surgery.
- Safety thermometer information showed risk assessments were being appropriately completed for all patients on admission to the hospital.

Cleanliness, infection control and hygiene

- Infection control information was visible in all ward and patient areas.
- Wards and patient areas were clean and we saw staff wash their hands and use hand gel between patients, bare below the elbow policies were complied with.
- All elective patients undergoing surgery were screened for Methicillin resistant Staphylococcus aureus (MRSA) and procedures were in place to isolate patients when appropriate in accordance with infection control policies. There had been no incidences of MRSA reported between April 2013 and November 2014.
- Monthly cleanliness audits were undertaken through announced and unannounced visits from domestic managers. These included patients and visitors views and results were discussed with staff and actions immediately taken to rectify any problems.
- Patient Led Assessments of the Care Environment (PLACE) visits examined the general cleanliness of each ward, area and equipment. These showed a 'pass' or 'qualified pass' in areas inspected and improvement plans had been developed, e.g. replacement of curtain hooks (Ward 28), door edge protection (Ward 30) and replacement of ceiling tiles (Ward 31).
- Clinical waste bins were covered with foot opening controls and the appropriate signage was used for the disposal of clinical waste. Separate hand washing basins, hand wash and sanitizer was available on the wards, theatre and patient areas.
- Infection control audits were completed every month and monitored compliance with key trust policies such as hand hygiene. Recent audits showed compliance with hand hygiene protocols averaged 93% on surgical wards. The results of audits were provided immediately to staff and displayed through the Nursing Dashboard in ward areas.
- Nursing staff had received training in aseptic non touch techniques. This covered the necessary control measures to prevent infections being introduced to susceptible surgical wounds during clinical practice.

Surgery

- The division participated in the ongoing surgical site infection (SSI) audits run by Public Health England. Each case of SSI was identified, discussed at formal meetings and actions identified to avoid a repetition.
- Swab, pack surgical instrument and sharp count audits were completed within theatre and these were discussed at divisional meetings and actions identified if required.
- Cleanliness in theatres and recovery areas was observed to be 'exceptional' by specialist advisors in the inspection team.
- Pre-assessment of patients was in accordance with British Association of Day-care Surgery (BADS) guidelines.
- The introduction of ward rounds with one of the trust's microbiologist had been introduced to focus on infection and antibiotic issues.

Environment and equipment

- We observed checks for emergency equipment, including equipment used for resuscitation and bariatric specific equipment such as hoists and tables. Resuscitation equipment in all areas had been checked daily.
- All freestanding equipment in theatres was covered and had been dated when cleaned. Equipment was appropriately checked and cleaned regularly. There was adequate equipment in the wards to ensure safe care.
- The trust had introduced procedure specific medical packs.

Medicines

- Medicines were stored securely in locked cupboards and fridges within all the wards and departments. Audits of controlled drugs were undertaken on each ward by two registered nurses at each shift change and quarterly by pharmacy staff.
- We observed the preparation and administration of controlled drugs was subject to a second independent check. After administration the stock balance of an individual preparation was confirmed to be correct and the balance recorded.
- Fridge temperatures were monitored on a daily basis with the temperature recorded.
- Ward based pharmacists had been introduced to review medication charts and discharge prescriptions and had monitored for errors during the prescribing process.

Records

- Care pathways were in use including enhanced recovery pathways.
- All wards completed appropriate risk assessments. These included risk assessments for falls, pressure ulcers and malnutrition. All records we looked at were completed accurately.
- We saw a daily ward round was led by senior nurses to assess all patients at risk of pressure damage or identified as having pressure damage to ensure appropriate management plans were in place.
- Audits showed 88% overall compliance (April 2015) with identified areas for improvement including the recording of GMC numbers and any deletions being countersigned, dated and timed.
- There was 100% compliance in completing early warning score documentation and undertaking appropriate actions in the records we reviewed.
- There was a comprehensive pre-operative health screening questionnaire and assessment pathway.
- Clinical notes were stored securely in line with Data Protection Act principles to ensure patient confidentiality was maintained.
- Nursing documentation was kept at the end of the bed and centrally within the wards and was completed appropriately.

Safeguarding

- Staff were aware of the safeguarding policies and procedures and had received training in this area. They were also aware of the trusts' whistleblowing procedures and the action to take including the safeguarding team they could contact for advice and support.
- Information provided by the trust showed 100% of staff requiring safeguarding adults (Levels 1 and 2) and safeguarding children (Level 1) within the division had completed the training. All consultants had carried out Level 3 safeguarding children.
- All staff we spoke with were able to describe action they would take if they had safeguarding concerns and examples were given where safeguarding concerns had been raised from the directorate.
- The trust had a Safeguarding Lead in place and safeguarding issues were fully investigated and lessons shared.

Mandatory training

- Performance reports within the care group showed staff were up to date with their mandatory training.
- For example training 95% of staff had received consent training, 90% had received record keeping training, 95% had received infection control training and 90% had attended medicines management training.
- Staff we spoke with confirmed they were up to date with mandatory training and this included attending annual cardiac and pulmonary resuscitation training.
- We were told the Emergency Admissions Unit had introduced days dedicated to the completion of training modules and this was being reviewed for roll out across the directorate.

Assessing and responding to patient risk

- All wards used an early warning scoring system for the management of deteriorating patients. There were clear directions for escalation printed on the observation charts and staff spoken with were aware of the appropriate action to be taken if patients scored higher than expected. We looked at completed charts and saw that staff had escalated correctly, and repeat observations were taken within the necessary time frames.
- A number of other appropriate risk assessments were also used including for the prevention of venous thromboembolism (VTE), to assess nutritional status (Malnutrition Universal Screening Tool), skin integrity and risk of falls.
- Tissue Viability Nurses were available when needed and there were protocols in place to prevent the development of pressure ulcers.
- Theatre lists were updated in 'real time' to reflect changing priorities and timescales.
- All patients were assessed for any health issues before the date of operation to identify any risks and individual needs.
- We observed that theatre staff practiced the 'Five Steps to Safer Surgery, World Health Organisation (WHO)' and audits across all specialities showed variable compliance results with the checklist . Compared to a baseline audit (July, 2015) there had been improvements in compliance with the completion of patient details (22% improvement) and sign out (25% improvement). Improvements were not identified in 'sign-in' and 'time out' aspects of the checklist. As a result the WHO checklist had been reformulated to improve compliance.

Nursing staffing

- Staffing levels for wards were calculated using a recognised tool and trust 'template' reviewed every six months to determine the effectiveness and safety of staffing, pressures on the ward and highlight required changes to staffing. We were given an example of changes made to nursing teams on one ward resulting from an identified change in the acuity of patients.
- We reviewed the nurse staffing levels on all wards visited and within theatres and found that levels were compliant with the required establishment, skill mix and staff to patient ratio.
- Vacancies for qualified staff (April 2015) ran from 1.63% (Ward 31) to 2.15% (Ward 28); turnover of staff throughout the trust was 11% (2014-2015).
- Bank or agency staff were used and staff told us they were also asked to cover staff shortages. Latest information (May 2015) confirmed the use of bank staff was between 5% (Ward 33) and 21% (Ward 32).
- There was a safe staffing and escalation protocol to follow should staffing levels per shift fall below the agreed roster and acuity needs of patients. Staffing numbers on surgical wards had been adjusted flexibly between registered and unregistered staff to meet the needs of patients and in line with the protocol.
- Daily staffing meetings were held to decide on staff shortfalls, moving staff between wards and across sites, agency usage and staff requests to the medical directorate. The Senior Clinical Matron 'Out of Hours' contributed to this process when appropriate.
- We were told when staff are moved at short notice to ensure another area is safe, there was an expectation that reasons for this are fully explained to the member of staff.

Medical staffing

- Medical staffing within the division was made up of 37% at consultant level (England average 40%), 22% registrar level (England average 37%), middle career 21% (England average 11%) and 20% junior doctors (England average 13%).
- Surgical consultants from all specialities were on call for a 24-hour period and arrangements were in place for effective handovers. The general surgical on call team comprised of the general consultant surgeon and a consultant vascular surgeon provided through a Tees-wide service.

Surgery

- Patients that required unscheduled inpatient surgical care were placed under the direct daily supervision of a consultant and the hospital published a rota for the provision of general surgical emergency provision.
- Difficulties in the recruitment of junior doctors had been covered through the use of locum medical staffing. The use of locums within surgery was 19% (February 2015). There was an escalation process in place to ensure numbers of medical staffing were appropriately managed.
- Advanced surgical care nurse practitioners and advanced trauma and emergency surgery nurse practitioners had been developed to support medical staff during the admission, care and treatment of surgical patients.
- Consultants were available on-call out of hours and would attend when required to see patients at weekends.

Major incident awareness and training

- Business continuity plans for surgery were in place and staff explained these during individual and group interviews. These included the risks specific to the clinical areas and the actions and resources required to support recovery
- A trust assurance process was in place to ensure compliance with NHS England core standards for emergency preparedness, resilience and response.
- The trust's major incident plan provided guidance on actions to be undertaken by departments and staff, who may be called upon to provide an emergency response, additional service or special assistance to meet the demands of a major incident or emergency.

Are surgery services effective?

Good

We rated surgery services as good.

Patients were treated based on national guidance and enhanced recovery (fast track) pathways were used. Local policies were written in line with national guidelines and updated appropriately. Local audits relating to infection control, checking of controlled drugs and use of personal protective clothing showed full compliance. Pre-planned pain relief was administered for patients and pain link nurse were identified. Patients were screened using the Malnutrition Universal Screening Tool (MUST) and where necessary referred to the dietician.

The hospital had lower than the standardised relative readmission rates for elective surgical patients than the England average for general surgery, urology and trauma and orthopaedics. Staff worked with local authority services as part of discharge planning. Access to diagnostic services was available seven days a week. The trauma and orthopaedics and surgery and urology directorates delivered a consultant led seven day service. Staff told us they had good access to physiotherapists, occupational therapists and speech and language therapists. Daily handovers were carried out with members of the multidisciplinary team.

A training suite had been set up to simulate procedures within surgery and enabled staff to practice and upskill in a safe environment. Anaesthetic nurses and nurses within the recovery area had received training to enable them to undertake both roles.

Appraisals were undertaken and monthly staff meetings were taking place, supported by informal one to one meetings did take place.

Evidence-based care and treatment

- Patients were treated based on national guidance from the National Institute of Health and Care Excellence (NICE), the Association of Anaesthetics, Great Britain and Ireland and the Royal College of Surgeons.
- Enhanced recovery (fast track) pathways were used for patients with fractured neck of femur, acute back pain, suspected septic arthritis, acute knee injury and cellulitis. We saw that trauma patients with complex shoulder injuries or acute spinal injuries were referred into the appropriate speciality by the on call trauma teams to ensure patients received the appropriate expertise at time of injury.
- Theatre time was available for the management of complex upper limb trauma.
- Differential waiting lists were managed by some facilitated theatre sessions at weekends.
- The introduction of a trauma hand service had enabled a direct patient pathway into the speciality and patients were reviewed with surgery, if required, arranged for the same day depending on the nature of the injury.

- From April 2014 to March 2015 the hospital met a local target of admission to a ward within two hours for 83% for fractured neck of femur patients.
- Agreed pathways for surgical cancer patients were in place and monitored through peer review. Each cancer speciality had a designated medical and nursing lead to support the cancer pathways.
- Sentinel Lymph Node Biopsy (SLNB) has been developed for breast care patients with an agreed pathway and was monitored for compliance.
- Local policies were written in line with national guidelines and updated every two years or if national guidance changed. For example, there were local guidelines for pre-operative assessments and these were in line with best practice.
- The surgery division and departments took part in all the national clinical audits that they were eligible. The division had a formal clinical audit programme where national guidance was audited and local priorities for audit were identified.
- Local audits relating to infection control, checking of controlled drugs and use of personal protective clothing in theatres and recovery showed full compliance.

Pain relief

- Pre-planned pain relief was administered for patients on recovery pathways.
- There was a pain assessment scale within the National Early Warning Score (NEWS) chart used throughout the trust. NEWS audits were in place and supported through feedback from the Friends and Family Test and directly from patients. Each ward and department had identified a pain link nurse.
- Patients were regularly asked about their pain levels, particularly immediately after surgery, and this was recorded on a pain scoring tool that was used to assess patients' pain levels.
- All patients we spoke with reported their pain management needs had been met. The trust had undertaken an audit of post-operative pain relief with patients.
- Patients with complex analgesia needs were referred to the pain service for additional assessment. The trust was in the process of introducing a pilot on Ward 30 to reduce the time required to administer analgesia.
- Hip fracture patients received fascia iliac blocks as appropriate as part of their pain management, to reduce the use of opioid analgesia and the unwanted side effects. Trauma nurse practitioners administered the blocks following training devised by the anaesthetic team.

Nutrition and hydration

- The trust had a Fluid and Nutrition Group (FANG) in place to oversee the management of nutrition and hydration.
- Patients were screened using the Malnutrition Universal Screening Tool (MUST). Where necessary patients at risk of malnutrition were referred to the dietician.
- We reviewed 18 records and saw that nurses completed food charts for patients who were vulnerable or require nutritional supplements and support was provided by the Dietetic department who attended the weekly multi-disciplinary meeting on the fragility fracture ward (Ward 32). Fluid charts were also completed appropriately.
- Records showed patients were advised as to what time they would need to fast from. Fasting times varied depending on when the surgery was planned and were individual to the needs of the procedure and the patient.

Patient outcomes

- Patient reported outcome measures (PROMs) matched the national improvement and had a comparable proportion of patients worsening to the England average.
- The hospital had lower than the standardised relative readmission rates England average (100) for elective surgical patients for general surgery (91), urology (82) and trauma and orthopaedics (81). For non-elective surgical patients the standardised relative readmission rates were lower than the England average for general surgery (98) and trauma and orthopaedics (97).
- The National Bowel Cancer Audit (2014) showed better than England average results for clinical nurse specialist involvement (93%, England average 88%), discussion at MDT (100%, England average 99%) and scans undertaken (99%, England average 89%); 66 % of patients undergoing major surgery stayed in the hospital for an average of more than five days (lower than the England average of 69%).
- The trust participated in the National Hip Fracture Audit. Findings from the 2014 report showed the hospital was better than the national average in areas such as

patients being admitted to an orthopaedic ward within 4 hours (83%, national average 48%), falls assessment (100%, national average 97%), bone health medication assessment (99%, national average 97%) and surgery on the day of or after day of admission (77%, national average 74%).
- The hospital was worse than the national average for pre-operative assessment by a geriatrician (36%, national average 52%), and the mean length of total trust stay (20 days, national average 19 days).

Competent staff

- Staff told us that appraisals were undertaken annually and records for 2014 showed that staff across all wards in surgery and theatres had received an appraisal or had an appraisal planned. We saw that 100% of nursing staff and 90% of consultants within surgery had an appraisal between April 2014 and March 2015.
- Monthly staff meetings were taking place and minutes were available to staff. These were supported by informal one to one meetings did take place
- Junior doctors we spoke with told us they attended teaching sessions and participated in clinical audits. They told us they had received ward-based teaching and were supported by the ward team and could approach their seniors if they had concerns.
- Training for surgical trainees had been developed and 'protected time' identified for completion. All trainees had clinical supervisors and the directorate had a dedicated Medical Education Committee to ensure training and supervision issues were discussed.
- Systems were in place for revalidation and appraisal of medical staffing. There was a consultant identified who takes the lead for revalidation on behalf of the Clinical Director.
- A training suite had been set up to simulate procedures within surgery and enabled staff to practice and upskill in a safe environment.
- Anaesthetic nurses and nurses within the recovery area had received training to enable them to undertake both roles.
- We reviewed patient records and saw medical patients had been placed on surgical wards ('boarders') when beds were not available on medical wards. Although medical 'boarders' were under the care of medical clinicians, surgical staff told us they did not feel able to provide the same level of care to medical patients.

Multidisciplinary working

- Therapists worked closely with the nursing teams on the ward where appropriate. Ward staff told us they had good access to physiotherapists, occupational therapists and speech and language therapists when needed.
- Daily handovers were carried out with members of the multidisciplinary team.
- There was pharmacy input on the wards during weekdays and dedicated pharmacy provision for each ward was planned. .
- Staff explained to us the wards worked with local authority services as part of discharge planning.
- The surgical cancer pathway had established multidisciplinary working, monitored through the Cancer Strategy Group and peer review. Emergency patient care plans are reviewed at daily emergency surgical meetings and a weekly bariatric multidisciplinary meeting was held as part of bariatric consortium arrangements.
- Trauma services held a daily meeting where all trauma patients care plans were discussed. In addition the directorate had established a weekly spinal multidisciplinary meeting where all surgical cases and complex cases were discussed. The lower limb service had established a monthly joint replacement multidisciplinary meeting and this was in the process of being replicated by the upper limb team.

Seven-day services

- Consultant led ward rounds were undertaken daily, including weekends, for all patients..
- Access to physiotherapist, occupational therapist and diagnostic services was available seven days a week, for example, X-ray services in emergency and urgent care situations.
- Pharmacy staff were available on site during the week and there was an on call pharmacist available out of hours.
- The trauma and orthopaedics directorate delivered a consultant led trauma service which provided a seven day service. Elective activity was not carried out when consultants were covering trauma services and cases were discussed at a dedicated multi-disciplinary trauma meeting every morning.
- The surgery and urology directorate delivered a consultant led seven day emergency surgical service.

Elective activity was not carried out when consultants were covering when covering emergency surgery and emergency cases were discussed at a dedicated multi-disciplinary emergency surgical meeting every morning.

Access to information

- Risk assessments, care plans and test results were completed at appropriate times during a patient's care and treatment and we saw these were available to staff enabling effective care and treatment.
- We reviewed discharge arrangements and these were started as soon as possible for patients. We saw discharge letters were completed appropriately and shared relevant information with a patient's general practitioner.
- There were appropriate and effective systems in place to ensure patient information was co-ordinated between systems and accessible to staff.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- We looked at clinical records and observed that all patients had consented in line with the trust policy and Department of Health guidelines.
- Mental capacity assessments were undertaken by the consultant responsible for the patient's care and Deprivation of Liberty Safeguards (DoLS) were referred to the trusts safeguarding team.
- Consent, Mental Capacity Act (MCA) and Deprivation of Liberty Safeguards (DoLS) training was delivered as part of staff induction. The development of Advanced Nurse Practitioners has enabled patients to be consented in a timely manner and MCA and DoLS assessments were included in risk assessments.

Are surgery services caring?

Good

We rated surgery services as good.

We observed patients treated with compassion, dignity and respect throughout our inspection, patients were spoken and listened to promptly and staff introduced themselves to patients by giving their name in a friendly and appropriate manner. Patients and relatives said they felt involved in their care and they had been given the opportunity to speak with the consultant looking after them. Ward managers and matrons were available on the wards.

The Care Quality Commission in-patient survey showed an increase in patients' belief that they were involved as much as they wanted to be in decisions about their care and treatment over the previous year.

We saw information leaflets and posters available for patients explaining their procedure and after care arrangements. There was information within care plans to highlight whether people had emotional or mental health problems and what support they required. Patients were able to access counselling services and the mental health team.

Compassionate care

- We observed patients being treated with compassion, dignity and respect throughout our inspection at this hospital. We saw that patients were spoken and listened to promptly and saw staff introduced themselves to patients by giving their name in a friendly and appropriate manner.
- Patients commented positively on the dedication and professionalism of staff and the quality of care and treatment received. Patients were complimentary about the staff in the service, and felt informed and involved in their care and treatment.
- We observed patients being kept informed throughout their time within the anaesthetic room and theatres.
- We saw patients with a dementia were spoken and listened to in an appropriate and calm manner which reassured the patient and enabled them to contribute fully to their care.
- Patients said they felt safe and confident in the nurses, doctors and support staff. Patients and relatives were positive about the care and treatment received.
- We saw staff were attentive to the comfort needs of patients. Doctors introduced themselves appropriately and curtains were drawn to maintain patient dignity.
- The Friends and Family Test response rate was the same as the England average of 32%, between December 2013 and November 2014 and scores similar across all areas with the England averages during that period.

- Patient-led Assessments of the Care Environment (PLACE) scored the trust above the England average for privacy, dignity and wellbeing (88, England average 87) in 2014.

Patient understanding and involvement

- All patients said they were made fully aware of the surgery that they were going to have and this had been explained to them.
- Patients and relatives said they felt involved in their care and they had been given the opportunity to speak with the consultant looking after them.
- Patients told us staff kept them well informed, explained why tests and scans were being carried out and did their best to keep patients informed.
- We saw ward managers and matrons were available on the wards so that relatives and patients could speak with them.
- Ward information boards identified who was in charge of wards for any given shift and who to contact if there were any problems.
- The Care Quality Commission in-patient survey (2014) showed an increase (7.2 from 7.1) in patients' belief that they were involved as much as they wanted to be in decisions about their care and treatment over the previous year.
- There was also an increase in patients responding positively (8.3 from 8.1) to say they received answers they could understand when asking important questions to a nurse.

Emotional support

- Patients said they felt able to talk to ward staff about any concerns they had either about their care, or in general. Patients did not raise any concerns during our inspection.
- We saw information leaflets and posters available for patients explaining their procedure, after care arrangements and addressing individual needs, e.g. hip replacement, total knee replacement.
- There was information within care plans to highlight whether people had emotional or mental health problems and what support they required for this.
- Patients were able to access counselling services and the mental health team.
- Assessments for anxiety and depression were done at the pre-assessment stage and extra emotional support was provided by nursing staff for patients both pre and post operatively.
-

Are surgery services responsive?

Good

We rated surgery services as good.

The hospital had an escalation and surge policy and procedure to deal with busy times and capacity bed meetings were held to monitor bed availability. The Emergency Admissions Unit had been developed to enable a rapid assessment of patients and track them effectively through identified care pathways. We saw that orthogeriatricians had input into the care pathway of elderly patients. The bariatric service had been developed as part of a consortium arrangement with neighbouring NHS trusts.

The service was responsive to the needs of patients living with dementia and learning disabilities. All wards had dementia champions as well as a learning disability liaison nurse. Patients requiring assistance from social services upon discharge were identified at pre-assessment and plans were continuously reviewed. We saw suitable information leaflets were available in pictorial and easy read formats and described what to expect when undergoing surgery and postoperative care. These were available in languages other than English on request. There was access to an independent mental capacity advocate (IMCA) for when best interest decision meetings were required.

Complaints were handled in line with the trust policy and were discussed at monthly staff meetings where training needs and learning was identified as appropriate.

Service planning and delivery to meet the needs of local people

- The hospital had an escalation and surge policy and procedure to deal with busy times.

Surgery

- Capacity bed meetings were held to monitor bed availability in the hospital; managers responsible for reviewing planned discharge data and assessing future bed availability had been appointed.
- During high patient capacity and demand elective patients were reviewed in order of priority for cancellation to prevent urgent and cancer patients being cancelled.
- We saw effective arrangements were in place for collaborative working between surgeons undertaking reconstructive surgery.
- The Emergency Admissions Unit had been developed to enable a rapid assessment of patients and track them effectively through identified care pathways.
- We saw that orthogeriatricians had input into the care pathway of elderly patients as appropriate.
- The bariatric service had been developed as part of a consortium arrangement with neighbouring NHS trusts to ensure the local population had access to this service.
- A business case for the expansion of orthopaedic services was agreed and is taking place which includes a reconfiguration of existing resources to provide foot and ankle services as a sub speciality service, increase the upper limb capacity and to develop a hand trauma service. The hand trauma service commenced in February 2015 allowing improved local access.

Access and flow

- A pre-assessment meeting was held with the patient before the surgery date and any issues concerning discharge planning or other patient needs were discussed at this stage. Patients requiring assistance from social services upon discharge were identified at pre-assessment and plans were continuously reviewed during the discharge planning process.
- The trust was not meeting the overall referral to treatment targets (RTTs) of 90% of patients admitted for treatment from a waiting list within 18 weeks of referral (November 2014). The RTT was not met within general surgery (88%). The reasons for this had been identified and additional recruitment to consultant posts undertaken and locum cover arranged to reduce backlogs
- RTTs were met for trauma and orthopaedics (91%) and urology (91%) during the same period.
- During the inspection we identified between three and six medical 'boarders' on surgical wards and did not identify any surgical patients placed on non-surgical wards. We did not identify any non-emergency bed moves at night from or to surgical wards.
- The directorate sent discharge summaries to GPs for 97% orthopaedic patients and 93% of patients for surgery and urology. A specific discharge co-ordinator and an occupational therapist had been appointed to support effective discharge.
- The average length of stay for elective and non-elective patients is comparable or lower than the England average across the trust. However, there are variations between sites and specialties.
- The average length of stay for elective patients was better than the England average for general surgery (3.3 days, England average 3.5 days), urology (1.8 days, England average 2.2 days) and trauma and orthopaedics (2.4 days, England average 3.5 days).
- Average length of stay for non-elective patients was better than the England average for general surgery (3.5 days, England average 4.3 days) and trauma and orthopaedics (5.9 days, England average 8.4 days).
- No patients had their operation cancelled and were not treated within 28 days between April 2011 and September 2014.

Meeting people's individual needs

- The service was responsive to the needs of patients living with dementia and learning disabilities. All wards had dementia champions as well as a learning disability liaison nurse who could provide advice and support with caring for people with these needs.
- Breast care nurses had worked with the local mental health trust to develop and adapt the care package for admission of patients with learning disability requiring breast surgery. We also saw nurses on the trauma unit had adapted the end of life care pathway for patients.
- We saw suitable information leaflets were available in pictorial and easy read formats and described what to expect when undergoing surgery and postoperative care. These were available in languages other than English on request.
- We saw that the care of patients following surgery was particularly effective through the provision of ongoing physiotherapy services.

- Wards had access to interpreters as required, requests for interpreter services were identified at the pre-assessment meeting.
- There was access to an independent mental capacity advocate (IMCA) for when best interest decision meetings were required.
- The trust had in place policies covering the 'Mental Capacity Act (2005) and Deprivation of Liberty Safeguards'. Training on these had been planned throughout 2014 and 2015 and 100% of staff had completed the training.

Learning from complaints and concerns

- Complaints were handled in line with the trust policy.
- Patients or relatives making an informal complaint were able to speak to individual members of staff or the ward manager and staff were able to explain this process.
- Staff were able to describe complaint escalation procedures, the role of the Patient Advice and Liaison Service (PALS) and the mechanisms for making a formal complaint.
- If patients or their relatives needed help or assistance with making a complaint the Independent Complaints Advocacy Services (ICAS) contact details were visible in the ward and throughout the hospital.
- We saw leaflets available throughout the hospital informing patients and relatives about this process.
- An example of learning from complaints included the introduction of a system to access specific neck collars out of hours. This also included ensuring access to physiotherapy staff trained to apply the collars out of hours.
- Complaints and concerns were discussed at monthly staff meetings where training needs and learning was identified as appropriate.

Are surgery services well-led?

Good

We rated surgery services as good.

Senior managers had a clear vision and strategy for the division and staff were able to repeat and discuss its meaning. Joint clinical governance and directorate meetings were held each month. The directorate risk register was updated following these meetings and we saw that action plans were monitored across the division. Staff said speciality managers were available, visible within the division and approachable; leadership of the service was good, there was good staff morale and staff felt supported at ward level. Staff spoke positively about the service they provided for patients and emphasised quality and patient experience.

At ward and theatre levels staff worked well together and there was respect between specialities and across disciplines. We saw examples of good team working on the wards between staff of different disciplines and grades. NHS staff survey data showed the trust scored as expected in 20 out of 30 areas and better than expected in three areas. The trust scored as worse than expected in seven out of 30 areas.

Vision and strategy for this service

- We met with senior managers who had a clear vision and strategy for the division and identified actions for addressing issues within the division.
- The vision and strategy had been amended to account for a delay in redeveloping the provision of services within the trust and staff were able to repeat this vision and discuss its meaning with us during individual interviews.
- The trust vision and strategy was well embedded with staff, who were able to articulate to us the trust's values and objectives across the surgical wards and they were clearly displayed on ward areas.
- We were told the trust had a commitment to a people centred approach delivering high quality care with robust assurance and safeguarding and saw this in practice during the inspection.

Governance, risk management and quality measurement

- Joint clinical governance and directorate meetings were held each month. Agendas and minutes showed audits, learning from complaints and PALS issues, learning from clinical risk management, peer review data, patient and public information involvement, infection control issues, alert notices, good practice, national service frameworks, clinical audits and research projects were discussed and action taken where required.
- The directorate risk register was updated following these meetings and when needed. Risks were assigned to specific staff responsible for the monitoring of actions and the revision of the risk assessment as required.

Surgery

- Reports identified risks throughout the directorate, actions taken to address risks and changes in performance. These monitored (amongst other indicators) MRSA and C.difficle rates, RTTs, pressure ulcer prevalence, complaints, never events, incidents and mortality ratios.
- We saw that action plans were monitored across the division and sub groups were tasked with implementing elements of action plans where appropriate, the risk register reflected identified risks and progress addressing them.

Leadership of service

- Staff said speciality managers were available, visible within the division and approachable; leadership of the service was good, there was good staff morale and they felt supported at ward level. Clinical director management meetings were held weekly and involved speciality managers.
- Within the surgical directorate there were five sub specialities and within orthopaedics there were four sub specialities. Monthly speciality meetings were held and discussed financial and clinical performance, patient safety and operational issues.
- Staff spoke positively about the service they provided for patients and emphasised quality and patient experience is a priority and everyone's responsibility.
- Nursing staff stated that they were well supported by their managers although we were told one-to-one meetings were informal.
- Medical staff stated that they were supported by their consultants and confirmed they received feedback from governance and action planning meetings.

Culture within the service

- At ward and theatre levels we saw staff worked well together and there was respect between specialities and across disciplines. We saw examples of good team working on the wards between staff of different disciplines and grades.
- Staff were well engaged with the rest of the hospital and reported an open and transparent culture on their individual wards and felt they were able to raise concerns.
- Staff spoke positively about the service they provided for patients. High quality compassionate patient care was seen as a priority.
- The directorate had recently taken part in a research programme to measure culture on one of the surgical wards in conjunction with a local university; the results were not available.

Public and staff engagement

- The Friends and Family Test response rate was the same as the England average of 32%, between December 2013 and November 2014 and scores similar across all areas with the England averages during that period.
- NHS staff survey data (2014) showed the trust scored as expected in 20 out of 30 areas and better than expected in three areas i.e. percentage of staff working extra hours, percentage of staff witnessing harmful errors, near misses or incidents in the last month and the percentage of staff experiencing harassment, bullying or abuse from staff in the last twelve months.
- The trust scored as worse than expected in seven out of 30 areas, e.g. and better than expected in three areas e.g. effective team working, percentage of staff feeling pressure in the last three months to attend work when feeling unwell, staff motivation at work.

Innovation, improvement and sustainability

- The development of Advanced Nurse Practitioners has enabled the hospital to respond to patients appropriately and mitigated difficulties from recruitment of junior doctors.
- The bariatric service had been developed as part of a consortium arrangement with neighbouring NHS trusts to ensure the local population had access to this service.
- A training suite had been set up to simulate procedures within surgery and enabled staff to practice and upskill in a safe environment.

Critical care

Safe	Good
Effective	Good
Caring	Good
Responsive	Good
Well-led	Good
Overall	Good

Information about the service

The Critical Care Service at North Tees Hospital was a 17 bed facility and was funded for ten Level 3 intensive care beds and six Level 2 high dependency beds. Level 2 beds are for patients requiring more detailed observation or intervention including support for a single failing organ system or post-operative care and those 'stepping down' from higher levels of care. Level 3 beds are for patients requiring advanced respiratory support alone or basic respiratory support together with support of at least two organ systems. This level includes all complex patients requiring support for multi-organ failure.

The service was led by a Clinical Director and eight consultant anaesthetists three of whom were intensivists, alongside a Senior Clinical Matron and a senior nursing team.

Outcomes for the service were closely monitored and mortality and length of stay data were improving. The service had an annual average 73% occupancy rate ranging between 69.6% and 113.8% with a significant increase to over 113% through January 2015.

From April 2014 to March 2015, 885 patients were admitted to the service via the emergency department, operating theatres and wards within the hospital. 91% of these patients were unplanned surgical and medical patients.

As part of our inspection we spoke with 20 staff, six patients and five relatives. We spoke with a range of staff including nursing staff, junior and senior medical doctors, physiotherapists, dieticians, a pharmacist, domestic staff and managers. We sought feedback from staff and patients at our focus groups and listening events. We looked at six sets of care records

Critical care

Summary of findings

We found critical care services to be good for safe, effective, caring, responsive and well-led.

There was a real commitment to work as a multidisciplinary team delivering a patient centred and high quality service. Staff knew how to report incidents and there was a good track record on safety with lessons learned and improvements made when things went wrong. The environment was clean but there was a lack of space due to the position of the unit within the hospital. The service had recently put in place a Critical Care Outreach Team (CCOT) to identify and monitor the deteriorating patient. The purpose of this service was to assess the critically ill or deteriorating patient on wards and to stabilise the patient at ward level and so avoid the need to escalate to the unit.

Medical and nursing staffing levels were adequate and there was evidence of a cohesive team working approach to patient care. The unit was staffed according to the Core Standards for Intensive Care Units and nursing and support staff provided flexibility within the department to provide the level of care that met patients' care needs.

Patients received treatment and care according to national guidelines and the service used an audit programme to check whether their practice was up to date and based on sound evidence. The service was obtaining good-quality outcomes as evidenced by its Intensive Care National Audit and Research Centre (ICNARC) data. We found there was good multidisciplinary team working across the service.

There was an open, transparent culture which had been established with the new leadership team. Staff felt valued and supported by their managers and received the appropriate training and supervision to enable them to meet patients' individual needs. Both medical and nursing staff we spoke with were passionate about providing a holistic and multidisciplinary approach to assessing, planning and treating patients. This was demonstrated by regular multidisciplinary meetings and excellent communication with the patients and relatives.

We observed individualised care and attention to detail given to patients and relatives evidenced by their work with the end of life team, care of patients with learning disabilities and implementation and consideration of the Deprivation of Liberty Standards (DoLS)

Critical care

Are critical care services safe?

Good

Overall the services within the unit were safe. Staff knew how to report incidents and felt confident that when incidents were reported they were listened to and acted upon. We were given examples where incidents had changed practice. All incidents were analysed and reported monthly to the Critical Care Delivery Group for further discussion and action. The unit had an outreach service to identify and monitor the deteriorating patient and follow up patients who were discharged from the unit. However, this service was resourced to cover the winter period when the number of patients increased. Further funding would be needed to resource the outreach team over a more substantive period.

Medical and nursing staffing levels complied with the national standards for intensive care units. There were two band seven nurses who were classed as both clinical and managerial. This meant these managers could be supernumerary when necessary but could also take on a clinical role if needed. Staff felt this was good as they felt more supported. There were experienced and skilled physiotherapists who were passionate about treating their patients and ensuring relatives were included in their actions so they could be more involved in caring and rehabilitating their loved ones.

The environment was challenging as staff found the space to be limited since the move to one single ITU site; however to enable the increase in number of beds, the trust incorporated a ward adjacent to the original critical care unit. There was no evidence to suggest that these arrangements compromised patient care. The unit was clean and staff adhered to infection control policies and protocols. Record keeping was comprehensive and audited regularly. Decision making about the care and treatment of a patient was clearly documented; although there was room for improvement in documenting the outcome of evening medical rounds.

Incidents

- There were no Never Events reported in the last year for this service.
- There was evidence of incident reporting processes, analysis, root cause analysis and learning. Datix reports were investigated and were reported via the monthly Critical Care Working Group, the Critical Care Delivery Group and the Anaesthetic Governance and Patient Safety meetings. For the three month period 1st December 2014 and 31st March 2015 there were 56 incidents reported.
- The unit investigated its serious incidents and action was taken to prevent reoccurrence. Between September 2014 and February 2015 there were seven serious incidents, one was rated green with the remaining six rated as amber. We reviewed two root cause analysis following serious incidents reports which demonstrated clear actions and changes to practice.
- We saw evidence of learning from an incident: following a misplaced central venous catheter, the guideline was reviewed and documentation revised and this was now used on the unit. This also resulted in a change across the whole trust as central venous catheter and arterial line sterile packs were in use throughout the trust.
- If the service experienced delayed discharges and early readmissions, these would be reported as an incident. The majority of incidents reported related to pressure sores, some acquired within the service and some being present on admission to the unit.
- The service had implemented new guidelines for prevention of pressure damage associated with endo-tracheal tubes.
- The service had identified through its analysis of incidents, a recurring theme relating to poor communication and the escalation of care of deteriorating patients. This resulted in remodelling the Critical Care Outreach Team (CCOT) in order to improve communications across the trust and to provide more appropriate support for deteriorating patients.
- Feedback on actions following the analysis of an incident was disseminated to the critical care team through emails, a communication file; hard copies were displayed on the notice board in the staff room (Patient Safety Brief) and handover which includes “Hot topics”.
- The service had regular mortality meetings. Its mortality rate stood at 14.4% for the period January 2014 to December 2014 which was lower than the national average.
- The Duty of Candour requires healthcare providers to disclose safety incidents that result in moderate or

severe harm or death. Staff could demonstrate they were aware of the principles of the Duty of Candour and implementation was evidenced in the Anaesthetics and Critical Care Serious Incidents weekly meeting minutes.

Safety thermometer

- The NHS Safety Thermometer was in use and was being monitored and displayed for patients and relatives to view in the reception area. The NHS Safety Thermometer is a monthly snapshot audit of the prevalence of avoidable harm such as: the development of pressure ulcers, catheter related urinary tract infections venous thromboembolism (VTE) and falls.
- The Safety Thermometer for April 2015 showed there had been no patients with pressure sores, methicillin-resistant staphylococcus aureus infection, falls or complaints, 43 compliments and 100% compliance with hand hygiene procedures.

Cleanliness, infection control and hygiene

- Audits of general cleanliness were undertaken monthly via the senior team quality visits and unannounced visits by the domestic managers. Compliance to hand hygiene within the service was monitored via unannounced visits from the Infection Prevention and Control team which demonstrated 100% compliance with good hand hygiene practice. The trusts local environmental audits took place annually and in March 2015 the unit achieved 100% with this audit.
- We observed staff adhering to infection control policy and saw them use personal protective equipment such as gloves and aprons. We saw staff adhered to the 'bare arms below the elbow' policy. Visitors were required to follow infection control protocols and we saw visitors using hand gel when arriving and leaving the unit.
- Equipment in the sluice area had stickers with 'I am Clean' and a date the equipment had been cleaned was attached.
- The service had no acquired MRSA/Clostridium Difficile over the period April 2104 to March 2015.
- Any confirmed infections related to central venous catheters (CVC) were subject to root cause analysis (RCA) and were reported through the Critical Care Working Group and Critical Care Delivery Group. During the last 12 months there had been two confirmed CVC related infections, both were investigated and the outcome shared within the unit.

Environment and equipment

- In 2013 the two critical care units had amalgamated into one location at the North Tees Hospital. To enable the increase in number of beds, the trust incorporated a ward adjacent to the original critical care unit. There was no evidence to suggest that these arrangements compromised patient care. The service had a 4 bedded area (Unit A), a 9 bedded area (Unit B), a 2 bed area (Unit C) and 2 single rooms. There were plans to undertake some refurbishment / redecoration work to Unit B and to the main entrance into critical care. Other work to upgrade the unit had been delayed due to increased capacity over previous months.
- All staff we spoke with told us they had found the expansion of the unit to be a challenging period. Patients were moved at regular intervals, sometimes daily so that Level 3 patients could be nursed as a single group therefore ensuring patients were not put at risk.
- Cardiac arrest and airway trolleys, transfer bags and emergency drug packs were clean and checked daily. There was a 'difficult airway' trolley which was checked daily. Equipment within the department was maintained either by the Medical Engineering Department or through external service suppliers.
- We saw records of medical devices training for staff. Staff could also self-assess themselves on the use of any medical devices as well as undertaking local training. This training was reported to the trusts medical device meetings.
- Funding had been approved via the Capital Replacement Plan to purchase new equipment, which had been agreed and ordered. The unit had a new transfer trolley and staff had to be trained on its use before they could use it to transfer of a patient.

Medicines

- The department used Omnicell, a computerised storage and dispensing system to store medication. This proved beneficial for stock provision and monitoring of medicines. There was a code on the door to access the room and finger prints were used to check signage of control drugs. The system was automatically temperature controlled and flashed an alert should the temperature rise above the safe storage temperature. There had been no temperature alerts by the system.
- Omnicell only allows staff to access medication once they have entered a password or access code. It requires

two appropriate staff to sign in before dispensing medication. Medication can however be dispensed without being assigned to an individual patient. Controlled drugs however must be assigned to an individual patient other than in case of emergency when this can be overridden to give a stat dose.

- Records showed medications were kept at the correct temperature and so would be fit for use. Refrigeration temperatures were checked and recorded each day.
- The service had a nominated pharmacist who visited the unit daily to review patients' medication regimes. Every patient's medication records were checked, along with the drug dosages, drug charts, supply and suitability of medications. Another pharmacist would visit the unit to check the stocks of medicines and to top up the stock so patients received medication in a timely and safe manner. This pharmacist was involved in developing the protocol for the management of delirium with staff from the unit.
- All medications incidents were reported via the Datix system and a local investigation was undertaken if an incident occurred.
- Patients' medicine records were well managed and were comprehensive, relatively legible and clear.

Records

- A monthly healthcare records audit was undertaken and results were reported via the Critical Care Working Group. The last audit in June 2015 found 97.5% compliance, with the lack of documenting the Malnutrition Universal Screening Tool (MUST) tool on one chart being the reason for not achieving 100%.
- Patients' notes were kept in the patients' bed space in a locked drawer for all disciplines to record their interactions with patients.
- We looked at seven sets of records and found the documentation to be comprehensive and of a high standard. Regular risk assessments were documented and the patient's plan of care was updated as necessary.
- However, there was no documentary evidence in the case notes of the medical decision-making that occurred beyond the morning ward round. This was fed back to the medical staff at the time of the inspection.

Safeguarding

- The service followed the trust and local authority guidance relating to safeguarding of both adults and children. There were policies, systems and processes in place for reporting and recording abuse.
- All staff within the service had completed level 2 safeguarding children training and safeguarding adults training. The latest report showed nursing staff compliance as 98% for safeguarding children and 92% for safeguarding adults.
- The staff we talked with demonstrated a good knowledge of what safeguarding meant in practice and were able to tell us the escalation process to raise a safeguarding concern.

Mandatory training

- We were shown the staff training matrix in place on the unit. This matrix demonstrated that all overall mandatory training had an attendance rate of 92%.
- All staff within the service had a training needs analysis (TNA) which was specific to their grade and job role. Training was offered in various formats for example face to face, E-learning and workbooks.
- The service had two band six sisters who monitored training and education and provided a monthly report to the service.

Assessing and responding to patient risk

- We saw risk assessments and monitoring undertaken for each patient including, falls, venous Thromboembolism (VTE), nutrition, invasive lines, urinary catheters, and peripheral cannulation. A new assessment tool had been developed relating to endotracheal tube holders which when used reduced the incidence of pressure ulcers. Compliance with this documentation was monitored through monthly senior team quality visits.
- There was a system to respond to the deteriorating patient via the Critical care Outreach Team. In order to ensure critical care staff comply with the care of patients that may be delirious, the critical care audit forward programme for 2015 included an audit of compliance with delirium management.
- Ward rounds took place at regular intervals. There were two ward rounds led by the consultant in charge on the day in the morning and evening. Staff including nurses, trainees and the microbiologist would attend and contribute to these rounds. We observed routine care being discussed such as analgesia, the management of intravenous lines and pressure ulcer care.

Critical care

- The service had a risk register which reported risks to the Critical Care Working Group, Critical Care Delivery Group and the service team meetings

Nursing staffing

- The nursing establishment within the service was in line with British Association of Critical Care Nurses (BACCN) and Intensive Care Standards (ICS). The critical care team consisted of one band 8a Senior Clinical Matron, two band 7 Ward Matrons, five band 6 Nurses, 66.9wte band 5 nurses, 5.79 band 2 unregistered staff and 1.79 band 1 housekeepers.
- Nursing ratios to patients were in line with national guidance, 1:1 for Level 3 patients, and 2:1 for Level 2 patients. Staff worked on a rotational basis of days and nights.
- The intensive care core standards recommended there was never more than 20% of any shift staffed by agency or bank staff workers. The use of agency nurses was very low (approximately 4%) and the service would try to use their own staff before going externally to request further nursing staff. The unit told us their vacancy rate for nursing at March 2015 was 9.22% and their use of agency nurses was on average 4%
- There were currently several nursing vacancies in the team with 5.65wte band 5 nurses being used to resource the Critical Care Outreach Team (CCOT). Finance had been secured to back fill the staff used to cover the CCOT. Some shifts were covered using an external NHS agency. The staffing within the service was reviewed on a daily basis and if shortages were identified, action would be taken to rectify the situation.
- When planning the staffing rota, managers used 'Red Rules' such as, making sure a band 6 or above was on duty on each shift to give specialist advice if needed.
- There was an air of calmness about the unit. There were two band 7 managers who would work in a managerial capacity but also be available to work clinically if the need arose. Staff felt this was very supportive and staff could ask for advice if needed throughout their time on duty.
- An initial handover between night and day shift staff took place including details of any issues that had arisen during the night, any additional analgesia needed and whether the patient's condition had changed. Each nurse was then allocated a number of patients for the next shift. The more comprehensive handover took place on a one to one basis by the patient's bedside and included going through the patient's condition and care plan in detail.

Medical staffing

- The service was led by a Clinical Director and eight consultant anaesthetists, three of whom were intensivists (consultants trained in advanced critical care medicine) working in rotation in critical care and on call. They were supported by a team of middle grade and junior anaesthetists. The daily staffing for the department included 2 consultants, 2 middle grades and a junior doctor. Of the two consultants, one worked on the unit until 1:30pm.
- The service met the intensive care core standards and had a named consultant immediately available 24 hours a day, seven days a week.
- Two new consultants had recently been appointed to help support reducing locum spend across the service. The use of locums was on average around 4 %.
- We found evidence of effective medical handovers. We noted a verbal handover in the mornings on the unit which was then followed up with bedside ward round which was documented. A further handover of patients occurred at night. However, the evening handover was not documented in the notes by medical staff

Major incident awareness and training

- The trust Major Incident Policy was in place. The service had an escalation plan which had been tested in October 2014 and involved other directorates across the trust. The department also had a business continuity plan in place.
- We were told the testing of the major incident procedures had raised awareness about the importance of early communication with non-clinical departments such as medical engineering, pharmacy, domestic services.

Are critical care services effective?

Good

Treatment by all staff, including therapists, doctors and nurses was delivered in accordance with best practice and recognised national guidelines and patients received

treatment and care according to guidelines. The unit participated in the Intensive Care National Audit and Research Centre (ICNARC) and data showed the unit was performing either the same as or better that their national comparators.

Both medical and nursing staff had access to education, training and development. Patients were at the centre of the service and the main priority for staff. Staff were continually updating their skills and competencies and were proactively supported to obtain new skills and share best practice.

Patients' pain was addressed and pain charts were used to ensure patients were receiving medication for their pain. Staff knew how to support patients' rights and understood the complexities of working with the Deprivation of Liberty Safeguards (DoLS). A number of patients had DoLS applied and were reviewed daily in line with local protocols.

Evidence-based care and treatment

- The unit had a Directorate Annual Summary and Forward Plan which included the guidelines the unit had audited, locally agreed audits, what actions were taken to improve practice and the implementation strategy to ensure practice was changed.
- The service was reviewing and developing its existing guidelines and protocols to ensure up to date evidence based practice was delivered to its patients.
- Guidelines were ratified through its Critical Care Working Group and Critical Care Delivery Group, Directorate of Anaesthetics and the Patient Safety Committee.
- Staff were undertaking work to support patients with tracheostomies following the NCEPOD report- 'On The Right Trach?' This had resulted in a tracheostomy passport being developed.
- There were a number of guidelines for common intensive care conditions in place demonstrating best practise such as: Ventilator-associated pneumonia (VAP) care bundles, Central Line-Associated Bloodstream Infections (CLABSI) guidelines (Matching Michigan) and the use of Sepsis bundles.

Pain relief

- Pain relief was well managed and was managed with different protocols depending upon the patient's treatment, for example: the use of oral medication, continuous infusions, patient controlled analgesia and epidural infusions.
- Pain was checked and recorded regularly and we checked patient charts to find them fully complete. We saw pain charts and pain scores were comprehensively completed.
- There was a trust wide pain assessment scale used for Level 2 patients. Sedated and ventilated patients were observed for signs of pain for example when having their position changed.
- The trust has recently invested in new epidural pumps and training on the use of this device had started.
- 82% of nursing staff on the unit had received training on Patient Controlled Analgesia (PCA) pumps with a further 18% of staff identifying they needed further training. Training arrangements and action plans were in place to support the extra training needed.
- We observed a medical handover and ward round where a patient with complex pain management needs was discussed and treatment planned.

Nutrition and hydration

- We reviewed seven records and all patients had a MUST score assessment on admission. This was then reviewed after seven days or when appropriate. Compliance with the MUST score was monitored through monthly senior team quality visits.
- Patients were reviewed on a regular basis by a dietician. All enteral and parenteral nutritional requirements were assessed and implemented as per recommendations by the dietician. We saw a number of guidelines developed by the dietician which were used by nursing staff.
- Basic nutritional needs were provided by the catering department meals service. We saw a selection of various meal options. There was also the provision to provide snacks, biscuits, cereals and toast for patients when needed.
- We saw how the housekeepers were very involved in patient nutrition. They told us they saw it as their duty to encourage nutrition in any patient who could eat. We saw the housekeepers actively tempting patients to eat/drink by trying to find something the patient would find appealing.
- We saw strict fluid monitoring in place for the seven patient records we reviewed which demonstrated hourly and daily input and output totals for all patients. Patients who were able to take oral fluids had their input encouraged.

- We saw risk assessments for patients who had nasogastric tubes in place which included x-rays taken to check whether the tube was still in the right place.

Patient outcomes

- The service made patient data contributions to the Intensive Care National Audit and Research Centre (ICNARC). This meant that the care delivered and mortality outcomes for patients were benchmarked against similar units nationally. The ICNARC case mix adjusted mortality rate was less than one which was similar to the national data.
- All delayed discharges from the unit were reported via the DATIX system so that further investigation could be carried out and improvements made to reduce delayed discharges.
- The service had six patients readmitted within 48 hours of discharge from the unit (1.2%) for the period January 2014 to December 2104 which was better than the national figure
- Patient deaths were monitored by the unit's senior management team and the Mortality Review panel for further review and analysis.
- We also saw evidence that patient pathways reflected national guidance and were continuously audited. When necessary, action plans were implemented and re-audits undertaken to improve patients outcomes and the unit performance.
- A monthly report was collated which provided information on patient outcomes and demonstrated compliance with regional and national quality indicators such as:
- Critical care performance and patient outcomes were monitored through critical care working group, critical care delivery group, the Anaesthetic Directorate meeting, CCU sisters meeting and team meetings.

Competent staff

- The senior nurse team for the unit had an extensive background in critical care nursing and 52% of the nursing staff were in possession of a post registration award in critical care nursing. This meets the core standards for intensive care units 50% standard of registered nursing staff being in in possession of a post registration award in critical care nursing.
- New starters to the unit had a full induction to critical care and had a period of six weeks supernumerary status and mentoring. After this period they were given a competency book which was linked to the national framework and was completed within 12-18 months.
- All staff had clinical supervision, it was expected they would have 12 clinical supervisions per year and 72% of nursing staff had received annual appraisal at the end of March 2015.
- Difficult airway training days, transfer training days and target days (simulation training for critical care staff) were being used to support staff.
- There was excellent support for junior doctors. Junior doctors had induction and a competency based training programme. There was a faculty tutor on the unit who led a teaching programme, a Wednesday afternoon journal club and Friday morning teaching sessions. There was also a consultant led radiology teaching session. Junior doctors told us they felt much supported and never left alone to manage. They would recommend the unit as a good place to learn.
- Middles grade doctors and consultants used the Continuous Professional Development matrix set out by Royal College of Anaesthetists to make sure they were up to date in current practices.

Multidisciplinary working

- There was a strong multidisciplinary approach to care through the unit. A daily ward round was carried out with critical care team, the microbiologist and the pharmacist and there were weekly radiology rounds and regular end of life multi-disciplinary meetings.
- Physiotherapists saw patients within 24 hours of admission and followed national guidelines to assess patient's needs. They attended ward rounds when necessary and contributed to the patients' notes so instructions could be picked up and acted upon by nursing staff.
- Physiotherapists worked on the unit throughout the day and provided a weekend service. The support for each patient would be dependent upon the patients' individual needs. The physiotherapists also included the families when they visited the patients so they could be more involved in their treatment. This also prepared the families to continue with patient's exercises once they were discharged from the unit.

Critical care

- Medical staff who transferred patients into the unit told us working relationships with the unit were good and there had been no occasion where admission to the unit had been refused.
- The trust was part of the UK National Organ donation programme and followed NICE guideline CG135; Organ Donation for Transplantation. The unit worked closely with the regional organ donation team and were achieving high referral rates for donations after circulatory death (100%) and donations after brain death (100%). The organ donation team reported their activity monthly to the Critical Care Working Group. The organ donation team also supported the unit through teaching sessions in order to improve the unit's organ and tissue donations.
- At present the unit did not communicate with the patients' General Practitioner (GP) either if the patient was discharged or if the patient had died. The unit were looking to implement this process in order to inform the GP about their patients.

Seven-day services

- Nurse staffing levels within the unit were consistent over the seven day week.
- There was a 24 hour consultant and resident cover, plus a middle grade doctor from 08:00 – 14:00hrs Saturday, Sunday and bank holidays. There was a medical staffing escalation plan should the requirements within the department change due to capacity and/or acuity of patients.
- There was a pharmacy service Monday to Friday 9am to 5pm and a presence at weekends Saturday 9am to 4pm and Sunday 10am to 4pm. Pharmacy could be accessed outside of these hours if needed.
- Physiotherapy was provided daily and individual patient needs and requirements were assessed and implemented accordingly.

Access to Information

- Staff used lap tops which could be taken to the patient's bedside in order to access relevant guidelines and policies without leaving the bedside.
- There were appropriate and effective systems in place to ensure patient information was co-ordinated between systems and accessible to staff.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- Consent training was provided to all staff on induction. Patients gave their consent when they were mentally and physically able and we saw good record keeping on consent where patients were able to provide it.
- The trust had delivered training on the use of the Mental Capacity Act. All staff within the unit were aware of the Mental Capacity Act. Staff used the guidance when assessing if a patient was being or could be deprived of their liberty. We saw patients on the unit had their mental capacity assessed as their conditions changed.
- Staff had undergone training in the Deprivation of Liberty Safeguards (DoLS) regulatory requirements. Staff felt more confident in determining when to apply for a DoLS and they were completing the documentation accordingly. At the time of the inspection there were two patients who had a DoLS in place. These patients had been discussed with the safeguarding team and social services team prior to applying a DoLS. We saw information relating to the DoLS procedures displayed in the staffroom. Staff told us they felt confident in using this procedure.

Are critical care services caring?

Good

Patients were at the centre of the service and high quality care was a priority for staff.

The patients we spoke to told us that they were treated with dignity and respect and had all their care needs met by kind and caring staff that went the "extra mile." Feedback from patients and their families had been extremely positive.

Staff cared for patients in a compassionate and professional manner. There were some difficult messages to give to some relatives which were carried out in a sensitive and supportive manner. There was a bereavement lead who gave advice and guidance to staff and support staff to give appropriate and sensitive care.

Compassionate care

- Family members said that the care in critical care was excellent and spoke highly of the service they received.

- The service had three "caremakers" within the team who led the work of the six C's team within the department. The six C's are: caring, compassion, competent, communication, courage and commitment.
- We observed unconscious patients being communicated with by nursing and medical staff in a compassionate way. Curtains were drawn around patients to ensure privacy and dignity and voices were lowered to avoid private and confidential information being overheard.
- Interviews with five patients all spontaneously mentioned how caring staff were; two patients who were admitted from out of area told us they would choose to be readmitted to this unit as they felt cared for and safe. Cards and comments displayed on the department, without exception, told of the kindness and care they had received.
- Visiting times were flexible and reflected the needs of the patients whilst ensuring relatives and loved ones were kept up to date and reassured. Staff would accommodate visitors as much as possible at all times but would ensure the patient had quiet times in order to rest.
- The atmosphere was calm and professional and nurses were observed talking to patients and explaining their care even when the patient was unconscious.

Understanding and involvement of patients and those close to them

- Patients were involved with their care and decisions taken. We saw evidence in the clinical notes that patients and their relatives were involved in making decisions about care and treatment.
- Relatives and loved ones were kept informed and involved with decisions when appropriate. They were able to ask questions and could telephone the unit when they were anxious. Staff would often ring relatives during the night if necessary to keep them updated.
- Relatives were approached with compassion when a patient was a possible organ donor. We were impressed with the knowledge and experience of the organ donation team and their commitment to ensure both relatives and staff were dealt with in compassionate and professional manner.

Emotional support

- The critical care team were involved with families of patients who were nearing the end of their life. There was open access for visitors and a room could be used if relatives wanted to stay overnight. We saw the unit's exceptional approach to family support at the end of the patient's life using memory boxes, teddy pairs and friendship bracelets.
- A sympathy card was posted to all bereaved families and a follow up telephone call was also initiated in order to provide extra support if needed and the chaplaincy were on call at all times.
- A very sick young patient described that all nurses who cared for her had 'popped in; to say goodbye to her on her discharge day.
- Another young patient described how when she was admitted and she was terrified she was going to die, a doctor stayed at her bedside all night.
- There were link nurses for specialist areas such as; learning disabilities, mental health and dementia. Nurses told us carers and care workers were encouraged to come to the unit to provide emotional support so as to alleviate the distress of any disorientated patients.
- An ICU support teams for ex-patients (STEPS) group had recently been set up in the Tees Valley area. Nurses from critical care attended the meetings so that they could provide support for ex patients and their families. We were told staff did this in their own time. This also provided patient experience feedback for the service.
- At the time of the inspection there was a patient who had carried an organ donation card. We saw staff supporting the family whilst waiting for the results of tests in order to continue along the organ donation pathway. Staff treated the family with compassion and sensitivity and we observed the team and the unit staff acting in a professional and calm manner.

Are critical care services responsive?

Good

The unit was responsive to patient's needs. Staff worked in a flexible manner in order to ensure all patients were looked after when demand increased. There was a formal process in place for medical staff to refer patients to the unit who may need intensive care support.

The unit had experienced high levels of occupancy, at times over 113%. However, the unit had no delays to admit patients over four hours, no elective operations were

cancelled due to bed pressures in the unit and no patients was refused admission to the unit when referred by another doctor. Interpreting services were available for people whose first language was not English and we saw patients with a learning disability or living with dementia were well supported.

Service planning and delivery to meet the needs of local people

- In January 2015 the unit had reviewed the way acutely ill patients were identified, treated and followed up after discharge from Critical care via a Critical Care Outreach Team (CCOT) approach.
- A Standard Operation Procedure was developed to outline working practices following the unification of the two Critical Care Units in 2013.

Meeting people's individual needs

- The cultural needs of patients on the unit were being met. There were menus for patients from different ethnic backgrounds. An interpreting service was available if needed and patients were asked whether they wanted their relatives to interpret on the patient's behalf. There were posters showing where to access interpreting services.
- Patient and relatives facilities were good. There was a relatives/visitors room with comfortable chairs and sofas and information about the unit. There was also a smaller room in the middle of the unit for relatives who may need to stay overnight.
- There was an abundance of booklets and leaflets for both patients and families. .
- Staff on the unit tried to avoid mixed sex accommodation. This was not always possible and where patients of different sex were placed in the same bay we saw staff using the bed curtains to ensure patients privacy and dignity was not compromised.
- The unit had a dementia champion and could access the dementia helpline. Staff could also access the safeguarding team for advice when necessary.
- Patients admitted to the unit living with a learning disability were flagged up on the Patient Administration system (PAS). The trust's specialist nurse for learning disabilities would be informed and would visit the patient on the unit. There were arrangements in place for patients with a learning disability to have their carers stay with them 24 hours a day.
- There was evidence of excellence joint working with the end of life care team when patients wished to go home to die. The unit had assisted six patients to return home.
- The unit had a file containing all information relating to the 'withdrawing treatment' pathway to ensure the patients' needs were met. This included informing the chaplaincy service.

Access and flow

- The unit provided a service with a capacity of 17 beds to 400,000 population which was proportionate for this population. The service had an annual average 73% occupancy rate, which peaked at 113.8% in January 2015, which meant at times they were working over capacity
- The average length of stay on the unit was three days for Level 2 patients and five days for Level 3 patients. The trust had a 'ward watcher' system which showed that out of 8,700 patients, there were no patient admissions to the unit delayed more than 4 hours.
- The service had recently developed a Critical Care Outreach team (CCPOT) to ensure the efficient and appropriate use of critical care resources. In April 2015 the CCOT saw 87 patients with 19 of these patients being admitted to the unit facilitated by the CCOT.
- The unit had a Standard Operating Procedure (SOP) to support the new referral process for all in-patients requiring a consultant to respond immediately. All potential patients would be reviewed by the Critical Care team for possible escalation of care. There were three categories of response: Red which required an immediate response, Amber which required a response within 30 minutes and Green to be seen within two hours.
- Between April 2014 and March 2015, 20 patients were transferred in to the unit, 11 of these were due to bed pressures. In April 2015 no patients had been admitted to the unit due to bed pressures.
- Where a decision to admit a patient on to the unit was made, all patients were admitted within four hours of the decision. Four hours is the indicator used for comparison with other units and set by ICNARC. It is used to demonstrate the ability to move patients into critical care in a timely manner.
- The discharge of patients from the unit was achieved at the right time for the majority of patients.
- Studies have shown discharge at night can increase the risk of mortality and cause stress to patients. Intensive

Care National Audit and Research Centre (ICNARC) data April 2015 showed there were 27 patients whose discharge from the unit was delayed. Eight of these patients were discharged between the hours of 10.00pm and 06.00 am.
- There were no cancellations of patients waiting for elective surgery due to lack of critical care beds and patients who needed a critical care bed were rarely not accommodated.

Learning from complaints and concerns

- There had been very infrequent complaints to the unit. Between April 2014 and March 2015, there had been 11 concerns raised about the unit. The majority of these related to missed communication. Action plans were developed and included; identifying the problem, specific actions needed to be taken in order to address the problem, who would take responsibility for the actions to be completed and a progress update and final evaluation.
- Learning from complaints was discussed at the monthly Critical Care Working Group, the Critical Care Delivery Group and at the weekly sisters meetings.
- Issues arising from complaints were used as scenarios for teaching purposes on study days.

Are critical care services well-led?

Good

The service had experienced some challenging times with its 'transformation' and move to a single site critical care model. The senior management team were relatively new to post during this period. However, we heard extremely positive messages about how this new team had managed the process. The leadership, governance and culture were used to drive person-centred high quality care and all staff were committed to their patients.

The service could demonstrate a clear vision and strategy for the service and the staff we spoke with were able to tell us about the strategy. Staff felt happy with the level of engagement and felt confident they could discuss any concerns with their leaders with ease and that they would be listened to.

Governance arrangements were formalised and firmly embedded within the service. Staff felt confident about risks being discussed and actioned. Risk registers demonstrated that risks were identified, recorded and actioned appropriately.

There was a high level of satisfaction with staff telling us they enjoyed working within the team. Nursing and support staff provided flexibility within the department to provide high quality care that met patient's care needs.

Vision and strategy for this service

- The unit had a one to five year clinical strategy. Staff could tell us what the strategy meant to them, which was to provide the best care for patients and to put patients first.
- There was a change to medical leadership three years ago and a new nursing model introduced eight months ago. Staff who worked outside the unit told us how improved communication and leadership had supported the clinical strategy to develop Level 1+ care areas across the trust.
- The new management team successfully managed the amalgamation of two distinct district units and implemented new ways of working on the unit resulting in a block working pattern for medical staff. The team were recruiting and retaining high middle grade staff with high qualifications in intensive care. There were also split rotas for medical staff so all doctors on the rota for the unit had an interest in intensive care. Only consultants with day time sessions were carrying out on call duties.
- The team had also managed to achieve the workforce staffing levels required to cover a single site, with the necessary skill mix to deliver safe care based on 10 Level 3 beds and six Level 2 beds.

Governance, risk management and quality measurement

- There was a clear structure that demonstrated how the unit fed into the hospital trust governance structure and how assurance was made through its committee structures from local meetings through to the trust board.
- There were link roles and dedicated staff to lead on governance and quality assurance and dedicated time to undertake their governance duties.

Critical care

- The service had a Risk Management Strategy. Staff felt confident about risks being discussed and actioned. Risks were presented and discussed at regular meetings.
- The service had a risk register. Whilst some of the risks on the register were dated 2009/10, risks were updated every three months. We were told the old risks were used as a monitoring mechanism to ensure past risks did not reoccur. The unit understood, recognised and reported its risks.
- The service had no red risks on the risk register and three amber risks. The amber risks related to cardiac monitors, the need for an electronic bed and a trust wide risk relating to the management of the deteriorating patient. All three risks were being actioned along with patient experiences and complaints.
- Risks were discussed at various groups such as the Critical Care Working Group through to sisters meetings. The unit investigated its serious incidents and action was taken to prevent reoccurrence. We reviewed two root cause analysis reports which demonstrated clear actions and changes to practice.
- Staff were represented at a number of trust wide meetings such as: the trusts Infection Control Committee, Mortality and Morbidity meetings and the deteriorating patient committee. This showed the unit were engaged with the governance activity of the trust overall.
- We found information from governance meetings was cascaded to staff via emails, meetings, handover 'hot topics' briefings and lunch time learning sessions.
- Patients received treatment and care according to national guidelines and the service used an audit programme to check whether their practice was up to date and based on sound evidence. The service was obtaining good-quality outcomes as evidenced by its Intensive Care National Audit and Research Centre (ICNARC) data.

Leadership of service

- The service was led by a Clinical Director and eight consultant anaesthetists three of whom were intensivists, alongside a Senior Clinical Matron and a senior nursing team. The team were committed to delivering an outstanding service and staff we spoke with had a high regard for their colleagues.
- Senior medical and nursing staff were visible on the unit and were respected by all the staff we spoke with.
- The Anaesthetic Directorate had developed an 'Anaesthetic Service Line Management Structure and Ways of Working' document which set out how the unit would be managed and led. This included; how the unit would work, individual roles and responsibilities for each tier of the management structure and formalised agenda items.
- A number of staff could access leadership training via the Emergency Leaders Course. There were also leadership courses available via the trust and the Critical care network.
- The unit had an intense and complex case mix of patients; even so, staff told us the management of the unit was excellent. Jobs were delegated, it was an easy working environment, leaders were good communicators, staff felt supported.
- Medical colleagues told us medical staff on the unit were 'top class', they felt they were listened to and their input was valued.

Culture within the service

- There was a strong culture of teamwork and staff spoke of being proud of their unit.
- Staff felt supported and spoke to us about the service being clear and open. A transparent culture had been established where the emphasis was on the quality of care delivered to patients.
- We were told about a number of staff who would support patients even when they were off duty and would visit their patients to say goodbye when they were being discharged from the unit.
- All patients we interviewed were highly complementary on safety, care and compassion.
- The culture was one of 'can do'. Staff were passionate about working as a team and were patient centred.

Public engagement

- Feedback about the service was currently through its compliments and complaints processes. There was recognition that public engagement needed further work. The service was due to participate in a patient feedback exercise through the evaluation of the CCOT.
- The unit used the NHS Choice cards to gain the public's views of the service. The results were positive. At present the unit did not use the Friends and Family Test but we

were told this may be used in the near future. However, the monthly dashboard included the number of compliments received and cards from ex patients and their relatives were displayed across the unit.
- The unit had access to charitable funds. These were used for such things as facilities for patients and education for the staff.

Staff engagement

- The unit had an 'Anaesthetic Directorate Engagement Plan' which set out the methods of engaging all staff. These included; staff briefings, newsletters and Big Jam. Individual activities were listed along with the purpose of the activity, a specific plan how this activity would be carried out, who was responsible for the activity and the timelines for the activity to be actioned.
- For example; the directorate management team (Quad plus) would visit existing staff meetings/unit meetings, to ensure they could hear what staff had to say, along with being more visible to staff. This would be undertaken every six months by the Quad team and was named the 'Big Jam'.
- We were told due to the increased activity over the winter period staff engagement had been challenging. Team meetings had not always occurred on a regular basis. However, we found team leaders were now holding regular meetings with their teams. We also saw formal and informal ward meetings and meetings in the staff rooms.
- Feedback on current issues was also disseminated to the teams through emails and a communication file. Also nursing handover was used to share a "Hot topics" at the change of shifts
- The 2014 NHS staff survey showed that 51 % of staff overall would recommend the organisation as a place to work which was worse than the 58% national average.

Innovation, improvement and sustainability

- The Critical Care team achieved a network award, which recognised excellent work in relation to "target" training. The team had also achieved recognition for their work related to critical care competencies, difficult airway and skills drills.
- The Critical Care Team achieved 58% for its consideration of patients for tissue donation. The team were the second highest achiever for corneal donations. Overall the team's approach to tissue and organ donation was impressive, demonstrating a compassionate and sensitive approach to patients and relatives.
- Funding was in place to support the Critical Care Outreach Team over the winter period. Given the expectations/aspirations medical staff across the trust had for this service, financial support would need to be more permanent to ensure the service was sustainable.

Maternity and gynaecology

Safe	Requires improvement
Effective	Requires improvement
Caring	Good
Responsive	Good
Well-led	Requires improvement
Overall	Requires improvement

Information about the service

University Hospital of North Tees provided a full range of maternity services for women and families within the hospital site and community setting and covered all areas of Stockton-on Tees, Hartlepool and East Durham. Services ranged from consultant led and specialist care for women with increased risks to midwifery led care for low risk expectant mothers.

The delivery suite has 14 delivery rooms; four of these are for low risk labour, delivery, recovery and post-partum care (LDRP) and use the active birthing centre approach. Ten rooms are for high risk women; there is one twin bedded induction room and two family rooms for bereaved parents. All of the rooms are en-suite. There is direct access to two dedicated obstetric theatres.

Antenatal and postnatal care is provided on Ward 22 which has 28 beds; an early pregnancy clinic was located by the entrance to the women's health unit (Ward 30) and a day assessment unit is located on the ground floor. The maternity services at University Hospital of North Tees delivered 3078 babies from April 2014 to March 2015.

Ward 30 has 30 beds and provides in-patient treatment for a range of gynaecological problems. General surgery and urology admissions were also received on this ward.

We visited the delivery suite, antenatal and post-natal ward, early pregnancy unit, the day assessment unit and the women's health unit. We spoke with 14 women, nine partners, 27 staff including senior sisters, senior midwives, midwives, student midwives, midwifery support workers, domestic and administration staff and doctors. We also spoke with the clinical director, head of midwifery, general manager, patient safety lead and the Local Supervisory Authority Midwifery Officer (LSAMO).

We observed care and treatment and looked at 21 sets of care records. We also reviewed trust performance data.

Maternity and gynaecology

Summary of findings

Overall the maternity and gynaecology services at University Hospital North Tees were rated as requires improvement; this was due to concerns in the areas of safe, effective and well-led. We found the service to be caring and responsive and rated these as good.

We lacked assurance around the consistent checking of emergency equipment and full completion and management of patient records in maternity services. We observed a staff handover on the delivery suite that was not comprehensive or inclusive of matters relating potential safety issues. We also had concerns about staffing and skills mix on the maternity unit.

The lack of a competency framework for midwives and the failure to achieve the recommended midwife to supervisor ratio led us to a rating of requires improvement for effective. Although we were informed the out of date guidelines had been updated on our return visit, we lacked assurance that the guidelines and learning from serious incidents were embedded with all staff.

Although some areas were well-led overall, the current risk register did not give assurance that risk within the department was being managed appropriately. The staff we spoke with and observed in practice were compassionate and patient focused and patients were very happy with the care they received.

Are maternity and gynaecology services safe?

Requires improvement

We rated safe as requires improvement.

The main areas of concern included midwifery staffing numbers and skills mix, resuscitation equipment checks not being completed, WHO surgical checklists not being fully completed, medicines management, lack of evidence of learning from patient safety incidents and the quality of handover between shifts. Staffing levels were managed with midwives working overtime to cover shortages and there were plans in place to fill vacancies. However the midwife to birth ratio at the time of inspection was 1:30 against a recommended ratio of 1:28. The checks of emergency equipment were not being done consistently across all areas and the handover we observed did not provide assurance that care and treatment for women on the maternity unit was discussed and shared with staff in a comprehensive way. We reviewed action plans and learning from incidents. When we spoke with staff there was a lack of evidence to support that learning has been shared and embedded throughout the service. The rate of stillbirths was higher (19) than the expected rate (15) for England and Wales for the number of births in 2014/15.

Mandatory training participation rates were good and staff could articulate how they would manage safeguarding concerns. Ward areas looked clean and tidy and PPE was available outside bays and in single rooms. On the gynaecology ward, staff conducted a 'reflection hour' at least three times a week to review each other's documentation. There were no reported cases of MRSA or Clostridium difficile from April 2014 to March 2015 and good hand hygiene practices were observed.

Incidents

- Trust policies for reporting incidents, near misses and adverse events were embedded in maternity and gynaecology. Incidents were reported on the trust electronic reporting system (Datix). The staff we spoke to were aware of how to use the system and could describe the process for a recent incident they had reported.

- Incident reporting was encouraged, and there were a number of ways learning from incidents or a change in practice was shared. This included weekly patient safety team meetings and newsletter, patient safety team visits to clinical areas, publication of a monthly newsletter 'Risky Business', face to face feedback of action plans to ward managers, and emails. Clinical incidents also fed in to mandatory training and were used as scenarios.
- There were no never events reported in 2014/2015. Never events are serious, largely preventable patient safety incidents which should not occur if proper preventative measures are taken.
- Between December 2014 and April 2015 there were 155 incidents reported in maternity, one causing severe harm, 14 moderate harm, 33 low harm and 106 no harm. Themes of incidents included: simple complication of treatment for example 2nd and 3rd degree tears, staffing shortages and blood sampling issues, in particular insufficient blood spot samples.
- There were eight serious untoward incidents (SUI) reported in maternity and gynaecology from September 2014 to March 2015. Root cause analysis (RCA) was undertaken following each incident. We looked at two SUI in detail and found action plans had been produced and there had been changes in practice. Seven staff told us about these incidents but not all were able to identify any recent serious incidents and the learning or actions arising from them. Minutes were reviewed from obstetric and gynaecology departmental teaching events, attendance by midwives was poor and one meeting noted disappointment as no midwives or ward manager were present.
- Actions taken following these incidents included updating the primary (within 24 hours of delivery) post-partum haemorrhage guidance and developing a flow chart for 'massive haemorrhage'. Other actions included undertaking competency assessments for all midwives on cardiotocography interpretation (CTG). CTG is a technical means of continually recording the fetal heartbeat and the uterine contractions during pregnancy. The 'fresh eyes' approach to CTG monitoring was also reviewed. The 'fresh eyes' approach can enhance the accuracy of CTG interpretation as the tracings are viewed by more than one person. We also saw examples of actions to improve practice to recognise maternal sepsis. Posters demonstrating the pathway to follow if sepsis is suspected were seen on the walls on the delivery suite and sepsis stickers were seen in clinical records. However staff were asked about the 'sepsis box' but did not know where it was or what it contained; the sepsis box was a recommended action from a SUI.
- There were 19 stillbirths reported between April 2014 and March 2015 on the trust's dashboard, this information was not rated or measured against a trust benchmark. In 2014, the national stillbirth rate remained at 4.7 per thousand total births (Office for National Statistics). The number of stillbirths (19) is therefore higher than the expected rate (15) at the trust for 2014/15 based on 3078 births. Staff in the maternity day assessment unit attended training on Gestation Related Optimal Weight (GROW) software which aims to reduce the number of stillbirths by using customised growth charts.
- There were 38 gynaecology incidents reported between December 2014 and April 2015; 29 caused no harm, 6 caused low harm and 3 caused moderate harm.
- Mortality and morbidity meetings took place monthly and minutes of these meetings were provided by the trust. We reviewed minutes of several meetings which confirmed a review of clinical incidents including a discussion of the case along with clinical details and suggestions for improved practice/management in the future were evidenced. It was noted that some minutes were very brief.
- Staff spoke about duty of candour and the importance of being open and honest with patients and provided the inspection team of examples. Staff explained following a clinical incident, patients would be invited to attend a meeting to discuss what had happened.
- We saw evidence of the Duty of Candour being implemented for two SUIs. Duty of candour information was stored on the trust's Datix system.

Safety thermometer

- The NHS safety thermometer is a local improvement tool for measuring, monitoring and analysing patient harms and harm-free care. The NHS safety thermometer allowed the proportion of patients who were kept 'harm-free' from venous thromboembolisms (VTE's), pressure ulcers, falls and urine infections to be measured on a monthly basis.
- Safety thermometer data was publically displayed on the in-patient areas we visited.

- The obstetric department and gynaecology department dashboards showed that from April 2014 to March 2015, they performed better than the trust target of 95% for VTE risk assessment completion. The care records we looked at all had a completed VTE risk assessment.
- From April 2014 to March 2015 there were no recorded cases of Methicillin-Resistant Staphylococcus Aureus (MRSA) or Clostridium Difficile within obstetrics and gynaecology.

Cleanliness, infection control and hygiene

- Women were screened for MRSA before undergoing elective caesarean section.
- Hand hygiene compliance was recorded on the gynaecology performance dashboard as between 95% and 100% from April 2014-March 2015. On the delivery suite and Ward 22, hand hygiene compliance was between 92.25% and 100% for the months of May and June 2015.
- Observations during our inspection confirmed the availability of alcohol hand gel outside each bay, in each single room and at entrances to clinical areas. The dispenser at the entrance to Ward 22 was empty on the day of our inspection, but when mentioned to a staff member was immediately replenished.
- Staff were observed using personal protective equipment (PPE) as required, we observed hand hygiene from all disciplines of staff whilst on site, and 'bare below the elbows' guidance was adhered to. The women we spoke to all said staff were seen to wash their hands and use hand gel when attending to them and their babies.
- Single rooms were available in all areas if a patient needed to be isolated.
- On our initial inspection, ward areas looked clean and tidy and PPE was available outside bays and in single rooms.
- When we revisited the trust, we looked at six unoccupied rooms on the delivery suite. All but one of the rooms appeared clean, however on closer inspection we found dust on high and low surfaces such as bed frames, television apparatus and ambient heaters over the neonatal resuscitation equipment. All of the rooms contained a record of a daily record of cleaning. We found large gaps in completion of these records, for example Room 6 had a gap of 13 days between recordings of cleaning and was not stocked with aprons.
- The domestic cleaning audit for March 2015 by Servicetrac lists the delivery suite as one of lowest scoring locations with a score of 89.2%, against a trust target of 93%. We were not told of any plans to address this.

Environment and equipment

- Access to the delivery suite and Ward 22 was via a voice activated intercom system, CCTV was also present.
- There were challenges with the layout of the delivery suite in complying with Health Building Note 09-02 – Maternity care facilities (2013). "The reception desk should be located to enable all visitors entering or leaving the unit to be monitored", this was not possible with the desk being located at the end of the entrance corridor slightly to the right, so the entrance could not be seen from the reception desk. The layout on Ward 22 also made observing people entering and leaving the ward difficult. This presented a challenge in adhering to the trust policy on prevention and management of infant and child abduction, particularly in relation to 'tailgating'. The policy stated "staff should be vigilant to visitors and should prevent where possible visitors enabling other people into the unit through non-manned security doors, this is called tailgating".
- The obstetric theatres were located off the delivery suite enabling easy access for staff.
- Ward 22 and Ward 30 were predominantly bays of four beds with six side rooms; space between beds was adequate and allowed for cots and chairs.
- Space was limited in the day assessment unit; all of the staff we spoke with highlighted the lack of space and how warm the unit gets.
- Resuscitation trolleys were easily located on the main corridors in each of the areas we visited; the only exception was Ward 30 whose resuscitation trolley was located on Ward 31, as it was shared between the wards.
- Best practice is for resuscitation trolleys to be checked daily (Royal Collage of Anaesthetics – Resuscitation – Raising the Standard). Records were checked from January 2015-March 2015 in the day assessment unit and daily checks of all emergency equipment were evidenced.
- We were not assured that the systems in place for identifying and checking emergency equipment were robust on delivery suite and Ward 22. For example the week prior to our visit, the emergency equipment i.e. neonatal resuscitaire, postpartum haemorrhage and

adult resuscitation trolley had not been checked for five consecutive days on Ward 22. Although this had improved in both areas on our return inspection, there were still gaps or signatures missing.
- We asked a member of staff about a trolley in Room 1 (high dependency room) on the delivery suite labelled adult resuscitation trolley. They were unclear as to its purpose and contents; we asked a second member of staff who stated said the trolley was for management of women with pre-eclampsia.
- We checked equipment for evidence of portable appliance testing (PAT). This is the term used to describe the examination of electrical appliances and equipment to ensure they are safe to use, and should be done on an annual basis. We looked at all types of equipment and with the exception of one fan on the delivery suite, all had evidence of in date PAT testing.

Medicines

- An electronic medicines management system for medication was in use on the delivery suite. Medicines were stored appropriately within locked cupboards and trolleys. The only exception was the epidural trolley on the delivery suite which was unlocked and contained boxes of Bupivacaine. The trolley was located in the equipment room which could be easily accessed from the corridor. A trust medicines audit in May 2015 had found an unlocked unattended medicine trolley in the corridor on the delivery suite. In Room 1 which was designated as a high risk birthing room, we found a 20ml glass ampoule of Lignocaine in an unlocked cupboard. The trust medicine audit in May 2015 had found an ampoule of Lidocaine on a work surface in the clean utility room.
- The drugs ergometrine and syntocinon were seen stored at room temperature in delivery rooms. Whilst syntocinon can be stored for up to three months out of the fridge, ergometrine should be stored at 4-8 degrees in the dark. On our return visit, both drugs were stored in the fridge.
- The trust medicines audit in May 2015 had highlighted some major concerns around the security of medications, 67 wards and departments had been audited over a two week period. The findings of the audit and subsequent actions had been shared with the most senior staff on duty.
- We checked drug administration records of 21 women and found these had been completed with second signatures where appropriate.
- An audit of obstetric antibiotic use is undertaken each four months. Findings from January 2015 showed there were areas for improvement as the audit showed the trust policy on drug prescribing and administration was being breeched.
- We checked the storage and administration records of controlled drugs in all clinical areas. We were assured that daily stock balance checks were completed on the delivery suite and Ward 30. On Ward 22, 13 days had been missed from the 1st April 2015. We randomly selected two controlled drugs on the delivery suite and Ward 22 which were found to be in date and the stock balance was correct.
- Fridge temperature checks were also recorded in the controlled drug record book and gaps in recording were noted. The minimum and maximum fridge temperatures were not recorded, but all temperatures were between 2° and 5°.
- Pharmacists visited weekly to 'top up' stocks of medication but were available at other times for advice if needed.

Records

- The maternity service had developed its own modular set of notes. The antenatal notes were carried by the women throughout pregnancy in line with National Institute for Health and Care Excellence (NICE) Quality Standard (QS) statement 3.
- The notes reviewed were individualised, clear and concise and it was possible from reading them to ascertain information regarding the woman's journey through the maternity service. The notes comprised of many loose sheets of paper which were often not secured in the notes and thus increased the risk of information being mislaid. This went against the trusts maternity records management policy which stated 'At no time should anything be stapled, stuck or un-filed within either the hand held or the hospital records'.
- The unit had developed its 'Fresh Eyes CTG Surveillance' on individual sheets of paper which were filed sequentially after antenatal or labour CTGs. We were concerned that errors could be made in ensuring records were contemporaneous.
- In the 12 sets of notes we reviewed on Ward 22, a patient had returned from theatre without case notes so a

supplementary history sheet was used. There was another instance where it was documented 'duplicate entry as unable to find notes on ward round'. We also reviewed notes which included the Caesarean Section Proforma of another patient.

- There was a documented risk on the risk register where a patient had been discharged with the wrong notes but the risk had not been reviewed since April 2014. Meeting minutes also highlighted an incident where an operation was delayed as case notes were missing.
- We did find within the 12 sets of notes reviewed, all women who had required either a urinary catheter or vascular access device had evidence of safety bundle documentation completed in line with NICE Quality Standard 61, statement 4 and 5.
- The records were all completed in a legible and comprehensive way and risk assessments were completed. The antenatal care pathway included risk assessments for raised BMI (body mass index), gestational diabetes, smoking and pre-eclampsia in line with NICE Quality Standard 22.
- The 'fresh eyes' approach was used for review of CTG's. 'Fresh eyes' was done every two hours by the shift co-ordinator. In the case notes we reviewed we found several omissions of this being documented. Staff we spoke with informed us of a proforma to assist the delivery suite co-ordinators in the two hourly Fresh Eyes evaluation of CTG foetal monitoring. This had not yet been approved for implementation. On ward 30 staff peer reviewed each other's documentation in relation to things such as description of pressure areas. We were told this 'reflection hour' took place at least three times a week.

Safeguarding

- The Head of Midwifery (HOM) was the safeguarding lead with support of another midwife in an interim post.
- There was an up-to-date safeguarding policy and all staff we spoke to could describe what the process was if they had concerns and how to contact the safeguarding teams for different areas. The staff also described good working relations with community midwives over safeguarding concerns.
- Training figures for all areas were reviewed with 85-100% of nursing/midwifery and medical staff having completed child and adult safeguarding training.
- We were told multi-disciplinary, pre-discharge meetings regularly took place on the ward in safeguarding situations.
- There was a policy and flow chart for the abduction of an infant and staff could describe the actions they would take if this situation occurred. In-patient areas with babies had swipe card access for staff and a verbal intercom means of access for visitors. Staff from different areas could describe the escalation process if a baby was abducted and staff felt happy to challenge people if identification badges were not seen or people were behaving suspiciously. However there was no evidence that a simulation of this procedure had taken place and staff were not aware of this happening.
- There was a draft flow chart for the care pathway of teenage mothers. The trust did not have a specialist midwife for teenage pregnancies. Staff could describe situations involving teenage mothers and what measures were put in place to support them.
- We saw the Female Genital Mutilation (FGM) guideline which had a multi-agency approach and clearly demonstrated the arrangements to safeguard women with or at risk of FGM. The guideline includes automatic safeguarding referral for female infants at risk of FGM as detailed in the Department of Health (DoH) guidelines.

Mandatory training

- Attendance rates for mandatory training were 88%-100% for staff on the gynaecology ward and 80-100% for maternity and obstetric staff.
- Mandatory training was a four day programme for midwives and nursing staff and two days for medical staff. These days were rostered into the duty rotas.
- The programme included safeguarding training, resuscitation, information governance, blood transfusion and moving and handling. We were told actual clinical incidents and SUIs were used as scenarios during training.
- In addition midwives and obstetric staff had skills drills training, which was a scenario based on an emergency situation, for example obstetric haemorrhage. The directorate also had 2 part-time training leads equating to 1.0 whole time equivalent (WTE) The service was planning to introduce simulated training drills in September of this year. Live skill drills took place within the delivery suite on a regular basis but there had been no skill drills undertaken within the ward area.

Maternity and gynaecology

Assessing and responding to patient risk

- Staff on the gynaecology ward used the national early warning system (NEWS) for assessing the condition of patients. A maternity early warning scoring assessment tool (MEWS) had also been implemented within maternity services. This assessment tool enabled early identification of women who required additional medical support or closer monitoring. The tool was in use and completed where required for each of the records we reviewed. In addition babies who required enhanced observation, such as those at risk of infection had their observations recorded on a neonatal track and trigger system.
- Within the day assessment unit, the staff we spoke with told us they used MEWS to triage women who attended. If staff were concerned that a woman was too unwell to be assessed in the day unit, they would transfer the patient to the ward.
- Risk assessment at antenatal booking was done for all women using trust guidance to determine whether individuals were high or low risk. The trust had an Antenatal Screening Specialist Midwife and we were told there were fail safes across all screening programmes. A failsafe is a back-up mechanism, in addition to usual care, which ensures if something goes wrong in the screening pathway, processes are in place to identify what is going wrong and what action follows to ensure a safe outcome.
- The World Health Organisation (WHO) devised a safer surgery checklist which includes five steps to be completed when anyone has an operation. This was adapted to include obstetric procedures in 2010. In the 12 records we reviewed, five sets of notes included the maternity WHO checklist. It was noted that women were not being signed out of theatre as per guidance for these checklists. A review of a further nine sets of notes revealed four of the woman had been to theatre and all had incomplete WHO checklists. The outcome of an audit undertaken October to December 2014 demonstrated that there were improvements to make regarding the completion of the checklists and using the maternity specific checklist. The results were fed back to an Obstetrics and Gynaecology learning event in December. There was no indication of how often the maternity WHO checklist would be audited and the trusts 2015 forward plan made no reference to it.

Midwifery and Nurse staffing

- The Safer Childbirth: Minimum Standards for the Organisation and Delivery of Care in Labour set by the Royal College of Obstetricians and Gynaecologists (RCOG), recommend a ration of 1:28. This being one midwife to 28 births. This ratio was not being met at the time of our inspection as it was 1:30, but we were told when recruitment of midwives reached establishment, the ratio will be 1:27.
- A Birthrate Plus Staffing review (midwifery workforce planning tool) had commenced but was not completed. The draft report was reviewed with some data was outstanding so no conclusions could be drawn from this.
- We were told midwifery was experiencing challenges with staffing due to 8.4 WTE on maternity leave and an average of 6.6 WTE on long term sick, in particular there were gaps in the band 7 establishment. This resulted in experienced band 6 midwives undertaking the role of the co-ordinator. The expectation that band 6 midwives would bridge gaps in the band 7 establishment was stated as part of the maternity risk management strategy. This presented a challenge in adhering to the principles of Safer Childbirth (RCM, RCOG 2007) and NICE NG4 safe midwifery staffing for maternity settings published in February 2015 which states: 1.1.3 'Provide midwifery staff to cover all the midwifery roles needed for each maternity service, including coordination and oversight of each service'.
- For obstetrics and gynaecology nursing and midwifery staff, turnover was reported as 6% he vacancy rate in May 2015 was 1.64 WTE.
- It was identified that in recent years newly qualified midwifery staff were recruited into vacant posts which had affected the skill mix within maternity; however we spoke to staff of all grades who said they felt supported in their role. This support was provided by their peers, although they said they could access more senior management if required.
- Women we spoke to said they had received 1:1 care during labour. This data is not captured on the obstetric dashboard. Of the 21 sets of case notes we reviewed one referred to not being able to provide 1:1 care during labour due to the acuity on the unit.
- To achieve safe staffing levels across the maternity and obstetric department, staff were moved between areas; we were told this could happen on a daily basis. There was an escalation policy in place and escalation of

midwifery staffing concerns was via the shift co-ordinators who would address the situation at a local level. We were told staffing shortages were covered by staff working overtime.

- On our unannounced inspection planned staffing numbers on Ward 22 had not been achieved. There were three midwives on duty when there should have been five midwives on duty. We were told other departments had been contacted for help and that a community midwife was expected to attend for the afternoon shift.
- We observed the evening handover on delivery suite; both the midwifery handover and medical handover took pace in a central rest room. The handovers were both informal with multiple distractions such as other staff washing up and eating meals. The midwifery co-ordinator was not present throughout the medical handover.
- The midwifery handover failed to provide a thorough detailed handover of clinical information regarding the women present on the delivery suite. For example no details were provided regarding one of the women listed on the information board and there were gaps in the clinical information relating to two women who had recently been transferred from the intensive care unit (ICU).
- There was a lack of professional language, for example a CTG was described as 'beautiful'.
- There was no patient safety update included as part of the handover, for example, two patients with near identical names were not highlighted as a risk. There was no update given to the co-ordinator on any women who may be cause for concern, or the numbers of women undergoing induction of labour on the antenatal ward.
- At the unannounced inspection we listened to a handover which was concise and included all women on the unit and Ward 22 who may be giving cause for concern. The handover did not include any safety communication regarding issues which needed wider dissemination.
- There were no formal guidelines on the format of handovers. Use of the SBAR (Situation, Background, Assessment, and Recommendation) tool and inclusion of a safety briefing is good practice. Encouraging the use of SBAR was a recommendation of a safety incident root cause analysis.
- In the early pregnancy clinic, a handover sheet which included details of all women who needed review of results or who could access the service with further bleeding was kept in a folder. The folder was kept on the women's health unit, Ward 30, out of hours.
- Ward 30 reported that they worked in three teams, with each trained nurse taking responsibility for eight to nine patients with the addition of a co-ordinator. The ward establishment was 30 WTE to accommodate for the ward taking direct admissions. The duty rota coordinator ensured that a nurse with gynaecology experience was on duty for each shift. The ward was fully staffed with plans in place to backfill a member of staff due to go on maternity leave. We were told since the introduction of a new sickness and absence policy last year, short term sickness had reduced.
- The manager from Ward 30 attended a daily staffing meeting to discuss any staff shortages and if help could be sought locally. NHS Professionals (NHSP) and overtime were used to fill short term staff shortages.
- Planned and actual staffing numbers were displayed on notice boards in each in-patient area we visited. On the day of our inspection there were no shortfalls with planned and actual staffing numbers on Ward 30.

Medical staffing

- Consultant obstetrician cover was provided on the labour ward from 8.00am to 10.00pm providing 98 hours cover each week. Consultants were contactable out of hours and medical staff told us they felt happy to do this. The same level of cover was provided by the gynaecology consultants. There was also on call cover provided by senior house officers and middle grade doctors for obstetrics and gynaecology. Staff from all areas we visited told us they could always speak to a doctor if advice or input was needed and if the situation required, doctors would attend the ward.
- Medical staffing skill mix was in line with the England average and there was 24 hour availability of an anaesthetist. The trust's business plan identified a lack of middle grade cover.
- The workforce strategy had an objective of utilising the Manchester workforce model to aid understanding of the risks to medical staff and planned to look at alternative roles to support the team.
- The staff in the maternity day assessment unit told us at weekends the doctors attended women with obstetric

needs coming into accident and emergency as well as their department and although attending the unit could be more difficult, they were always available on the phone.
- If agency locums were needed, we were told they were initially booked for a week's trial. At the time of inspection there was one locum doctor in post.
- We observed the medical handover during which the consultant joined the meeting half way through. Handover was given on all women including those women booked under midwife led care, it included all women on the unit who may cause concern i.e. women undergoing induction of labour and postnatal woman recently discharged from ICU.

Major incident awareness and training

- Business continuity plans were in place for maternity and gynaecology services which included risks specific to each clinical area. There was an escalation plan in place to manage shortage of midwifery staff and potential closure of the delivery suite.
- Midwives and medical staff attended skills drills training at least twice a year which were scenarios based on maternal or neonatal emergencies.
- The trust had a major incident plan which outlined the roles and responsibilities of staff in each area. There had not been a major incident exercise on the maternity unit and staff in some areas were not clear on their roles and responsibilities.

Are maternity and gynaecology services effective?

Requires improvement

We rated effective as requires improvement. We were not assured that midwifery staff had a competency framework which evidenced their progression to a senior level. Guidelines and action plans were in place, although some required updating and we were not assured changes in practice, for example related to cardiotocography (CTG) interpretation, were embedded.

Patient outcomes were in line with national averages. With the exception of the early pregnancy unit, seven day working was provided. A range of effective pain relief was available for women. The women we spoke to in midwifery and gynaecology said they felt they were in control and pain relief was good. Gynaecology staff on duty highlighted any patients at risk of falls or pressure damage and reviewed their documentation along with their workload for the shift.

Evidence-based care and treatment

- The care and treatment provided was based on guidance from NICE, RCOG and evidence based practice. Guidelines were reviewed as part of the patient safety group then assessed for approval at directorate meetings. Guidelines were accessed on the trust intranet. There were policies and standard operating procedures (SOP) in place for infant and neonatal transfers.
- One of the criteria the Local Supervising Authority (LSA) audit reviewed was the involvement of supervisors of midwives (SOM) in development or sharing of new guidelines. Their audit on the 25th November 2014 found no evidence of this. We looked at guidelines in the early pregnancy unit and found that they were out of date. This was raised with the Head of Midwifery and on our unannounced inspection we were assured that these policies had been updated, along with the female genital mutilation (FGM) guidelines. We were also told the guidelines in the gynaecology department were in the process of being updated by the consultants. Quarterly guideline meetings had been arranged to monitor progress and maintain the currency of guidelines.
- The trust was partially compliant with Babyclear. Babyclear is a co-ordinated approach to address maternal smoking in the north east region and carbon monoxide monitors were in use.
- The small for gestational age NICE guideline had not yet been implemented due to the lack of scanning capacity.
- UNICEF baby friendly initiative is a global accreditation programme developed by UNICEF and the World Health Organisation. It was designed to support breast feeding and promote parent/infant relationships. The maternity unit had full baby friendly initiative accreditation but was waiting reassessment. However, when asked staff were not aware of this status.

Pain relief

- There were several methods of pain relief available to women in labour and information on these were provided during pregnancy

- A birthing pool was available and a hypno-birthing service. Entonox gas and opiates were also available and 24 hour anaesthetic cover provided access to epidural pain relief.
- The women we spoke to said they felt they were in control and pain relief was good. One lady on the antenatal ward said she experienced a lot of pain following an emergency caesarean section but staff were responsive to this and tried lots of different medications to get her pain under control.
- A patient on the gynaecology ward said she was been given regular analgesia for her pain and staff were always available to assess her pain if she felt she needed more pain relief.
- A pain assessment was included within the early warning observation chart.

Nutrition and hydration

- Meals were provided on the in-patient areas by a menu ordering system. Meals were available for different dietary requirements. On Ward 22 meals were served in the dayroom, but could then be taken by women to their own room if that was preferred. Help was offered to those who could not walk to the dayroom.
- Patients who had recently given birth told us they were offered tea and toast and hot and cold drinks were available 24 hours, seven days a week. A range of infant feeding formulae were available for mothers choosing to bottle feed their babies.
- The unit had a breastfeeding initiation rate of between 47.8% and 52.9%; the trust had its own target of 50% however the England average is 81%. Breastfeeding support was provided, and there was a specialist midwife for infant feeding.

Patient outcomes

- The average annual number of births at University Hospital North Tees was 3,200.
- The maternity dashboard was reviewed with data from Hospital Episode Statistics (HES) and in most areas national expectations were achieved. The trust was not an outlier for maternity services.
- Normal vaginal deliveries were promoted and the trust achieved better than the national average.
- Emergency caesarean section rates were between 8.6% and 13% from April 2014 to March 2015 with the national average being 13% (NHS Maternity Statistics 2013/14). Elective caesarean sections for the same time period were between 8.6% and 12%, lower than the nation average of 13.2%.
- The trust had a higher than national average rate for induction of labour, this was audited and criteria put in place for referring women for induction of labour.
- The homebirth rate was very low at 0.6%. The trust had adopted a birthing team approach to try and address this.
- There had been one fourth degree tear in 12 months and the incidence of third degree tears (1.53%) was consistently below the national average (2.9%) throughout 2014-15.
- A trust learning event in March 2015 identified 33% of all women were having carbon monoxide readings done at their 28 week appointment. The regional average of women who smoke whilst pregnant (18.9%) is more than the national average (12%. Following this staff have been re-trained to raise awareness.
- An audit in July 2015 showed that the trust is not meeting the Royal College of Obstetricians and Gynaecologists standard of seeing all women within 14 days who have been referred for a termination of pregnancy (TOP). An action plan had been developed to address this with work expected to be completed by December 2015.
- The department audited the documentation of swab counts to review systems to prevent the retention of a vaginal swab. It found that the documentation of swab counts in 2014 pre (74%) and post (78%) delivery and prior to suturing (91%) demonstrated improvement from 2013. However further work was needed to ensure 100% compliance was achieved.
- Also an audit of vaginal birth after caesarean (VBAC) had taken place in March 2015 which demonstrated higher than expected success rates and recommendations for further improvement.
- The unit is continuing with the former audit schedules of the clinical negligence scheme for trusts (CNST).

Competent staff

- The trust had a preceptorship programme for newly registered midwives, however this followed the trust format for all new registrants and was not specific to midwifery.

- We reviewed some specific competency sheets for the preceptorship programme; however the programme did not include a comprehensive competency skills framework to demonstrate that midwives were assessed to a consistent standard.
- We were told a competency based framework was under development for band five midwives and it was hoped this would be in place by September when newly qualified staff would be starting. The unit did not have a competency skills framework for band six midwives to undertake to ensure that they had necessary skills to undertake the role of co-ordinator, although it was part of the band six midwives job description. This meant managers could not provide evidence that midwives in a band six role or 'acting up' in the absence of a band seven midwife had the required skills and experience for that role.
- The 2014 Local Supervising Authority (LSA) report identified 72% of annual reviews had ben competed and recorded on their database for 2014/2015, with a recommendation for SOMs to ensure all are completed. The staff we spoke with said they had had their annual supervisory review.
- We were not assured that staff were confident in interpreting cardiotocography (CTG). Some midwives were unable to describe the difference between the 2007 guidelines (CG55) and the new 2014 guidance. Some midwives interpreted a CTG appropriately but lacked insight into the clinical detail of the CTG. We were not assured that all midwives understood the cause of the CTG pattern and its relevance to clinical decision making.
- We observed handover and the discussion of a diabetic patient who had been kept nil by mouth overnight for a procedure the following day. We were not assured that staff recognised the importance of effective management of diabetes both on delivery suite and Ward 22.
- At the time of our inspection, information provided by the trust showed between 88% and 100% of staff within maternity and gynaecology had undergone an appraisal in the last 12 months. This was supported by many of the staff we spoke with who confirmed their appraisal had taken place.
- All midwives must have a supervisor of midwives (SOM). This is a statutory role which provides guidance and support for all practicing midwives. The national recommendation is a ratio of 1:15. This ratio was not being achieved at the time of inspection and was a ratio of 1:18, with some staff reporting a ratio of 1:20. There were plans in place to address this and the recommended ratio was expected to be achieved by summer 2015.
- Each midwife we spoke with had a designated SOM. There was availability of a SOM 24 hours a day with additional dedicated days three days a week.
- The trust had specialist midwives for antenatal screening, infant feeding and addictive behaviour.
- Other areas such as diabetes and twin pregnancies are supported by midwives with an interest in this area. There were also specialist nurses in breast care and diabetes available for advice. It was reported that recently there had been several women with FGM. One of the midwives in the unit had a special interest in FGM and had acted as a useful resource for those staff who had limited experience.
- The unit had a preceptorship programme for newly registered midwives, however this followed the trust format for all new registrants and was not specific to midwifery.
- We spoke to a staff nurse and a midwife who had recently completed their preceptorship; both had a positive experience and felt well supported throughout.
- Many of the maternity assistants who had a significant role in breastfeeding support rotated between the hospital and community enabling them to share experience and knowledge.
- On ward 30 we saw evidence of staff reflection, we were told this took place at least three times a week and daily when the acuity of the ward allowed. During this time the staff on duty highlighted any patients at risk of falls or pressure damage and reviewed their documentation along with their workload for the shift.

Multidisciplinary working

- There was good multi-disciplinary (MDT) working evident in clinical areas. Band seven staff reported good communication and information sharing between departments.
- There were close links with community staff on the maternity unit and gynaecology ward with regards to safeguarding concerns or complex cases.
- There were clinics available for women who were pregnant and may require additional help or support, for example mental health and physiotherapy.

- The early pregnancy clinic took referrals via GP's, community midwives or the emergency department for women up to 18 weeks gestation. The service was nurse led but on call medical cover was provided via the gynaecological medical team.
- A consultant clinic took place on a Wednesday afternoon for review of women with early pregnancy problems. The consultant also performed ultrasound scans if needed.
- The staff on the gynaecology ward had access to the critical care outreach team if they were concerned about a patient who was deteriorating.
- Babies had to be taken to the neonatal unit to be given intravenous antibiotics; there was good communication between the units to ensure these were given on time.
- Midwifery support workers felt valued in their role and had held daily group discharge meetings providing a range of information for women on caring for themselves and their babies.
- We observed ward rounds with nursing/midwifery and medical staff with good communication. Most staff said they felt happy escalating concerns to doctors.

Seven-day services

- Medical staff were available on the maternity unit and gynaecology ward 24 hours a day. Out of regular working hours there was always a consultant available on call.
- Access to dedicated obstetric theatres and anaesthetic and theatre staff were available seven days a week. There was also access to critical care facilities at the trust.
- The maternity day assessment unit was open seven days a week; they took referrals from GP's, community midwives as well as self-referrals.
- The early pregnancy clinic could be accessed from Monday to Friday, but not at weekends. Each day the service had seven booked slots for ultrasound. If extra were needed we were told the ultrasound scanning department could usually accommodate. During out of hours women up to 18 weeks gestation would be admitted to ward 30.

Access to information

- Information leaflets were available in ward areas on a variety of subjects such as contraception, perineal tears and post-natal care.
- Bounty representatives provided advice and information on products and services available to parents.
- Women who were pregnant carried their antenatal record with them in a file.
- Information relating to discharge was sent to patients GP's electronically and an electronic referral were sent to district nurses if ongoing treatment was required.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- The women we spoke to all felt involved in their care and that they had been provided with sufficient information to make informed choices.
- A review of nine sets of patient records revealed that verbal consent was obtained from the woman for episiotomies and repair of the perineum whilst formal consent was sought for procedures such as caesarean section and instrumental birth. This was supported by the Local Supervising Authority Report which stated for all the case notes they reviewed, verbal consent for procedures had been obtained and documented.
- Midwives and nursing staff were able to articulate how they would ensure consent and decision making met the requirements of legislation such as Mental Capacity Act 2005 and the Children's Act. There was an overview chart to refer to.
- Staff on Ward 30 spoke about a recent deprivation of liberty safeguard which had been applied and the use of Gillick competency for consent of patients under the age of 16.
- Termination of pregnancy must be performed within the legal requirements of the 1967 Abortion Act. A requirement of this is the completion of the relevant certificates and consent forms. An audit of 50 forms completed by the trust in July 2015 found that the necessary signatures were present in all cases, however there were omissions in fully completing the forms. This included the names and qualifications of the persons completing the form. One improvement action was to send letters to GPs who used the service to remind them to fully complete the forms.

Are maternity and gynaecology services caring?

Maternity and gynaecology

Good

We rated caring as good. We were given positive feedback from patients who felt involved in their care and treatment. Friends and family test data for maternity services from June 2015 (NHS England) showed a low number of responses; however these were positive with 92-97% recommending services at the trust Staff were compassionate and caring and there were counselling and bereavement services available when required. There was an issue with the privacy and dignity on the delivery suite, but this had been addressed when we returned on an unannounced inspection.

Compassionate care

- Friends and family test data for maternity services from June 2015 (NHS England) showed a low number of responses; however these were positive with 92-97% recommending services at the trust.
- Friends and family test data for gynaecology showed a higher response rate (74.9%) with 98% of these respondents recommending the service.
- We spoke with 19 women; with the exception of two all had a positive experience. All had a named midwife and staff were available if they needed them, they said staff used the adjunct 'hello my name is'. Women reported regular checks were made on them during the night.
- We observed staff interacting with women and they were polite and friendly.
- There were some concerns about partners visiting times and the lack of provision for partners to stay on ward 22.
- We observed a woman arrive on the delivery suite in labour very distressed, who had to walk past patient rooms with doors open and women in labour. She did not see a member of staff until she reached the reception desk. We noted leaving doors open was the case for all women in labour. We expressed concerns regarding the privacy and dignity for these women. We found on our return inspection this practice was no longer taking place and all the doors to delivery rooms were closed.
- Ward 22 was visited by Bounty representatives on a daily basis; Bounty provides pregnancy and parenting information on a commercial basis. We were assured that the representative always liaises with staff on a daily basis regarding women who may be more vulnerable.
- In the maternity day assessment unit staff reported it could be difficult if sensitive issues had to be discussed as there were only curtain partitions between assessment areas. This was on the risk register with an action of using the counselling room which was what staff said they would do.
- Single rooms were provided for medical management of pregnancy or miscarriage.
- Comments from patients on ward 30 described staff as 'brilliant' and said although the ward was busy staff always came straight away if you needed them.

Understanding and involvement of patients and those close to them

- The women we spoke to all felt involved in their care and had been provided with information to allow them to make informed decisions.
- The in-patient areas we visited had information boards with photographs identifying the person in change.
- A patient on the gynaecology ward told us her partner was allowed to visit outside of visiting times as she had been to theatre.
- Women were involved in decisions about their preferred place of delivery and options during labour, and care plans were developed with their community midwives.

Emotional support

- There was a midwife who had a specialist interest in bereavement and there were policies and guidelines in place to support mothers and their family in the event of a stillbirth or neonatal death. There were rooms for mothers and their partners to stay separate to the delivery suite if they had experienced bereavement. The chaplaincy service could also provide support in these situations.
- Counselling services were available on site for women attending the pregnancy advisory clinics. There was a midwife who had a specialist interest in bereavement and there were policies and guidelines in place to support mothers and their family in the event of a stillbirth or neonatal death. There was access to two British Association for Counselling and Psychotherapy (BACP) accredited counsellors, who had a focus on pregnancy loss, termination and bereavement.

- Midwives and the chaplaincy service could also provide support in these situations.
- There were rooms for mothers and their partners to stay separate to the delivery suite if they had experienced bereavement.
- Families were particularly encouraged to be involved in the care of patients with learning disabilities and teenage pregnancies as appropriate.

Are maternity and gynaecology services responsive?

Good

We rated responsive as good. Patient pathways and flow through departments was appropriate.

The trust served a community with a wide range of nationalities and there were good systems in place to ensure effective communication. The trust identified the demands on services and business planning was aligned to this. Complaints were discussed and recommendations given but not all staff could articulate learning from complaints

Service planning and delivery to meet the needs of local people

- Women had the option to delivery at home, in the midwifery led unit at Hartlepool or at University Hospital of North Tees.
- The introduction of hypnobirthing to increase active birthing had been positively received.
- Maternity and gynaecology services worked with local commissioners of services, the local authority, other providers, GP and patient groups to co-ordinate care pathways. The maternity services liaison committee had an active role in maternity services.
- In 2014 the pregnancy advisory service and early pregnancy assessment clinic was moved to the women's and children's directorate. This was seen as a positive change and would support the development of care pathways.

Access and flow

- From 2013 to the time of our inspection the maternity unit had not closed. Bed occupancy for the previous 12 months was between 43% and 50% this was lower than the England average of 59%; however there was an escalation guideline to support staff during peaks in activity.
- The trust did not collect data on the percentage of women seen by a midwife within 30 minutes and a consultant within 60 minutes during labour, however none of the women we spoke with described any time when they were left unattended. The schedule for antenatal appointments was in line with NICE Clinical Guideline 62.
- Women could be referred by their GP, midwife or self-refer for a variety of problems such as reduced foetal movements or abdominal pain in pregnancy.
- We observed good flow through the departments if women needed transfer from one area to another, and staff told us during times of increased activity services could be flexible to ensure continuity of provision. For example in the maternity day assessment unit if capacity became an issue, women could be seen in the delivery suite.
- The maternity day assessment unit was open seven days a week, staff we spoke with would like to offer a 24 hour service. The early pregnancy unit and pregnancy advice clinic provided a service from Monday to Friday. These areas were identified as an area of focus in the trusts business plan for 2015/2016.
- The 18 week referral to treatment time was being achieved for gynaecology patients. The dashboard highlighted underutilisation of gynaecology theatre time. Between 3% and 10% of operations were cancelled on the day.
- Beds for emergency gynaecology admissions were not 'ring-fenced' they were admitted to ward 30 which took female patients from other surgical specialities.
- The staff we spoke with told us they tried to keep one bed available for emergency admissions but this was not always possible. We were told a bed would always be made available but this could mean moving a surgical patient to another ward to accommodate. This information is not captured and staff said they would not complete a Datix for this situation.
- The dashboard indicated length of stay following elective and emergency gynaecological procedures was not an issue. However, during September – October 2014 an audit was conducted as the readmission rates

for elective and emergency gynaecological surgery were greater than the standards set by the trust. An action plan was produced to try and reduce the number of readmissions.
- The business plan outlined the development of an ambulatory area for emergency gynaecology services to improve the pathway for patients.

Meeting people's individual needs

- Women carried their own paper records with them and had contact numbers for their midwives, this included outside of normal working hours. Parent education classes were available in the community setting and information relating to labour and birth was provided at antenatal appointments.
- In all areas we visited we were told how staff could access translation services via everyday language solutions. This could be over the telephone or face to face if it was a planned appointment. Written information could be provided in different languages on request. During our visit we witnessed the delivery of a poster with a variety of languages to assist staff in determining the language requirements of women who did not speak English.
- The maternity services provided care for women in vulnerable situations; we were given examples of how midwives would create a situation where they could speak to women alone if they had concerns about domestic violence. There were specialist midwives in substance misuse and safeguarding.
- Bariatric equipment was available if required and wheelchair accessible rooms were available on the delivery suite.
- Women who underwent planned termination of pregnancy (TOP) and those who had miscarried were cared for in dedicated areas. We were told they were always provided with a single room and nurses with gynaecology experience would be responsible for their care.
- 100% of staff on ward 30 had received training in dementia care.
- We spoke with women and observed practice and found care was patient centred. Individual needs were met and women felt listened to and actively participated in care decisions. MDT working was evident and discharge meetings took place for complex situations.
- There were also were two rooms which were used for bereaved mothers. They could be accessed from a separate entrance meaning families did not have to walk through delivery suite to get to them.
- The rooms on the delivery suite were large and all had en-suite facilities, there was a birthing pool available.
- Private rooms were available in the early pregnancy unit and although space was limited in the day assessment unit, staff had access to a counselling room and said they found ways to get mums on their own if they had safeguarding concerns.

Learning from complaints and concerns

- There was a complaints policy and procedure which staff were aware of. Daily rounding was seen to be used in some areas. This was a form asking women about aspects of their care and staff said this was often a way of identifying any concerns.
- The number of complaints were displayed on ward information boards.
- Complaints were discussed at patient safety meetings, we reviewed several minutes of these meetings which evidenced discussions and lessons learnt. Actions from these were shared with staff via various means such as newsletters or discussion at ward meetings. From January 2015 to March 2015 there were eight complaints; themes of these were on management of clinical situations.
- Not all staff were aware of any recent complaints or could give examples of learning from them.

Are maternity and gynaecology services well-led?

Requires improvement

We rated well-led as requires improvement.

Concerns included the management of midwifery staffing numbers and skills mix, the lack of performance benchmarking; the risk register not being used effectively and the midwifery management structure resulted in individuals having a wide range of responsibility which

limited maternity leadership capacity. Additionally we were not provided with evidence that midwives 'acting up' in the band seven co-ordinator role had the required skills and experience to carry out this role.

We spoke with staff and in some areas staff were very engaged and felt involved in service development; this was not evident throughout the service. There were areas of good local leadership but this was not evident throughout all services. All areas we visited were patient focussed; this was evident from speaking with staff and patients.

Vision and strategy for this service

- There was a vision and strategy for maternity and gynaecology services but staff in some areas could not articulate this. Other areas had a very clear direction for their department and all staff were aware of this.
- Some areas had their own vision or 'mission statement' displayed on the wall and the clinical services strategy model was visible in clinical areas.
- All areas we visited were patient focussed; this was evident from speaking with staff and patients.

Governance, risk management and quality measurement

- We reviewed the maternity service dashboard; it did not have a rating system to indicate if there was an area of concern. There was a lack of trust targets with no indication if figures provided were within agreed acceptable limits**.**
- The gynaecology risk register used a traffic light system or red, amber, green to highlight levels of concern.
- The obstetric risk register identified 45 risks; several of these had not been addressed for over 12 months. Risk management meeting minutes from January 2015 identified 52 outstanding actions.
- Staff in clinical areas had little knowledge of the risk register and it was felt risks were of a generic nature rather than being pertinent to specific areas. On our return inspection we were told of plans to review the risk register, although no specific information was provided.
- The risk management strategy had recently been updated. The LSA explained the risk management strategy should "clearly identify the role of the LSA and of Supervisor of Midwives being integral to trust governance. Additionally the Risk Management Strategy must describe the reporting arrangements for Supervisors of Midwives following investigations, audits or reviews". This was not evident from reviewing the strategy.
- Patient safety meetings took place twice weekly and risk management meetings occurred monthly. SOMs were sometimes present at these meetings.
- Staff were aware of how to complete incident report forms and were encouraged to do so, not all staff could describe feedback or an outcome from completing one.
- We were told a gap analysis and action plan had been completed following the Kirkup recommendations however this had not yet been implemented and was awaiting ratification by the Trust Board.

Leadership of service

- The service was led by a clinical director, head of midwifery and children's services, a general manager and a divisional finance manager. We had concerns about the midwifery management structure which meant that some individuals had a wide range of responsibilities which limited capacity for maternity leadership. Additionally we were not provided with evidence that midwives 'acting up' in the band seven co-ordinator role had the required skills and experience to carry out this role.
- The next level was band seven clinical leads and the patient safety lead. Some individuals had a large remit and their roles were challenging.
- Staff told us they felt supported by their line managers but more senior management were not always as visible in clinical areas. The structure meant some individual staff carried a lot of responsibility over a range of different areas, this combined with the flat structure limited maternity leadership.
- The use of band six midwives acting in the band seven co-ordinator role without a competency framework to evidence their ability to provide this role was a concern. Discussions with staff highlighted inconsistencies in the approach to preparing staff for this role.
- Discussions with the senior management team demonstrated a team which was patient focused and committed to improving services.
- Leadership within clinical areas was varied. Some demonstrated clear direction involving the whole team, with an awareness of risk, learning and action plans. However this was not evident in all areas.

Maternity and gynaecology

Culture within the service

- We observed good teamwork between disciplines and staff were happy and enjoyed working at the trust. We were told managers worked clinically and staff felt this meant they understood the pressure of the role.
- Staff spoke in a very positive way about department managers.
- Midwifery staff rotated and staff were happy with this arrangement, we were told it improved relations with colleagues from Hartlepool.
- Staff felt they were encouraged to be open and honest with patients and examples of such situations were provided.
- The reflection hour on Ward 30 gave staff the opportunity to look at their practice and the practice of others, and allowed for learning in a positive environment.
- We observed good care with the focus on the needs of the patient.

Public engagement

- It was identified that getting mothers from the local area involved with service planning had been a challenge, and work with this was ongoing.
- The trust had a Maternity Services Liaison Committee which had good representation at board level and was committed to bringing together service users and providers.
- Friends and family test was used in ward areas. We saw an example of how information provided from patient feedback had been publically displayed to show what changes had been made to improve patient experience.

Staff engagement

- There was no directorate specific information in the 2014 NHS staff survey results for staff engagement. The national survey showed on a scale of 1-5, with 5 being highly engaged and 1 being poorly engaged, the trust scored 3.63. This score placed the trust in the lowest (worst) 20% when compared with similar trusts.
- We spoke with staff and in some areas staff were very engaged and felt involved in service development; this was not evident throughout the service.

Innovation, improvement and sustainability

- Staff in the maternity day assessment unit attended training on Gestation Related Optimal Weight (GROW) software which aims to reduce the number of stillbirths by using customised growth charts.
- 'NIPE Smart' had recently been implemented within the maternity directorate. This is an information technology screening management system which has a robust system of capturing data on new-born and infant screening examinations with the aim of reducing the number of babies diagnosed with a medical congenital condition at a late stage.

Services for children and young people

Safe	Good
Effective	Good
Caring	Good
Responsive	Good
Well-led	Requires improvement
Overall	Good

Information about the service

The women and children's services directorate at the North Tees and Hartlepool NHS Foundation Trust was responsible for providing neonatal and paediatric service services for children and young people. Inpatient services for children were provided at the North Tees site on ward 15, which had a mixture of single, two and four bedded rooms. The North Tees site also had a neonatal unit on ward 23, a day care unit adjacent to ward 15 and a children's outpatient department.

There were 4275 children's admissions between July 2013 and June 2014. Of these 94% of which were emergencies, 5% were day cases and 1% were elective. There were 6612 outpatient attendances between April 2014 and March 2015.

During our inspection we visited all of the clinical areas where children and young people were admitted or which they attended on an outpatient basis. This included the children's ward, day care unit, children's outpatients department, theatres, neonatal unit, emergency department and the adult critical care unit.

We talked with seven medical staff, 12 nursing staff, including five matrons, two healthcare assistants, a play specialist and a ward clerk. We also met with three members of the management team. We reviewed 13 sets of medical/nursing records and spoke with 14 parents, family members and children/young people. We also attended two medical handovers and two nursing handovers.

Summary of findings

Overall, we rated safe, effective, caring and responsive as good and well led as requires improvement.

Staff knew how to report incidents and these were followed up appropriately. Lessons learned were shared and preventive measures put in place. Staff of all grades confirmed they received appropriate mandatory training to enable them to carry out their roles effectively and safely; training included awareness of safeguarding procedures. There were sufficient well-trained and competent nursing and medical staff to ensure children and young people were treated safely. There were some gaps in the medical staffing establishment; however, several new doctors were due to start in post. Children and young people did not always have access to appropriate pain relief as and when required, there was no evidence of the use of pain assessment tools in the care records reviewed.

Children, young people, and their families told us they received supportive care. They said the staff were kind and provided them with compassionate care and emotional support. They also felt well informed and involved. Staff and families both told us they would recommend the service to their families and friends and feedback from surveys carried out by the children's service was all positive.

The children's service was responsive to the individual needs of the children and young people who used it and there were effective systems and processes in place for

Services for children and young people

dealing with complaints from people using the service. The management team were committed to the vision and strategy for the children's service and feedback from staff about the culture within the service, teamwork, staff support and morale was positive. However, systems and processes for risk management within the service were not effective and timely. The need to improve risk register management was known by the trust board and a plan was in place but not yet implemented. The risk register was not regularly reviewed at the patient safety and risk management meetings and risks were not actively managed by using the risk register. There was no resuscitation trolley in the children's outpatient department. Staff were able to describe the procedure they would follow but the trust response to mitigate this risk was not clearly documented in the risk assessment or on the risk register and both documents required updating.

Are services for children and young people safe?

Good

Overall, we rated safe as good.

Staff knew how to report incidents and these were followed up appropriately. Lessons learned were shared and preventive measures put in place. Staff of all grades confirmed they received appropriate mandatory training to enable them to carry out their roles effectively and safely; training included awareness of safeguarding procedures. Clinical areas were visibly clean and there were effective systems and processes in place to reduce the risk and spread of infection. The environment and equipment used by the service was fit for purpose and well maintained. However, in the children's outpatient department, we found patients and families could be overheard when speaking with reception staff. There was no resuscitation trolley in the children's outpatient department and the related risk assessment required updating. Medicines were administered correctly and medical records were stored securely and handled appropriately. However, temperature monitoring for medication stored at room temperature did not follow manufacturers or best practice guidance.

There were sufficient well-trained and competent nursing and medical staff to ensure children and young people were treated safely. There were some gaps in the medical staffing establishment and medical locum staff were covering gaps in the rotas. However, there were plans in place to address this issue. Medical staff had been recruited and advanced neonatal nurse practitioners, were being used to ensure safe care was provided to children and young people.

Incidents

- There had been no never events recorded in the service and we were told about one serious incident (SI) which was a confidential information breach. Information submitted by the trust showed there had also been a SI related to a delay in the diagnosis of meningitis reported in the previous four months. We saw in the minutes of the paediatric morbidity and mortality meeting that this SI had been discussed and actions for improvement had been discussed and shared.

- Incidents within the service were reported on the trust's electronic system (Datix) and all staff we spoke to were familiar with the process for reporting incidents. One of the medical staff interviewed told us incident reporting within the service was "Robust and good for patients."
- The bimonthly risk management meeting included feedback about incidents, and was attended by the medical staff and senior nursing staff. When we reviewed minutes of these meetings, we saw they included the review of incidents and discussions around practice, lessons learnt and action plans to improve clinical practice.
- The common themes identified from incidents in the 18 months to June 2015 were medication errors, patient's healthcare records (records, documents, test results, scans) and electronic document management. An action plan had been developed to identify different strategies to reduce the number of medication errors. One of the medical staff told us the number of incidents relating to gentamicin prescribing and administration errors on the neonatal unit was declining. We saw extra checks had been put in place to reduce the risk of these types of errors. For example, there was a revised gentamicin chart in use, which included additional information to minimize the risk of errors. This showed actions were taken and lessons learnt when incidents occurred.
- Staff were able to explain the requirements of the duty of candour to us. We observed information on display in neonatal unit staff room about the requirements for a duty of candour.

Cleanliness, infection control and hygiene

- There were effective systems in place to reduce the risk and spread of infection. There had been no cases of MRSA or C.difficile in the children's service.
- All of the areas we visited were visibly clean, including the communal areas, toilets and bathrooms. There was an isolation policy was in place and, while on the CW, we observed the associated processes were being followed.
- We saw personal protective equipment (PPE) was readily available for staff to use and we observed staff using the PPE appropriately. However, there were not enough hand gel dispensers available and there were no sharps bins for use at the bedside. This meant there was a risk of IPC procedures not being followed correctly.
- The infection prevention and control (IPC) team carried out hand hygiene audits on the wards. If the scores were less than 100% then the IPC team did audits weekly. Hand hygiene results were on display and showed scored of 99-100%.
- Play specialists cleaned all the toys weekly and the housekeepers cleaned ward equipment as part of their duties.
- We did observe three issues relating to IPC which we felt could be improved:-
- Blood samples were observed being stored inappropriately in the medications fridge on the neonatal unit. Staff removed these immediately they were informed.
- Tape measures used to measure babies head circumference on neonatal unit were not disposable and there was no evidence that they were cleaned in between use; this practice was an infection risk. Staff on the neonatal unit told us disposable tape measures were available.
- Post-transfusion blood bags being stored in an open receptacle on a surface in the housekeeping room on the neonatal unit. When we asked about these, we were told these were kept for 48 hours before disposal. This practice was an infection risk.

Environment and equipment

- We visited all of the areas where children and young people were cared for in the trust; this included the two children's wards, the neonatal unit, the adult critical care unit (CCU) and the children's outpatient department.
- All of the areas we visited were suitably designed, spacious and well maintained with child friendly décor, providing excellent facilities for children, young people and their parents. Staff facilities were also good.
- We received positive feedback from children, young people and parents about the environment and facilities available, apart from the lack of access to the new garden area on the children's ward. Staff told us they were hoping to get easier access to this area from the children's ward in the near future.
- Equipment was all portable appliance test) tested and up to date. The matron on the children's ward told us there were, "no problems" getting equipment fixed. They said the service was fortunate, as it had access it had to charitable funds, which could be used to buy equipment.

- Staff told us there was a shortage of thermometers and blood pressure monitors on the children's ward. When we asked about this, we were informed blood pressure monitors were on order.
- There was a microscope in the sluice on the children's ward for urgent urine microscopy; we saw quality assurance and staff training records were available.
- Staff told us the inpatient ward temperature was 'variable' especially when the weather was hot. We were told fans were available and the catering department would bring ice creams and ice-lollies when the ward temperature was too hot.
- When we visited the theatres, we found there was no segregation of children from adults in the recovery areas. We spoke with the theatre matron who showed us there were 'child-friendly' screens they could use to screen children from other patients. They told us there were specific paediatric airways trolleys available in the theatres.
- We noted there were filing cabinets and tables on a corridor leading from the children's ward to a fire exit. We pointed this out to the matron on the ward on the second day of the inspection. When we returned on the third day, all of the obstructions had been cleared from this fire exit route.
- When we visited the children's outpatient department, we observed a crowded waiting room next to the reception desk. We observed and heard that patients were not afforded privacy when speaking with the reception staff. There were seven clinic rooms and one did not have hand-washing facilities. However, we were informed this room was not used for examinations.
- The environment provided on the adult CCU was suitable for the provision of critical care and treatment of the sick child or young person and care was provided in single rooms. There was paediatric resuscitation equipment available on the adult CCU.
- The children's ward resuscitation trolleys (one for paediatrics and one for adults) were checked daily. However, we found an oxygen cylinder on one of the resuscitation trolleys had expired. This was replaced immediately when it was pointed out to the ward matron.
- There was no resuscitation trolley in children's outpatient department. Staff described the procedure in the event of resuscitation to us, which was to take the child or young person through to the paediatric resuscitation room in the emergency department. We walked through the pathway a patient would take from the children's outpatient department to this room and found there were two sets of double doors to go through and a locked door.

Medicines

- Appropriate arrangements were in place in relation to obtaining, recording and handling of medicines. Medicines were prescribed and given to children and young people appropriately. Procedures were observed to be safe and medication documentation was good. However, temperature monitoring of medication stored at room temperature on the inpatient wards required improvement.
- We reviewed five paper based treatment records on the children's ward and six on the neonatal unit, and observed administration of medications; this included the administration of intravenous antibiotics. We saw appropriate checks were carried out prior to giving medications.
- The children's ward had an Omnicell system, this was linked the hospital's patient administration system (PAS). This system ensured no expired medications could be administered to patients. The pharmacy department staff ensured the stock levels were maintained. Medications dispensed using the Omnicell were double-checked. For administration of controlled drugs two staff fingerprints were needed before drugs were dispensed. Staff told us medications errors had reduced since the Omnicell had been in use (about a year).
- On the children's ward and neonatal unit the medicines fridges were locked and temperatures recorded. However, temperatures in the rooms where medicines were stored were not being recorded. We observed these rooms contained medications for storage at room temperature (5 – 25oC). The children's ward medications room felt very warm; however, we did not record the temperature during the visit, as there was no thermometer in place. Thermometers were in place in the neonatal unit medications room, but we saw room temperatures were not regularly recorded.
- Medicines should be stored appropriately to ensure that their quality is maintained (Safe and secure handling of medicines in hospital wards, theatres and departments, April 2008). Extreme temperatures (hot and cold) or excessive moisture causes deterioration of medicines; this may reduce the effectiveness of the medications

given to patients. The lack of temperature monitoring for medication stored at room temperature meant the service was not following manufacturer's guidance or best practice guidance on the storage of medications
- On the first day of the inspection, we noted that the neonatal unit medicines room was not locked. This meant the medicines stored in the room were not secure. We raised this immediately with staff on the neonatal unit. Later in the inspection, we found that a digital lock had been installed on this room. Staff on the neonatal unit told us the pharmacists visited the ward regularly.
- The matron on the children's ward and three nurse practitioners (NPs) had undertaken a non-medical prescribing course in September 2014.

Records

- Children's and young people's medical records were accurate, fit for purpose and stored securely. We did not see any unattended notes during our inspection.
- We reviewed eight care records on the children's ward and five on the neonatal unit. We found these were all appropriately completed with risk assessments and observations well documented. Multidisciplinary notes were also well documented.
- We found policies and guidelines used by the children's service were all in date. The medical staff wrote the guidelines in use by the service and staff signed to say they had read the new guidelines when they were changed.
- The WHO surgical safety checklist was used for all patients undergoing surgery. The team inspecting surgery confirmed that these had been completed correctly.

Safeguarding

- Safeguarding for adults and children was a high priority within children's services and was well embedded. We found there were on-going safeguarding training, supervision and awareness sessions for all staff. All staff had undertaken level 3 safeguarding training.
- Staff told us the safeguarding team had carried out group supervision with the team following a traumatic incident.
- There were good working relationships with the safeguarding lead nurse and doctor. Staff working in the service knew how to make a safeguarding referral and said they felt confident to escalate concerns. We saw contact numbers and photographs of the safeguarding team on display in the inpatient wards and emergency department.
- We saw information on display about safeguarding children in the inpatients ward areas visited.

Mandatory training

- Staff we spoke with all told us their mandatory training was up to date; senior nursing staff we spoke with and records we reviewed confirmed this. The matrons received a RAG (red-amber-green) report of their staff's mandatory training from the trust once a month.
- External agencies, such as the child and adolescent mental health services, came in to train staff working for the service as part of their mandatory training day. There was a part-time clinical educator, who worked 18 hours a week, whose role included training staff.
- Staff told us mandatory training may be increased to two days instead of one; this would allow training in continuous positive airways pressure and use of a defibrillator to be included in staff mandatory training.

Assessing and responding to patient risk

- Systems and processes were in place for the management of critically ill or deteriorating paediatric patients. Children and young people who required high dependency care and/or transfer to another hospital were transferred to the adult critical care unit. There were no high dependency facilities on the children's ward. Staff told us the service did look after children and young people on the children's ward until the retrieval team came for them. Children and young people who required high dependency care and/or transfer to another hospital were transferred to the adult CCU.
- We visited the adult CCU and found there were procedures in place, which were followed, for the resuscitation of children and young people. The adult CCU followed the same standards as paediatric intensive care units.
- The role of the adult CCU was to stabilise the patient and prepare them for transfer by the retrieval team. Staff told us if a patient needed resuscitation, a medical consultant would decide where to move the patient to, so that patient safety could be maintained. This might

include theatres, the intensive treatment unit (ITU) or the emergency department. This showed robust systems and processes were in place for the management of critically ill or deteriorating patients.

- We observed nursing staff preparing and dispensing medication in the medicines room on the children's ward. We observed the door was kept closed and a sign was put up asking other staff not to disturb the nurses unless it was an emergency. This showed the service had plans in place to minimise the risk of medication errors occurring.
- We observed a patient who had been identified as having a medication allergy; we saw they wore an additional wristband. This meant patients with medication allergies could be easily identified visually by staff.
- Senior nursing staff told us patient care records included the paediatric early warning score (PEWS), the Screening Tool for the Assessment of Malnutrition in Paediatrics (STAMP) tool (dietary) and skin care bundles if these were required. They said all of the patient care plans were individualised and then there would be appropriate charts and records in place. For example if the patient had a cannula. They said patients would be referred to dieticians if required. This information was confirmed when we reviewed eight care records on the children's wards.
- We observed expressed breast milk on the neonatal unit labelled with the mother's name, baby's name, date and time. We saw the labels also included an 'out of freezer' date for milk, which had been frozen and transferred to the fridge.
- Staff told us there were two patient safety champions who attended meetings and met with the patient safety co-ordinator.
- We did observe two issues relating to risk which we felt could be improved:-
- We attended nursing staff handover meeting on the children's ward; discussions about patients on the ward took place in the open ward areas and could have been overheard. However, we did observe issues such as safeguarding were discussed in private in a ward office.
- The doors between the day care unit and children's ward were not locked and there was no CCTV. This meant there was a risk a child or young person could leave one area without being noticed.

Nursing staffing

- There were sufficient numbers of qualified, skilled and experienced staff to meet the needs of the children and young people using the service. The recommended minimum staffing levels for children's wards were being met, as advised by the Royal College of Nursing staffing guidance – Defining staffing levels for children and young people's services (2013).
- Band six nursing staff were site based and all other staff groups worked cross-site.
- The neonatal unit had 22 cots in total, we were told 4.5 of these were for intensive care and five were for high dependency. The neonatal unit also had two transitional care beds and two single rooms, which were used as isolation rooms. The neonatal unit was level 3 and took babies from other hospitals.
- Staff on the neonatal unit worked 12-hour shifts. The neonatal unit had introduced advanced neonatal nurse practitioner ANNPs. There were five qualified ANNPs on the neonatal unit (three WTE). Neonatal unit staffing was six or seven nurses in the day and six nurses at night, including the team leader. There was a neonatal unit dashboard on display showing planned and actual staffing levels.
- There were adequate numbers of neonatal trained staff available as per the British Association of Perinatal Medicine (BAPM) staffing standards (August 2010).
- The children's ward had 24 beds in summer and 30 in winter; from 10 August 2015, we were told this would be 20 beds in summer and 24 in winter. On the second day of the visit, there were 21 inpatients on the children's ward.
- The children's ward was staffed by five RNs and two HCA day and night, and one or two play specialists during the day. RNs and HCAs worked 13-hour shifts from 8am to 9pm.
- The day care unit had 10 beds and was staffed with two RNs and (usually) a nurse practitioner (NP). We were informed that from 10 August 2015 there would always be two RNs and a NP. We were also told that the length of the shifts would be reduced from August and that staff were on flexible working arrangements.
- Staff numbers were adjusted according to the number of beds open on the ward. For example, we were told there might be four RNs and two HCAs in summer and five RNs and two HCAs in winter.
- Each shift had a co-ordinator, who would be a band five or six RN with paediatric intermediate life support (PILS) or advanced paediatric life support (APLS).

- Paediatrics also had up to 10 student nurses at one time; they spent 8 – 10 weeks at a time working in the service on placement. None of the staff we spoke with raised any concerns about this number of students affecting the service provided.
- Two play specialists worked in paediatrics seven days a week, one on the children's ward and one on the day care unit. They told us they were very busy and often called on by other departments within the hospital to help distract children, such as in theatres, ED and children's outpatient department. This meant they were not always able to meet the individual needs of all the children and young people using the service.
- The trust's e-rostering system (MAPIS) was used to produce staff rotas. Senior nursing staff said these rotas were not produced in a timely manner due to staff shortages in the e-rostering team. They said staff should know their shifts six weeks in advance but this did not always happen. Staff we spoke with said sometimes the rotas came out three weeks in advance, they said there was a lot of shift swapping.
- Following workforce planning and the consultation process, two RN and one HCA posts had been advertised for the paediatric service
- We were told six staff from the children's wards were on maternity leave at the time of the inspection. This meant the service was using staff from NHS Professionals (NHSP). The matron on the children's ward told us these staff were usually trust staff from the children's service doing extra shifts. The trust did not use staff from any other agencies. We checked the staff rotas for the children's ward and day care unit for the three weeks prior to the inspection and saw three shifts covered by staff from NHSP in the previous week and one shift in each of the previous two weeks (commencing 22 June 2015 and 15 June 2015).
- We observed two nurse handovers on the children's ward and found them to be well structured, professional and informative. All of the staff on the team coming on duty were involved, including the play specialists and HCAs
- Staff were regularly moved between areas within the service to meet demands. For example, staff from the children's ward told us they would help on the neonatal unit, children's outpatient department or in the ED. The theatre matron told us children's nurses would come up from the ward if necessary, for example if a child or young person was intubated. Staff in the children's outpatient department also told us they were often called to help on the inpatient wards and vice versa. One said, "It works both ways." Staff told us there was not always a RN on duty in the children's outpatient department; however, they said there would always be a consultant.

Medical staffing

- There were sufficient numbers of qualified, skilled and experienced medical staff to meet the needs of the children and young people using the service. Gaps in the medical staffing establishment had been recruited to and several new medical staff were due to start in post during August and September 2015.
- The neonatal service employed a professor in neonatology, four consultant neonatologists and seven middle grades; one post of the seven was vacant. However, poor staffing numbers at foundation year (FY) 2 level on the neonatal unit increased the workload for the SpRs. Medical staff on the neonatal unit told us there were eight senior house officers (SHO) in post, although there was provision for 12. They said the frequent gaps in the SHO rota meant SpRs were stretched and, at busy times, this could lead to delays in the treatment of patients/
- At the management meeting, the clinical director told us the service was planning to advertise for a neonatal clinical fellow.
- In paediatrics, there were five resident paediatric consultants, 13 FY2 and 1.2 WTE ANNPs. On call was 1 in 7. There were two consultants on the day care unit and ward 15 during the day. Out of hours, a senior consultant was available until 10pm Monday to Friday and a SpR worked from 9am to 9pm.
- We were told that the number of consultants on the middle grade rota was increasing. For example, GP trainees had increased from three to five and the number of foundation year junior doctors had increased. Three FY2 doctors were in post at the time of the inspection and this was due to increase to four from August 2015.
- We were told there would be 13.8 staff on the first on call rota from August 2015, two of which were FY1 junior doctors. Two clinical fellows also participated in the rotas. The service was proactive with its recruitment of medical staff; however, the middle grades were more

difficult to recruit. The service was developing advanced neonatal nurse practitioners to cover the gaps in the middle grade rota. This showed the service was proactive in dealing with identified staffing issues.

- There were two separate rotas, one for neonatal and one for paediatrics. The management team told us they needed six on each rota and currently had 5 and 5.6. The service was planning to employ a locum for six months. Senior consultants only worked as middle grades when on call.
- Medical staff told us the first on call rota could be stressful and onerous. For example, one doctor told us they had recently had three weeks of continuous on call. The management team told us there had been appointments of two trust doctors who were due to start in September 2015.
- There were nine intensive care consultants on the paediatric anaesthetic rota.
- The management team told us there was a Royal College of Paediatrics and Child Health review report pending and that the feedback had been positive. This report recommended nine people on the medical rota. This document was not available for us to review during the inspection.
- We attended a morning medical handover on the neonatal unit. Doctors and nurses attended but there was no consultant present. The handover was well structured; patient's care and treatment needs were identified and discussed and management plans or plans for the transfer of care were well mapped. We observed there was no identified lead person, although the registrar who had been on the night shift did try to lead the meeting.
- We attended a medical handover on the children's ward. This was consultant led, with two consultants, eight medical doctors and the ward sister in attendance. The handover was observed to be informative and professional.

Major incident awareness and training

- Staff knew how to deal with major incidents.
- There was no formal training in major incidents; however, there was a MAJAX plan and a list of the contact details of all staff. We saw there was a MAJAX folder available, this contained an up to date staff list with contact numbers.
- Staff told us there had been scenario training three months prior to the visit which had involved a bus crash with children. Staff had simulation training once a month where a member of staff was nominated to use the crash (resuscitation) trolley in a scenario on the ward. This was followed by a feedback session. The matron on the ward said that all of the staff on the ward had undertaken this training at least once.

Are services for children and young people effective?

Good

Overall, we rated effective as good.

The children's service had systems and processes in place to review and implement NICE guidance and other evidenced-based best practice guidance. We observed evidence based care practices, for example the Screening Tool for the Assessment of Malnutrition in Paediatrics was being used. The children's service participated in national audits relating to patient outcomes and no problems were identified. Staff, teams and services worked together well to deliver effective care and treatment for children and young people using the service. All staff undertook paediatric intermediate life support training annually

Staff were competent to carry out their roles and received appropriate professional development, including an annual appraisal. There was good evidence of multidisciplinary working within and between teams and children and families using the service were provided with appropriate information. Consent procedures were in place and followed.

We found children and young people did not always have access to appropriate pain relief as and when required. There was no evidence of pain assessment tools in the care records reviewed and feedback from patients confirmed they had not always received pain relief when they needed it.

Evidence-based care and treatment

- The children's service had systems and processes in place to review and implement NICE guidance and other evidenced-based best practice guidance
- Staff told us guidelines for use in the service were available to staff in hardcopy and on the intranet. We looked at these guidelines and found they were current,

in line with current recommendations of the Royal College of Paediatrics and Child Health and NICE (National Institute of Health and Clinical Excellence). One of the medical staff interviewed told us the service had, "Good guidelines in use," another said the guidelines were, "Comprehensive and useful."

- We found the standard of care provided for paediatric patients on the adult CCU followed guideline and evidence based best practice. For example, the unit followed best practice guidelines for the provision of a place of safety for critically ill children and young people prior to transfer.
- We observed evidence based care practices. For example, we saw the Screening Tool for the Assessment of Malnutrition in Paediatrics (STAMP) completed in the eight sets of paediatric care records reviewed. STAMP is a validated nutrition-screening tool for children and is used for children between the ages of 2 and 16.
- We reviewed safeguarding children audit data from 2014. This identified there was:- a lack of awareness of key staff, poor identification of those staff that needed level 3 training and some staff were not satisfied with the advice obtained from the safeguarding team. However, we could not find any evidence to show what follow up actions had occurred following this audit.
- The pharmacy department carried out medication audits and feedback given to medical staff. Issues identified by these audits were usually related to prescribing; there were no ward level medication audits.
- We were told nursing staff carried out care records audits were every month. Meeting minutes showed these audits had identified good compliance with completion of documentation in care records. There were issues with staff not dating and signing when records had been altered. Medical staff were not including their GMC numbers when they signed documents. The matron on the children's ward explained the service would have standard signature lists with GMC numbers in the front of each patient's care record. However, these were not in place in the care records reviewed during our inspection.
- When we reviewed staff meeting minutes from 21 May 2015, we saw audit results were discussed. This showed staff were kept informed about audits and their results.

Pain relief

- We found children and young people did not always have access to appropriate pain relief as and when required. There was no evidence of pain assessment tools in the care records reviewed and feedback from patients confirmed they had not always received pain relief when they needed it. A recent audit also showed the pain score had not been documented and the totalling of the PEWS had not been carried out in 30% of care records reviewed.
- We were told, and we observed, that the PEWS used by the service had a pain scale from one to five. We were told pain should be assessed every time baseline observations or intentional rounding were carried out. A pain 'smiley face' and a pain ladder were available to show to children when assessing their pain levels.
- Staff confirmed there could be a delay in administering pain relief due to the requirement for a two-nurse check on all drug administration. They said patients might need to wait for a doctor or nurse prescriber to prescribe their medication. They said medical staff were based on the day care unit. A nurse practitioner was on duty on the day care unit during the day, who was a nurse prescriber.
- The service did not use patient group directions (PGDs). PGDs identify who can supply and or administer specific medicines to patients without a doctor and which medicines can be administered.

Nutrition and hydration

- Children and young people on the children's wards could choose from the children's menu provided or from the adults menu if they preferred. We saw drinks and snacks were available on the children's ward throughout the day, these included fruit, yogurts, crisps and biscuits. There was a drinks trolley on the day care unit near the nurse's station. Senior nursing staff told us snacks were also available from the catering department throughout the day.
- Hostesses came to the wards and took the food orders each day and feedback from children, young people and families about the food was positive.
- Three meals a day were provided for breastfeeding mothers and siblings on the neonatal unit. Kitchen facilities were provided for other resident parents, where they could make hot drinks and snacks.
- In the care records reviewed we saw the STAMP nutritional assessment tool was being used and all patients admitted were nutritionally assessed (growth chart). This meant children and young people had their nutrition and hydration needs assessed. However, we

did not see any food and fluid charts in the care records reviewed and an audit had shown 83% of patients were weighed on admission, when all patients should be weighed on admission. This meant there was a risk children and young people who needed additional support with nutrition may not be identified.

Patient outcomes

- The children's service participated in appropriate national audits relating to patient outcomes. No problems were identified with patient outcomes during the inspection visit; outcomes for children and young people using the service were good and comparable or better than national averages.
- The service participated in national audits such as diabetes and paediatric asthma. The latest available paediatric diabetes audit from 2012/2013 showed results similar to the England and Wales average. For example, the median HbA1c (average blood sugar) at the University Hospital North Tees and University Hospital Hartlepool was 66 mmol/l; slightly lower than the England average of 69 mmol/l. The rate of multiple emergency admissions for asthma was in line with the England average whilst for epilepsy it was slightly higher. There was no multiple emergency admission rate recorded for diabetes indicating that the number of children who had multiple emergency admissions for diabetes was below six.
- The emergency readmission rate within two days of discharge was comparable to the England average for each area. For example, there had been no emergency readmissions after elective admission in the under one age group and less than six in the one to 17 age group (source: HES Dec 2013-Nov 2014)
- The non-elective emergency readmission rate in paediatrics was 3.6 in the under one age group, compared to the England average of 3.3. In the one to 17 age group the rate was 1.9, which was significantly lower than the England average of 2.7.
- We were told that breastfeeding rates in the local area were not good. However, the service had seen a significant improvement in the rates of breastfeeding on discharge from the neonatal unit; increasing from 30% to 60%.
- The service had been identified as an outlier in the national neonatal audit programme performance. This had been due to a retinopathy of prematurity case. Further investigation showed there had been a data entry error and the date had not been entered correctly. As a result, staff had been retrained and shown how to enter data on the system and consultant staff now did a quality assurance check. At the time of the inspection, the service was due for a re-audit.

Competent staff

- Staff were competent to carry out their roles and received appropriate professional development, including an annual appraisal
- Staff told us the service supported their development of skills and knowledge and they received the training they needed to carry out their role safely and competently. Staff feedback about opportunities to develop was positive.
- All staff undertook paediatric intermediate life support training annually. The matron on the children's ward told us four new staff did not have advanced paediatric life support yet. Nursing staff filled in medical devices updates and two nurses were booked to undertake training in long lines in September 2015.
- The play specialists were band 4 and told us they had recently attended a course in Edinburgh.
- We visited the adult critical care unit as we found there were occasions when children and young people would be cared for on this unit while waiting for the regional retrieval team. The personnel involved in caring for paediatric patients on the adult CCU were up to date with relevant clinical professional development. For example, nursing staff were trained in advanced paediatric life support and paediatric intermediate life support with regular updates. However, we found surgery recovery nurses were not paediatric intermediate life support trained.
- Medical staff working on the adult CCU were on the paediatric anaesthetic rota and regularly anaesthetised children and young people. This meant they were clinically competent to intubate children.
- However, when we visited the emergency department we found that a relatively inexperienced children's nurse (qualified six months and in post for seven weeks) was the only nurse in the paediatric department and was triaging paediatric patients without supervision. This meant there was an increased risk to patients by using a relatively inexperienced nurse to triage patients. We discussed this with the trust who told us the nurse had good experience and had undergone triage training as part of their induction.

- Medical staff we spoke with were happy with their training, educational supervision, appraisal and induction. They found the induction processes informative and useful. They said they received informal and formal feedback. The clinical director told us there were more opportunities for learning for trainee medical staff at this service, compared with other similar services.
- Staff told us staff received clinical supervision with one of the clinical supervisors at least four times a year. Nursing staff we spoke with confirmed they had clinical supervision sessions, both individually and in groups.
- Staff told us they were concerned that nursing staff from the children's areas could be moved to provide cover on adult wards, to meet the needs of the service. When we asked senior nursing staff about this they said children's nurses were only 'specialling' and the agreement was that cover would only be provided for a maximum of two hours. The matron on children's ward told us they did not keep a record of how often this happened. We spoke with the patient flow manager about this; they told us children's nurses would not be allowed to work on adult wards. Therefore there was a disconnect between what we were told by staff and the patient flow team.
- Staff raised concerns that the trust's bed managers could override the advice of the shift co-ordinators in the service. They said bed managers did not always understand the acuity of the workload in children's services, where inpatient numbers do not always reflect the workload.
- The service had an appraisal system for staff and appraisals were all up to date. However, we found appraisals records were not available to view, as the managers did not keep records appraisals they had carried out. This meant the managers did not have a record of the objectives set, action plan or time scales. We saw one completed appraisal document, which a staff member had on site with them.

Multidisciplinary working

- Staff, teams and services worked together well to deliver effective care and treatment for children and young people using the service. We found good examples of multidisciplinary working, both within children's services, with other hospital departments and with outside agencies. For example, the service had good links in place with pathology, the point of care testing group, social services, community children's nursing teams, the local safeguarding teams and the local hospice. The neonatal unit held multidisciplinary pre-discharge meetings. However, senior nursing staff told us there were vacancies in the community children's team, which meant children and young people who were discharged with intravenous antibiotics had to come back into the day care unit for between 14 and 21 days because community nurses were not available to care for them at home.
- Social services attended strategy meetings on the children's ward, along with named nurses and named doctors. The children's ward matron said the service saw a lot of looked after children and the relevant people were always involved. We received positive feedback about the care of looked after children by the service.
- The management team told us services were variable for the transition of young people into the care of adult services. For example, at around age 16 young people with asthma would have their lead adult consultant identified. In diabetic services, the trust held four adolescent clinics for young people aged 16 to 19 and young people were introduced to their adult diabetes nurse. At the time of the inspection, there was a vacant post for a diabetologist to care for adolescent patients.
- We were told transition services for young people with complex or long-term conditions were "not so good." We were told all trusts used different models for transition in these patient groups. For oncology patients the trust worked together with the Freeman Hospital in Newcastle and young people living with epilepsy remained under the care of the paediatricians for six months during their transition period. This meant some transition services were well established, while others were not.
- There were no problems with accessing the local Child and Adolescent Mental Health Services (CAMHS). Senior nursing staff told us the local CAMHS had recently changed and now provided 24-hour cover. They said CAMHS came in when the patient was ready for discharge. Senior nursing staff also told us the children's service saw a lot of children and young people who had self-harmed, approximately two or three patients a week. This was corroborated by the management team. We were informed no child was discharged until a CAMHS review had taken place. For children over five CAMHS took the lead and for children under five the

paediatrician took the lead. The head of midwifery and children's services told us CAMHS worked closely with schools and there were joint training and teaching sessions. The management team said acute CAMHS patients were assessed in a timely way and patients with long-term conditions had pathways in place.
- The team who cared for children on the adult CCU liaised regularly with other teams, such as the paediatrics team and the emergency department team. Staff on the CCU told us there was also good external network support available.

Seven-day services

- The inpatient wards (children's ward, day care unit and neonatal unit) were open seven days a week and no significant problems with accessing services over seven days were identified by the inspection team. The five play specialists' shifts covered the service seven days a week.
- Staff told us pathology, pharmacy and CAMHS services were available 7 days a week. For example, the hospital pharmacy was open from 8.45am to 5.15pm and we were told physiotherapy staff were always available on site. However, dieticians were not available at the weekends and nursing staff on the children's ward also told us it would be useful to have ward clerks working seven days a week.
- At the time of the inspection, the children's outpatient department service opened from 8am to 5pm Monday to Friday. We were told these opening times were likely to change, following staff consultation, and clinics would probably run later into the evenings and be open on Saturdays in the future.

Access to information

- Access to information, different languages and translators was available. The trust used the 'everyday language solutions' translation service. Staff told us there were no problems accessing translation services for black and minority ethnic (BME) families that required them.
- However, we found there was a lack of information for meeting the needs of deaf patients and relatives. We asked senior nursing staff about this they said they had never needed to consider the needs of deaf patients or relatives; they did not have any staff proficient in sign language. They said the trust had hearing loops available.
- Patient leaflets were available in metal drawers at the nurse's station on the children's ward. We observed these were not easily accessible for children, young people and their families. This meant patients and their families could not pick up leaflets without having to ask staff for them. When we raised this with staff we were told us there were plans in place to have the leaflets on display, and a rack had been ordered for this purpose.

Consent

- Families we spoke with were happy with the consent procedures. We saw evidence of consent being obtained in the care records we reviewed.
- We saw the service had a policy for consent to examination or treatment. We reviewed this policy and saw it described obtaining consent from children and young adults deemed Gillick competent, and assessing their understanding of the process to which they were giving consent. The policy also stated it was good practice to establish whether the parents agreed. Staff we spoke with showed they understood the Gillick competency standard surrounding consent.

Are services for children and young people caring?

Good

Overall, we rated caring as good.

We spoke with 14 parents, family members and children/young people during our visits to the different areas of the trust where children and young people were seen. Everyone told us the care received was supportive. Both staff and families told us they would recommend the service to their families and friends.

Children, young people and family members we spoke with all told us staff kept them informed and involved them in making decisions about their care and treatment. They said the staff were kind and provided them with compassionate care and emotional support, which met their individual needs.

Feedback from surveys carried out by the children's service was all positive. This showed the children's service was meeting the needs of the children and young people who used it.

Services for children and young people

Compassionate care

- We spoke with five children and young people, and nine family members, who all gave positive feedback about the care provided. They also told us they had been treated with dignity and respect. One parent told us they were, "Confident the staff would give good care."
- We observed and heard staff providing care and treatment. Staff were talking with children and young people, using language appropriate to their age and level of understanding.
- Children, young people and family members told us they were happy with the service and would recommend the service and the hospital to family and friends. Staff we spoke with also told us they would recommend the service to family and friends. They told us they felt their patients received good care.
- Feedback about staff was positive, one patient said, "The nurses are always around to help." Other people told us staff they were "helpful" and "approachable." One young person said they were seen promptly in the emergency department and welcomed onto the ward on arrival.
- Children and young people appeared happy and comfortable. Those we spoke with told us their medication and food was on time.
- The service was not using the friends and family test, the matron on children's outpatient department told us, "It's coming in soon."
- We saw feedback cards in the children's outpatient department. The matron told us the patient experience team analysed the results. We saw compliments on display including: friendly and helpful, happy with service, pleasant and helpful, helpful and calming, excellent experience and even though we had to wait we were kept informed.
- The patient satisfaction survey for the neonatal unit was the best in the region for neonates. Medical staff told us parents were very appreciative of the staff on the unit.
- Results of the 2014 national children's inpatient and day case Picker survey for the Stockton site showed 30 patients aged between eight and 15 and 101 parents and carers had responded. The Picker survey is undertaken by the Picker Institute to measure patients' experiences of in-patient care in order to assess the quality of care. Results showed 99 out of 101 parents and carers felt their child had a good experience of care in the hospital, overall and 30 out of 30 children and young people said they had a good overall experience of care in the hospital
- A young person's questionnaire for the 12 months of 2014-2015 had been published in June 2015. We saw children and young people had completed 91 surveys and the majority of the comments were positive. For example 99% found the doctor or nurse practitioner easy to talk to, 98% said they understood the answers to their questions, 98% said they were treated with dignity and respect and 93% said they were given enough privacy
- The service also had 'You're Welcome' accreditation from the Department of Health. This showed the children's service was meeting the needs of children and young people who used it.

Understanding and involvement of patients and those close to them

- Families told us they were always kept informed and that the information was clear. We saw evidence of involvement in care planning in the care records we reviewed.
- Medical and nursing staff we spoke with told us children and young people were encouraged to be involved in decisions about their care and treatment.
- Staff told us young people had been involved in planning the decoration and facilities available in the teenage / adolescent area on the children's ward.
- Staff administered medicines to individual children and young people as required; the service did not do 'medicine rounds.'
- We heard nursing staff administering intravenous antibiotics explaining the procedure to the child and the parent beforehand; for example, they told them what drugs they were giving and how long it would take. We also heard nurses talking to the child and parent throughout the intervention.

Emotional support

- Parents and children told us they had been well supported during their visits or stays on the children's wards, neonatal unit and children's outpatient department.
- There was a quiet room on the neonatal unit, which could be used for mothers to express breast milk or for having any sensitive discussions around care.

Services for children and young people

- Medical staff we spoke with told us pastoral help was available for those children and young people that needed it.
- Staff told us the trust had a bereavement officer; however, nurses working within the service tended to talk to families following bereavements. There was also a nurse trained in emotional support. They said emotional support for families was also available from the social workers or community nursing teams. We were told of an example of a child who had been on end of life care, and how the service had worked together with the local hospice to provide appropriate care and treatment within the inpatient ward.
- Debrief meetings were held for staff following a traumatic event or the death of a child, to provide emotional support for staff involved. If further support was required staff could access the trusts occupational health department or counselling service.

Are services for children and young people responsive?

Good

Overall, we rated responsive as good.

Systems for access and flow was well established within children's services. There was open access to the day care unit and ED for certain patient groups, such as children discharged from the neonatal unit with a named consultant or children with long-term conditions. We saw the adult CCU had robust pathways for children and young people in place However, the service had identified that discharge processes needed improving to improve patient flow. Plans were in place to change the opening times and shift patterns in paediatrics, which should reduce the numbers of delayed discharges from the service.

The children's service was responsive to the individual needs of children, young people and their families. For example, there were good facilities for parents on the neonatal unit with open visiting for parents and siblings. There were six rooms available for parents to stay overnight. There were effective systems and processes in place for dealing with complaints from people using the service.

Service planning and delivery to meet the needs of local people

- We found that the children's service had good links within the trust, and with commissioners, the local authority and other providers. These helped ensure services were planned and delivered to meet the needs of the local population
- During the winter period (November to March 2015), paediatrics increased the number of inpatient beds to 30 from 24 and staffing levels were increased to accommodate the winter pressures.

Access and flow

- Access and flow was well established within children's services. The ED facilities for children were separate from the adult service and included a paediatric resuscitation room. Women and children's services had no direct influence over the provision of emergency services within the ED; however staff from the two departments told us they worked together well.
- The children's ward had 24 beds and was immediately adjacent to the day care unit, which had 10 beds. Children and young people (age 0-16 years) were admitted to the day care unit via either the emergency department or following referral by their GP. Here they received an initial assessment, and treatment if required. Staff told us patients on the day care unit would remain on the unit until they were either sent home or transferred to the children's ward.
- At the time of the inspection the day care unit was open from 8am to 9pm; we were told the latest a patient would be admitted was 7pm. From 10 August, the day care unit would open from 10am to 10pm. We were told there were not many patients on the unit before 10am, as they were mainly referred by GPs.
- The median length of stay for non-elective patients on the inpatient wards was one day (source HES July 2013 to Jun 2014). This was the same as the England average for the same period.
- There was open access to the day care unit and ED for certain patient groups, such as children discharged from the neonatal unit with a named consultant or children with long-term conditions.
- The neonatal unit had 22 cots in total; there were 12 babies on the unit on the first day of the inspection.
- Medical and nursing staff told us about ongoing problems with delayed discharges in particular delays in

writing prescriptions. Staff on the children's ward said the discharge process needed improving to improve patient flow. As a result, the service was planning to change shift patterns to match the peaks and troughs in demand. Staff hoped this would address the issues identified with delayed discharges.
- We saw clear and prompt discharge summaries in neonates and paediatrics.
- There were problems with long waiting lists for some clinics in children's outpatient department and there were problems with children and young people who did not attend (DNA) their appointments. Staff told us a 'task and finish group' had been set up to look at the problems the service had with DNAs.
- We saw the adult CCU had robust pathways for children and young people in place Staff on the adult CCU told us children and young people who required isolation were nursed in single rooms on the intensive treatment unit (ITU). They also told us the regional retrieval team were usually responsive.
- Patients came into the day care unit for elective surgery; for example, there were dental lists on Tuesdays and Fridays. The planned changes included moving the elective day cases into a surgical day unit on the children's ward.

Meeting people's individual needs

- The children's service was responsive to the individual needs of children, young people and their families. For example, there were good facilities for parents on the neonatal unit with open visiting for parents and siblings. There were six rooms available for parents to stay overnight. Shower facilities were available and adequate; the matron told us these were due to be upgraded.
- The children's ward had a disabled toilet and baby changing facilities. We saw there were no tracked hoist(s) available in the bathrooms at the time of the inspection. The matron told us these were to be installed in August 2015, along with a wet room.
- Two bays on the children's ward were allocated for adolescent /teenage patients, these were spacious and the décor was appropriate. We saw the play areas for younger children were functional and well stocked, with plenty of toys and craft equipment. Tablets were available and play specialists told us these were popular with children and young people when they were going to theatre.
- Camp beds were available for parents to sleep next to their child. There were 22 camp beds available. We were informed there was a risk assessment in place for the use of camp beds on the children's ward; however, we did not review this.
- Staff we spoke with told us some parents would get into bed with their children. We asked whether the service had a bed sharing policy, we were advised that the maternity service had a policy on co-sleeping; however we could not find this on the intranet. We were later told this was because the policy was under review. Therefore, at the time of inspection, there was no clear guidance about parents sleeping in the same bed as their children.
- The children's outpatient department regularly had visiting consultants from larger hospitals in the area; they held clinics such as endocrine, immunology, cardiac, muscular dystrophy, genetics, epilepsy and cystic fibrosis. There was a mixture of in-house and visiting consultants running outpatient clinics. Dieticians and the speech and language therapy service also held outpatient clinics.
- The service ran a small satellite outpatient clinic at Peterlee hospital; however, we did not visit this hospital site during this inspection.
- HCAs in the children's outpatient department were trained in phlebotomy, one told us they could call on play specialists from the inpatient wards to help them distract patients if this was needed. This meant children and young people did not have to attend adult clinics to have blood samples taken.
- The care and treatment of paediatric patients on the adult CCU was responsive and met the needs of this patient group.
- Staff told us children and young people with learning disabilities had a health passport, this had recently been implemented by the service. They said health passports were part of the transition process for this group of service users. They explained that the service saw patients with learning disabilities regularly, as they made up a significant proportion of the patients on the elective dental lists.

Learning from complaints and concerns

- The service had a complaints policy and the feedback following complaints was timely. For example, 100% of complaints received met the initial trust timescale of a response within seven days.

- There had been 38 complaints recorded over the previous 12 months at the UHNT sites; 15 of these had been in the outpatients departments. We saw evidence which demonstrated that verbal complaints were also recorded and acted upon. This showed there were effective systems and processes in place for dealing with complaints from people using the service.

Are services for children and young people well-led?

Requires improvement

Overall, we rated the well-led domain as requires improvement.

Systems and processes for risk management within the service were not effective and timely. The need to improve risk register management was known by the trust board and a plan was in place but not yet implemented. The risk register was not regularly reviewed at the patient safety and risk management meetings and risks were not actively managed by using the risk register.

The management team were committed to the vision and strategy for the children's service and feedback from staff about the culture within the service, teamwork, staff support and morale was positive. Staff said there was an open culture within the service. They also told us communication within the service was good, and they were kept well informed.

There were systems and processes in place to regularly assess and monitor the quality of service that children and young people received, and we saw evidence that demonstrated the service acted on feedback to improve children and young people's experience of using the service.

Vision and strategy for this service

- We were informed that there had recently been a consultation with the staff working in paediatrics, due to the regular backlogs of children and young people waiting for admission onto the children's ward in the early evening. The management team told us the service was formally in consultation; staff had been sent letters about the proposed changes and copies of the consultation. This showed the service was following the trust's organisational change policy.
- At the time of the inspection, plans were in place to open a six-bedded elective care unit within the children's ward and change the opening times of the day care unit to include weekends and later evening shifts. These changes were to start from 10 August 2015. Staff we spoke with in paediatrics were aware of the planned changes. They told us having a surgical day unit on the children's ward for elective day cases would free up emergency beds on the day care unit meaning more beds would be available to admit sick children and young people. One staff nurse said, "The new opening times and shift times will improve things on the ward."
- The matron in children's outpatient department told us the service was planning a similar consultation for department staff; staff working in outpatient clinics at the satellite site would be included.
- The management team told us children's service on the two hospital sites, Stockton and Hartlepool, had merged in 2008. They said the services were working together well, but it had taken some time to bring the two cultures together. The head of midwifery and children's services told us they had adopted a 'best of both' approach during the transition from two services, which had worked effectively.

Governance, risk management and quality measurement

- An effective framework was in place for governance and quality monitoring. There was a patient safety team for women and children's services and meetings were held in a regular basis. For example, patient safety and risk management meetings, morbidity and mortality meetings and ward meetings. Staff we spoke with felt governance within the service was good. They said staff training in patient safety, complaints and incidents was included on mandatory training days for staff. Staff we spoke with were knowledgeable about these elements of their training.
- However, we found systems and processes related to risk management in the service were not robust. The need to improve risk register management was known by the trust board and a plan was in place but not yet implemented. The risk register was not regularly

reviewed at the patient safety and risk management meetings and risks were not actively managed by using the risk register. One matron told us the risk register was reviewed annually to see whether the risk remained applicable, but documents we reviewed stated the risk register should be reviewed monthly as a minimum. This meant risks that may have been addressed were not being removed or transferred from the active risk register.

- At the time of the inspection, we found children's services had 59 risks on the risk register. Senior nursing staff told us all staff knew about the risks on the risk register; they showed us a signature sheet that had been signed by staff to confirm this. We looked at the risk register and noted a number of high-risk issues had been on the register for some years, and had not been appropriately managed. For example, on 17 July 2006 a risk was added about the risk of injury from the use of camp beds. When we asked a matron why this was still on the register, they told us this was because a member of staff had hurt their back.
- Resuscitation procedures in children's outpatient department were first identified as a risk on the risk register on 20 April 2007. This was due to resuscitation equipment being accessed via A&E. We were shown the original Corporate Risk Assessment Form (CRA). The risk register showed this risk had last been reviewed on 12 June 2015. The initial risk was categorised as 'catastrophic consequences' with the likelihood as 'rare'. We saw the current risk level for this risk on the risk register was also categorised as 'catastrophic consequences'. The trust response to mitigate this risk was not clearly documented in the risk assessment or on the risk register and both documents required updating.

Leadership of service

- Children's services were managed by the general manager, clinical director and head of midwifery and children's services.
- During our interview with the management team (clinical director, head of midwifery and children's services and general manager), we found they were aware of the challenges the service faced with regard to delayed discharges and gaps in medical staffing. The service had clear plans in place to address these.
- The management team told us they felt staff realised the benefits of working together across the two sites, which were originally separate. They felt the supportive leadership of the service was well embedded and the introduction of research nurses had been stimulating.
- Reporting structures were clear; there was a clinical director, directorate manager and nurse manager, with unit leads for paediatrics and neonates. Managers held regular monthly meetings, which included IPC and HR staff. This showed the service worked together with other trust teams to deliver effective care and treatment.
- Medical staff told us the management team were innovative, responsive, understanding and supportive. Staff we spoke with gave positive feedback about the leadership of children's services. Comments about managers included, "very supportive" and "takes an interest." Staff in the inpatient areas said the nurse manager was visible on the children's wards.
- Staff all told us they felt well supported by their immediate managers, confident about raising concerns and confident concerns would be acted upon. Staff told us the service was "quite responsive" when issues were raised, senior nurses were approachable and they felt confident in the ward managers.
- We were told that the trust's director of nursing represented children and promoted children's rights and views at the trust's board, as required by the National Service Framework (NSF) for Children (2003) Standard for Hospital Services.

Culture within the service

- Staff feedback about the culture within the service was positive. Staff told us they felt supported, there was good teamwork and the teams worked well together. We were told us the service always got good feedback from student nurses.
- Staff said there was an open culture within the service. They also told us communication within the service was good, and they were kept well informed.
- Staff were less positive when asked about the wider trust managers. For example, staff told us bed managers on duty at night did not always support staff when making decisions about moving staff from the children's ward to other wards in the hospital
- Medical staff we spoke with told us the consultant team and clinical directors were supportive.

Services for children and young people

Public engagement

- Local and national feedback surveys had been carried out by the service and we saw evidence that improvements had been made as a result. Good results had been obtained in the BLISS patient satisfaction survey on the neonatal unit and the service had come out top in a regional survey in 2014.
- We found evidence that demonstrated parents whose babies had been on the neonatal unit were engaged and involved. For example, staff told us the neonatal unit had received 27 compliments to date in 2015 and the neonatal unit ran a neonatal playgroup for babies. Staff of the neonatal unit offered support for breastfeeding mothers, to encourage breastfeeding.
- The directorate participated in the trust's patient experience survey. This was done every two years and we were told this was next due in September 2015. As part of a 'You're Welcome' assessment, young people had inspected the children's ward. Feedback about staff said they were "friendly, down to earth and had young people's interests at heart."
- There had also been a 'youth parliament', which gave feedback about the food and music available to young people using the service.
- The service sent letters out individually to young people, rather than to their parents.
- We were told the children's outpatient department had obtained good results in the Patient Reported Experience Measure Survey (PREMS). This survey is designed for children and young people and measures the experience of paediatric patients aged 0-16 years in urgent and emergency care settings.

Staff engagement

- Staff we spoke with confirmed they had been consulted about the proposals to change their shift patterns.
- Staff told us there were monthly ward meetings and they could add items for discussion to the agenda. We saw issues discussed included the 6 C's, research, clinical governance and safeguarding. We noted there was no review of actions from the last meeting or discussion matters arising in the minutes we reviewed. There were also regular team meetings with the play specialists. Minutes from staff meetings were emailed to staff.
- Medical staff were aware of the issues leading plans for reconfiguration of services. They told us there had been no impact on patient care.
- Information was shared with staff via a 'risky business' monthly bulletin and 'lessons of the week.' The patient safety bulletin covered three topics every week, such as female genital mutilation and the paediatric risk register.
- Information for staff was clearly visible in the areas we visited. For example, on the neonatal unit we saw a dashboard on display showing current audit information.

Innovation, improvement and sustainability

- The paediatric and neonatal departments participated in a number of national and local research studies and were involved in a large number of clinical trials. The management team and several other staff told us the department had recently obtained a 3.5 million pound grant for an 'OSCAR study.' This study is for high frequency OSCillation in Acute Respiratory distress syndrome, comparing conventional positive pressure ventilation with high frequency oscillatory ventilation.
- Medical staff told us research within the service helped improve clinical practice and patient health outcomes. Medical and nursing staff at all levels were involved in the research within children's services. The service had also recently been acknowledged as the 'most improved unit' 'for research. There also were regular research meetings, which children's nursing staff benefited from attending.
- The management team told us the trust was supportive of the research carried out within the service; research was discussed and encouraged and was "on the trust's agenda."
- The neonatal unit had implemented the 'Small Wonders' initiative for premature babies; this was designed by the charity Best Beginnings. Small Wonders supports parents in their baby's care in ways shown to improve health outcomes for their babies.

End of life care

Safe	Good
Effective	Good
Caring	Good
Responsive	Good
Well-led	Good
Overall	Good

Information about the service

End of life care (EOLC) was delivered by nursing and medical staff throughout University Hospital of North Tees (UHNT). The specialist palliative care team (SPCT) provided support and advice for the care of patients with complex needs and symptom management issues at the end of life. The SPCT delivered a Monday to Friday 9-5 service, with palliative care consultant support being available out of hours for telephone advice as part of a Teesside on-call rota. The SPCT were part of a multidisciplinary team approach with the community team based at the Stockton and Hartlepool localities of North Tees and the University Hartlepool Hospital (UHH).

The integrated acute and community SPCT was managed by a senior clinical matron. A Nurse Consultant in Palliative Medicine was in post who covered both acute and community. There was one 0.9 WTE (whole time equivalent) SPC consultant who was the palliative care clinical lead for the acute hospital. There were two WTE SPC nurses based at UHH, a nurse consultant in palliative medicine and a WTE end of life co-ordinator.

We spoke with the senior clinical matron who told us there were ongoing plans within the SPCT to review the structure of the service with the aim to deliver a fully integrated team across both localities with the aim to ensure equity of service. Currently, the two locality teams operated a multidisciplinary approach but were not structurally integrated across the region.

We visited medicine and respiratory wards, emergency access unit, critical care plus accident and emergency where end of life care could be provided. We also visited the chapel, the hospital mortuary, viewing room and the EOLC team offices. We observed care being delivered by both SPCT nurses and ward staff. We spoke with relatives. We spoke with members of the SPCT including the clinical matron, community consultant, nurse consultant and specialist community nurses. In addition we spoke with ward nurses, ward doctors, healthcare assistants, allied health professionals, bereavement office staff, porters and a hospital based discharge facilitator. We saw the porters transporting patients with dignity and respect. We looked at the records of patients receiving end of life care and 35 DNACPR (do not attempt cardiopulmonary resuscitation) forms.

End of life care

Summary of findings

We rated End of Life Care services as good. Patients were provided with an end of life care service that was safe and caring. We found the specialist palliative care team, mortuary and chaplaincy team were effective, responsive and well led and delivered safe and caring services. There were also concerns about staff not always being clear on who was or was not for resuscitation and the validity of DNACPR forms when a patient was discharged. The local teams were very responsive to patient requests with evidence of end of life patients able to be discharged under the Trusts Fast Track Rapid Discharge process. We saw good links with the community services, General Practitioners and Care and Nursing homes within the Trusts geographical area.

The service provided good effective person centred care to patients through support of people and their families for example the introduction of the Family Voice project. The Family's Voice is a diary given to relatives or friends of dying patients inviting them to be a part of care. It is a standard of care that the health care team aim to achieve and by use of the diary relatives are invited to assess if the care provided by the ward achieves it. The Family Voice project and its outcomes were now being disseminated to trusts nationwide.

The staff throughout the hospital knew how to make referrals and people were appropriately referred to and assessed by the specialist palliative care team in a timely fashion, therefore individual needs were met. The hospitals new integrated technology system (e-hospital EPIC) had improved efficiency within the SPCT department giving staff better access to patient information.

Staff had access to specialist advice and support 24 hours a day from a consultant on-call team for end of life care. An out of hours system in place for hospital staff community colleagues to access appropriate equipment for example syringe drivers. The chaplaincy and bereavement service supported families' emotional needs when people were at the end of life, and continued to provide support afterwards. The mortuary was clean and well maintained infection control risks were managed with clear reporting procedures in place. We spoke with staff who were confident in their role and the reporting protocol in place.

End of life care

Are end of life care services safe?

Good

There were systems for reporting actual and near-miss incidents across the hospital. There were systems in place in the mortuary to ensure good hygiene practices and the prevention of the spread of infection. There were sufficient numbers of trained clinical, nursing and support staff with an appropriate skill mix to ensure that patients receiving end of life care were well cared for. There were adult safeguarding procedures in place, supported by mandatory staff training. Staff knew how to report and escalate concerns regarding patients who were at risk of neglect and abuse. Do not attempt cardio-pulmonary resuscitation' forms were appropriately completed and the decision had either been discussed with the patient themselves or, in cases when patients did not have capacity to consent to end of life care, decisions were made in accordance with the patient's best interests, with the inclusion of relevant professionals and those close to the patient.

Incidents

- There had been no Never Events for this service during the previous 12 months. Never Events are serious incidents that are wholly preventable as guidance or safety recommendations that provide strong systemic protective barriers are available at a national level and should have been implemented by all healthcare providers.
- Only one incident specific to the palliative care team had been reported in the previous six months related to a needle stick injury.
- Staff delivering end of life and specialist palliative care understood their responsibilities with regard to reporting incidents and they knew how to report them. They also told us that they received direct feedback relating to the incidents and we saw that they were given time to reflect and learn at weekly team meetings.
- The SPCT told us they were involved in the review of incidents trust-wide where end of life care treatment had been identified. This was a standing agenda item for the SPCT monthly team meeting which we observed.
- Should a serious incident occur, there were systems in place for these to be investigated with the involvement of relevant staff.
- Staff spoke with some understanding about their duty of candour, they understood their responsibly to be open and transparent. They gave us an example of when they had used the duty of candour to explain treatment options and outcomes to patients when the prognosis had not been as expected.

Cleanliness, infection control and hygiene

- We visited the wards and found there were infection control and prevention systems in place to keep patients safe with appropriate signage around the wards.
- We visited the mortuary at North Tees Hospital and saw that it was clean and well maintained and that hand washing facilities were available. Cleaning records were easily accessible and up to date. We saw appropriate hand washing facilities were available.
- We saw staff had access to personal protective equipment (PPE), such as gloves and aprons and were seen to be using the equipment and hand hygiene facilities
- Mortuary protocols were reviewed and we saw that relevant infection control risks were managed with clear reporting procedures in place. We spoke with staff who were confident in their role and the reporting protocol in place.

Environment and equipment

- Staff we spoke with told us they had no problems accessing equipment for patients at the end of life in the hospital.
- Syringe drivers were available and obtained from a trust wide equipment library. Staff told us they were available out of hours with a system in place for community colleagues to access them.
- Staff told us that equipment was accessible within a few hours for patients at the end of life who were being discharged via the fast track route. Each ward area and the mortuary had sufficient moving and handling equipment to enable patients to be safely cared for.
- We visited the mortuary at UHNT. We saw the mortuary was well equipped and that the capacity was adequate. We saw specialist equipment that included bariatric trolleys. We looked at records relating to cleaning rotas and equipment checks and saw these were updated regularly.

- The temperature of the mortuary fridges was recorded on a daily basis and the fridges were alarmed with alerts directly to the estates department should the temperature fall outside of the normal range.

Medicines

- Medicines were well-managed. There were guidelines on the trust intranet (NHS North of England Cancer Network) for medical staff to follow when prescribing anticipatory medicines. Medical staff we spoke with were aware of the guidance and how to access the SPCT for advice should they need it.
- Anticipatory end of life care medication was appropriately prescribed. We saw that the specialist palliative care nurses worked closely with medical staff on the wards to support the prescription of anticipatory medicines (medication that patients may need to make them more comfortable). The guidance the specialist nurses provided was in line with the end of life care guidelines and was delivered in a way that focused on developing practice and confidence in junior doctors around prescribing anticipatory medicines.
- We spoke with staff on the wards and the SPCT team who told us the system was effective and staff were confident patients would receive the appropriate medication even at short notice.
- We looked at patients' Medication Administration Records (MAR) and we saw they were completed clearly; including administration of medicines prescribed 'as required'.
- The SPC nurses were advanced practitioners which enabled them to prescribe medication for patients.

Records

- There was a trust wide electronic record system in place that enabled sharing of patient information within the team and with other health care professionals.
- We viewed 35 DNACPR forms when visiting the wards and found on 33 occasions these were recorded appropriately with discussions with the patient and relatives recorded where appropriate. Forms were kept in the front of patient notes, had clearly documented decisions with reasoning and clinical information and had been signed by a consultant.
- We saw evidence of audits of DNACPR forms being carried out and saw decisions were being recorded with actions in place to address the issues raised.
- Information governance training was part of the annual mandatory requirement for all staff and 89% of the SPCT were up to date with this against a target of 100%.

Safeguarding

- We spoke with staff around safeguarding. Staff were knowledgeable about the trusts safeguarding policies and their role and responsibilities. Staff could give examples of what constituted a safeguarding concern and how they could raise an alert.
- Specialist palliative care staff mandatory training completion for safeguarding adults level one was at 95% against a target of 100%. Completion of safeguarding children level 2 training was 100%.

Mandatory training

- Mandatory training was provided for all staff and was undertaken by all staff providing end of life care. We were provided data by the provider which showed that 95% of specialist palliative care staff were compliant with training requirements in relation to consent, infection control and managing violence and aggression. 80% of staff had attended training in fire safety, resuscitation and patient handling.
- 50% of specialist palliative care staff had attended training in dementia, against a target of 75%.
- We spoke with the SPCT manager who told us they were aware of areas where mandatory attendance at training needed improving and there was an expectation of staff to ensure they attended training. The trust was aware of their obligations in providing adequate dates for the training.
- The SPCT provided education on a formal and informal basis which included delivery to staff from external organisations, including those working in local nursing homes.

Assessing and responding to patient risk

- Staff told us about how they assessed a patient and that managing identified risks was part of that process. We saw completed MUST assessments in place covering nutrition and hydration.
- Ward staff told us the SPCT team were a visible presence on the wards. Any changes to patient's conditions instigated a visit by the SPCT. We saw patient's daily notes by nursing, medical and therapy staff with updates on any changes.

End of life care

- The EOLC team held a weekly team meeting to discuss ongoing patient care. We sat in on a meeting and observed the discussion between staff.
- The SPCT were using a virtual ward approach to identifying patients in the last year of life. The aim of the virtual ward was to prevent unplanned admissions by using the systems of a hospital ward to provide multidisciplinary case management in the community. This meant that the SPCT were able to identify and monitor patients at risk of deterioration. Allocation to a virtual ward was based on the identification of patients who were likely to be in the last year of life, frequency of hospital admissions and where patients were being cared for using the care for the dying patient document.

Nursing staffing

- We found staffing levels were sufficient to ensure that patients received safe care and treatment. Specialist palliative care was provided from 8am to 5pm five days a week. Outside of these hours and at weekend, general inpatient staff could access specialist support from a consultant on call rota.
- Link nurses had been identified for most wards with an emphasis on medical wards. The first meeting was planned for August and would be monthly (link nurses are nurses on the wards who take a special interest in end of life care, attend meetings with the team and take back learning to the ward staff).
- We were told a review was underway to look at the equity of service across the region with an aim of ensuring that access to services was equitable and based on the needs of the local community. We saw evidence of a time lined action plan to confirm this.

Major incident awareness and training

- Major incident and winter management plans were in place. Senior staff had access to action plans and we saw that these included managers working clinically as appropriate, staff covering from different areas and prioritisation of patient need.

Are end of life care services effective?

Good

During our inspection we visited patients who were in receipt of end of life care. Patients spoke positively about the way they were being supported with their care requirements. Staff in all of the ward areas we inspected were aware of the tools used for patients receiving end of life care and all staff were aware of how to contact the specialist palliative care team. We saw that training in end of life care was part of the mandatory training delivered to all staff. The specialist palliative care team coordinated multidisciplinary care and visited people on end of life care on a daily basis.

Ward staff were aware of the trust's definition of end of life care. They were appropriately trained and essential nursing care for assessment and monitoring of pressure ulcer management, pain relief, comfort and managing distress was delivered appropriately. Mortuary and the bereavement centre staff were also aware of the trust's definition of end of life care and they were able to demonstrate an understanding in the principles and values of the trust's strategy for end of life care.

Evidence-based care and treatment

Pain relief

- Palliative medicines (which can alleviate the pain and symptoms associated with end of life) were available at all times. Staff told us that they had access to an adequate supply of syringe drivers and appropriately trained staff to set up this equipment.
- Staff told us they could contact the specialist palliative care team for advice about appropriate pain relief if required.
- There were tools in place to assess and monitor pain. Staff told us pain control was an important element in end of life care. Staff confirmed processes were in place to assess and monitor pain.
- Appropriate medication was available in the ward areas, and there were examples that anticipatory prescribing was being managed.

- Staff told us there were adequate stocks of appropriate medicines for end of life care and that these were available as needed both during the day and out of hours.

Nutrition and hydration

- EOLC staff told us as part of the initial assessment, nutrition and hydration needs at the end of life were assess
- Staff told us that those patients identified as being in the last hours or days of life had their nutrition and hydration needs evaluated and appropriate actions followed.
- We saw that patients had been assessed using a Malnutrition Universal Screening Tool (MUST), which identified nutritional risks. Records showed that, following MUST assessment, appropriate nutrition and hydration monitoring tools had been used by staff. These included monitoring charts for food and drink taken. Specialist dietician support was available on all wards and we saw records of their involvement.
- We observed SPCT staff visiting patients and discussing care including nutrition and hydration options with the patient.
- Staff told us that snacks were available for patients throughout the day and night.

Patient outcomes

- We viewed an audit of the CDP document that had been undertaken by the nurse consultant and saw that ongoing improvement work was being carried out in the areas identified through the NCDAH audit.
- Plans were put in place to deliver Mandatory Training and a workbook that focuses on the use of the Care of the Dying Patient and the Family's Voice.
- To develop and deliver a road show to trust staff and external partners.
- The trust collects feedback from the family of patients cared for at the end of life using the Family's Voice carer's diary. We spoke with the SPCT team who told us they shared the findings with the ward staff. Ward staff spoken with confirmed this.

Competent staff

- The palliative care team across the acute trust consisted of two WTE nurses, 0.9 WTE consultants, an end of life coordinator and nurse consultant.
- Staff told us they had received an annual appraisal and records confirmed this
- SPCT staff told us they had opportunities to shadow community colleagues. Staff told us they found this very beneficial.
- The specialist palliative care team delivered training to staff as part of their mandatory training. For example, training delivered to ward staff around the CDP document enabled staff to assess patient needs or deliver care more confidently.
- All members of the SPCT were trained in level two psychology support.
- A group supervision session took place with opportunities for staff to reflect on the service and their roles.

Multidisciplinary working

- The palliative care team had established positive working relationships with community services, including GPs, district nurses and the community palliative care team at the local Butterwicke Hospice.
- The specialist palliative care team worked in a collaborative and multidisciplinary manner. The service included spiritual support from the chaplaincy team and bereavement support from the bereavement centre.
- The specialist palliative care clinical nurse specialists planned and attended weekly palliative care multidisciplinary meetings where new referrals to the service were discussed.
- The palliative care team told us they benefited from good working relationships with staff at the hospital and in the community. For example, there were opportunities to attend ward meetings on occasion.
- We observed an MDT meeting with discussions around patient care and how staff across the teams could meet the patient's needs.

Seven-day services

- Plans were in place to provide a seven-day service with an integrated service Trust wide.
- All staff told us without exception they felt it would benefit patient care if there was a seven day specialist care service.

End of life care

- The Trust end of life care strategy was in development with a commitment to move the service to a seven-day model by April 2016 following a review of the integrated palliative care service across acute and community settings.

Access to information

- We saw records of plans of care for patients identified by end of life. We spoke with staff who confirmed risk assessments were available and confirmed by checking patient records where we saw evidence of appropriate risk assessments in place.
- We saw documentation available for staff to record patient's decisions around advance decisions, spiritual needs and hydration.
- We saw guidance documentation by the SPCT that could be accessed by ward staff.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- Specialist palliative care staff training around consent was at 95%. Staff we spoke with all had confidence of their understanding of the mental capacity act and deprivation of liberty safeguards.
- We viewed DNACPR forms; we saw examples of DNACPR patients who did not have the capacity to be involved in discussions about the situation. We saw evidence of assessments being completed with lack of capacity clearly recorded. We saw that the decision had been discussed with the patient's relatives and that the decision had been recorded.
- We viewed assessment documents for patients identified as being at end of life. We saw prompts for guidance for staff to follow in relation to best interest decisions for patients who did not have capacity to make decisions about care and treatment, including in relation to nutrition and hydration.

Are end of life care services caring?

Good

We observed care that was attentive and sensitive to the needs of patients and staff treated patient with dignity and respect. We received positive comments from patients and their visitors. Patients' feedback or views on their experiences were regularly collated and updates on action that had been taken, as a result was available on display in each ward area. Patients and their relatives had good emotional support from the specialist palliative care team, chaplaincy, and bereavement office and ward staff.

Compassionate care

- During our inspection, we visited the mortuary and spoke with the mortuary technicians. On discussion, staff were able to demonstrate compassion, respect and an understanding of preserving the dignity and privacy of patients following death. We observed staff interacting with patients with compassion and we saw staff were not rushed in speaking with patients and their relatives.
- During our inspection, we also visited the bereavement office and the chaplaincy staff. They also demonstrated a good understanding of the issues relating to end of life care and showed compassion and respect.
- Ward staff were aware of patients who were receiving end of life care. They were able to discuss their needs and the support that they required. They showed a good understanding and demonstrated compassion and respect.
- We viewed feedback from patient's relatives in the format of video that included comments about how caring staff were towards their family member and how staff showed the utmost respect and dignity.
- During initial and pre assessments, the needs of the patient were identified and their wishes incorporated in their plan of care.
- We saw information readily available offering advice for relatives with guidance on viewing arrangements, how to register a death, organ and tissue donation, funeral arrangements and a list of advice and support organisations and how to contact them.
- Patients and relatives were offered support with emotional and psychological pain through the SPCT, the chaplaincy service and ward staff. We saw this support was documented within care records.

Understanding and involvement of patients and those close to them

- We saw that clinical staff spoke with patients about their care so that they could understand and be involved in decisions being made.
- We saw that where patients had been assessed as not having capacity to make decisions, care options had been discussed with their next of kin.

End of life care

- There was evidence of patients and/or their relatives being involved in the development of their care plans.
- Staff were aware of the Family Voice project. This was discussed at ward meetings.
- The Family's Voice is a diary given to relatives or friends of dying patients inviting them to be a part of care. It describes a standard of care that the health care team aim to achieve and by use of the diary, relatives are invited to assess if the care provided by the ward achieves it. There are questions about pain, sickness, agitation, breathlessness, whether the staff are treating the dying person with dignity and sensitivity and whether the relative or friend are being included and involved in the care. It also asks if there was anything more that could have been done to improve the care. The CDP document contains a section where it can be documented that the Family Voice has been offered.
- We saw advance wishes were discussed with patients and their relatives and recorded within the care planning documents.
- We saw that the care of the dying patient document used by the trust included prompts to assist them with patients and their relatives.
- We saw that bereavement packs were available in the ward areas with information about access to support.

Emotional support

- We saw that privacy and dignity was maintained and opportunities were taken to keep the patient and their family informed of their condition. We observed that patients and relatives were central to this process and this was in the form of a discussion.
- Throughout our inspection, we saw that staff were responsive to the emotional needs of patients and their visitors.
- We were shown 'oasis' rooms which were on three separate wards. The 'Oasis' rooms were private areas where family could stay with the patient and had the opportunity to bring along special mementos.
- The specialist palliative care team, the chaplaincy staff and ward based staff provided emotional support to patients and relatives.
- During our inspection we visited the bereavement centre where we saw there was a bereavement counselling service.

Are end of life care services responsive?

Good

Patients' individual needs were responded to by ward and SPCT staff and patients individual needs were central to the planning and delivery of their care. The involvement with community services in patient care was integral and as a result discharges were seen to be managed quickly to meet patients' needs. We heard and saw instances of how the SPCT within the hospital worked with the local hospice and Hospice at Home team within the community to improve patient support. Fast track discharges were seen to be managed efficiently and in the patients best interest and a proactive approach was taken to ensuring the support and safety of vulnerable patients.

Service planning and delivery to meet the needs of local people

- The palliative care team told us that the model delivered was to see patients within 48 hours of referral. We spoke with the nurse consultant who explained the process via the virtual ward system. This was initially a project which aimed to differentiate palliative care patients who were in the last year of life within the hospital setting from all other patients.
- There were three virtual wards. The palliative care green ward included patients who had previously been identified as in their last year of life and the GP was informed. The palliative care amber ward included patients who had had two or more admissions since being identified as in their last year of life. The end of life ward included those patients likely to be dying and all curative treatment had stopped. The staff on the ward identified this group of patients.
- End of life care tools had been rolled out within the ward areas to facilitate coordinated care that gave the patient choice. Emphasis had been placed on ensuring care was carried out in the patient's preferred place of care. For example, the trust delivered a fast track discharge process for dying patients. It identified which wards were discharging dying patients and highlighted the preferred place of death as home, nursing home or

hospice with small numbers transferring to another hospital. Figures produces showed from January to June 2015, 115 patients had been recorded as receiving a fast-track discharge.
- We viewed figures for fast track discharges to a patient's preferred place of death across a two-year period and saw that there had there had been a 27% increase in fast track discharges across the trust in 2014/15 compared with the previous year. Staff we spoke with told us a good proportion of this was patients wishing to die at home, as well as those being discharged to hospices and care homes.
- A move to providing a seven-day specialist service was being developed. We saw evidence of plans being implemented by April 2016.

Meeting people's individual needs

- Patients were cared for by staff with experience in end of life care and we saw that members of the SPCT had attended specialist training, for example dementia awareness
- The multidisciplinary team documented their information in the patient's notes, which ensured the social and health care professionals involved were aware of the care and treatment patients were receiving.
- Staff we spoke with had a good understanding of safeguarding issues and of the Mental Capacity Act (2005) and how this affected caring for patients who did not have capacity. We saw evidence of best interest meetings being carried out in this situation.
- Staff across the trust could access support from specialist teams for, example dementia services, safeguarding team and best interest assessors.

Access and flow

- The specialist palliative care team developed a care pathway tool for patients in all areas of the hospital. This was to ensure that patients who required end of life care
- Patients were identified at the earliest opportunity to facilitate the most appropriate care in the most appropriate place for each patient.
- Patients were referred to the specialist palliative care team were seen
- The wards had an open visiting policy for relatives to visit patients.
- We were shown 'oasis' rooms which were on three separate wards which were side room where patients and relatives were able to have a private room. Additionally, open visiting was available.
- Plans were in place to provide a seven day integrated specialist palliative care service Trust wide by April 2016.
- All staff told us without exception they felt it would benefit patient care if there was a seven day specialist care service.

Learning from complaints and concerns

- Information was available in the hospital to inform patients and relatives about how to make a complaint.
- The palliative care nurse consultant showed us how they regularly conducted searches of the electronic system in order to identify any complaints that involved patients at the end of life.
- The SPCT would provide specialist input when required, in relation to reviewing complaints to ensure learning related to end of life care was identified and cascaded.

Are end of life care services well-led?

Good

We found that staff on the ward areas shared the visions and values that the specialist palliative care team were working to promote. The culture was seen to be that End of Life care was 'everybody's business' and all staff shared a commitment to ensure the care provided was right for the patient. We saw the team had developed the 'virtual' ward system which identified people in the last year of their life. This helped the team and the trust to provide the best treatment for the patient. Leadership within the end of life specialist palliative care team was clear however we did not see evidence of a proactive executive involvement in terms of the development of the end of life care strategy

Vision and strategy for this service

- Staff told us with confidence of the trust's vision around providing a quality service.
- There was a commitment by the trust to provide the best treatment for the end of life patient and this was underpinned by staff committed to ensuring that patients were cared for in a timely and appropriate manner in their preferred place of death.

End of life care

- The trust end of life care strategy was in development with a commitment to move the service to a seven-day model.

Governance, risk management and quality measurement

- Team meetings were held on a weekly basis and a standard agenda included reviewing any new risks identified. The team liaised with the patient safety team and the senior clinical matron.
- Patient safety and quality was addressed at the In-Hospital Care directorate meetings, which were held on a monthly basis.

Leadership of service

- The SPCT was managed by a senior clinical matron, with clinical responsibility for the palliative care consultants, including one community-focused consultant.
- Leadership of end of life services by the specialist palliative care team was clear to staff throughout the trust. All staff we spoke with on the wards and in departments valued the expertise and responsiveness of the Specialist Palliative Care Team.
- Staff we spoke with were happy with the leadership within the team. They felt more confident with the plans in place to ensure the realignment of the end of life services trust wide.

Culture within the service

- Staff at ward level told us End of Life care delivery was part of daily role. They spoke positively of the involvement of the SPCT and considered their involvement essential. Staff on wards and departments spoke passionately about the end of life care provided.
- The specialist palliative care team promoted a culture of sharing knowledge and developing the skills of others.
- All staff we spoke with could provide examples of how the patient's needs were at the centre of the end of life care being delivered and offered.

Public engagement

- We spoke with the nurse consultant who told us about the family voice project. An element of this was the Family Voice diaries. Staff we spoke with found this a positive learning tool. This was often discussed at ward meetings and patient review meetings.
- The specialist palliative care team presented information to groups with the trusts geographical area. These included training sessions and awareness meetings to GPs and local care homes.

Staff engagement

- Staff members of the SPCT told us they attended ward level meetings regularly basis. Additionally, they had been involved regional forums, which were attended by key partners within the region.
- We observed the SPCT weekly team meeting. This was attended by every member of staff. We saw the meeting gave the opportunity for all members of staff to raise items on the agenda additionally, every member of staff felt confident to raise issues that were prevalent to their role or they could add value to the discussion.

Innovation, improvement and sustainability

- The trust had established and developed a nurse consultant role which had been key in the delivery of the family's voices research, as well as the practice of providing cognitive behavioural therapy for patients at the end of life.
- The trust's care for the dying patient review group had led on the development of the care of the dying planning document that in turn influenced the development of network wide regional documentation.

Outpatients and diagnostic imaging

Safe	Good
Effective	
Caring	Good
Responsive	Good
Well-led	Requires improvement
Overall	Good

Information about the service

The outpatients departments at North Tees University Hospitals NHS Trust organised a total of 2,200 clinics a year. The University Hospital of North Tees outpatients departments and diagnostic imaging department were situated on the main hospital site in Stockton. There were a total of 132,132 outpatient appointments at University Hospital of North Tees between July 2013 and June 2014. There was a total of 155,271 attendances for diagnostic imaging procedures at University Hospital of North Tees between April 2014 and March 2015; 47,685 were inpatients and the remaining 107,586 were GP patients, outpatients and accident and emergency department patients. The DNA rate (percentage of patients who did not attend an outpatient appointment was 8% which is slightly higher (worse) than average when compared to other Trusts in England.

The elective dare directorate manages the outpatient department as a support function. There are also specific specialties who manage their own outpatient department. Each specialty was responsible for its own performance activity. Outpatient clinics were held in different locations within the main hospital site across a large number of specialties such as General Surgery , Orthopaedics, Gynaecology and Medicine with sub-specialities of Breast, Oncoplastics, Upper GI, Bariatric service, Endocrinology, Colorectal, Urology, Cardiology, Gastrology, Rheumatology, Thoracic medicine, Elderly Care, Haematology and Pain Management. The department was open between 9am and 5pm from Monday to Friday every week and on Saturday mornings. Diagnostic imaging services were available from 9am to 5pm on weekdays for outpatients although the department provided a service to breast services on Saturdays and Sundays as required. For inpatients and trauma there was a 24 hour, seven days a week plain film and CT service and the ultrasound service was extended until 8pm for inpatients from Mondays to Thursdays. A mobile breast screening service was provided on weekdays and one Saturday per month. There was a shuttle bus to provide patient transport between the hospitals at Stockton and Hartlepool.

There was a hub and spoke arrangement with neighbouring trusts to provide the following services for local residents: dermatology; both consultant and nurse led treatments, ENT (ear, nose and throat), plastic surgery, vascular, ophthalmology, oral surgery, oncology, nephrology, psychiatry and genetics. Visiting consultants utilised resources including treatment rooms, diagnostics, nurses and some reception staff provided by the trust.

Orthopaedic clinics included Upper limb – including one stop shoulder clinics, musculoskeletal ultra-sound, shoulder and elbow clinics, hand and wrist clinics and therapist-led clinics. Lower limb – including hip and knee clinics, joint replacement clinics, foot and ankle clinics, acute knee injury clinics and therapist-led knee clinics. Trauma clinics – including new injury clinics, fracture review clinics, new hand injury clinics and dressings clinics, spinal clinics, physiotherapy for new fractures patients. There was a plaster room service for the treatment of trauma clinics, post-operative patients as well as specialised services for podiatry and paediatric patients. Nurse led clinics provided sessions for orthopaedics, trauma review and telephone review clinics.

Outpatients and diagnostic imaging

Clinics not held in the main outpatient department included: Lung health, including nurse led clinics and Rheumatology. Women's Out patients clinics included Specialist gynaecology, colposcopy, rapid access, pessary clinics and, obstetrics. In addition there were clinics for high risk anaesthetics and glucose tolerance test clinics. Clinics were led by different professionals who included nurses, allied health professionals and doctors.

Diagnostic imaging and outpatient services were mainly provided from four locations: University Hospital of North Tees at Stockton, University Hospital of Hartlepool, the One Life Centre at Hartlepool and Peterlee Community Hospital. The acute clinical work was concentrated at the University Hospital of North Tees which offered a range of diagnostic imaging and interventional procedures, as well as substantial plain film reporting and ultrasound service. Diagnostic imaging services were managed by a clinical lead radiologist, who was also the head of service.

During the inspection at University Hospital of North Tees we spoke with 19 patients and five relatives, 14 nurses, three health care assistants, 10 allied health professionals, one phlebotomist, one student radiographer, and eight doctors. We observed the diagnostic imaging and outpatient environments, checked equipment and looked at patient information.

Summary of findings

Overall the care and treatment received by patients in the University Hospital of North Tees outpatient and diagnostic imaging departments was safe, caring and responsive. Patients were very happy with the care they received and found it to be caring and compassionate. Staff worked within nationally agreed guidance to ensure that patients received the most appropriate care and treatment for their conditions. Patients were protected from the risk of harm because there were policies in place to make sure that any additional support needs were met. Staff were aware of these policies and how to follow them. The departments learned from complaints and incidents and put systems in place to avoid recurrences.

We rated well-led as requires improvement. Senior managers were familiar with the trust's vision for the future of the outpatients department and were aware of the risks and challenges. However staff told us they felt the service was fragmented and changes to meet current and future departmental needs could not be considered because there was no clear departmental strategy following a pause in plans for a new hospital at Stockton. It was not always possible to see from the risk register which risks had been managed and which were still waiting to be actioned. The expected implementation of an electronic booking system that was due in September 2015 was not identified as a risk at the time of inspection and was not included in the departmental or trust risk registers. The diagnostic imaging department had good leadership and management and staff told us they were kept informed and involved in strategic working and plans for the future.

Outpatients and diagnostic imaging

Are outpatient and diagnostic imaging services safe?

Good

The level of care and treatment delivered by the outpatient and diagnostic imaging services was good. Staffing levels were based on the knowledge and expertise of department managers and were flexible to meet the different demands of clinics and patients. There were sufficient staff to make sure that care was delivered to meet patient needs.

Incidents were reported using the hospital's electronic reporting system. Incidents were investigated and lessons learned were shared with all of the staff. The cleanliness and hygiene in the departments was within acceptable standards. Personal protective equipment (PPE) was readily available for staff and was disposed of appropriately after use. Guidelines around the use of PPE by staff drawing blood required updating in line with WHO (World Health Organisation) best practice.

Staff were aware of the various policies designed to protect vulnerable adults or those with additional support needs. Patients were asked for their consent before care and treatment was given. Patients were, on the whole, protected from receiving unsafe care because diagnostic imaging equipment and staff working practices were safe and well managed. Medical records were available for outpatient clinics, with a few exceptions and electronic records were available to supplement these if necessary. Staff in all departments were aware of the actions they should take in the case of a major incident.

Incidents

- The departments had robust systems to report and learn from incidents and to reduce the risk of harm to patients.
- The trust used an electronic system to record incidents and near misses. Staff we spoke with had a good working knowledge of the system and said they could access the system and knew how to report incidents. Staff were able to give examples of incidents that had occurred and investigations that had resulted in positive changes in practice.
- There had been no never events reported and a total of 55 incidents, of which one was classed as a serious incident, were reported across the Trust in the 12 month period from June 2014 to May 2015. Themes included patient accidents and two breaches of data protection where letters had been sent to the incorrect patient or address. The trust had carried out an audit of patient letters to address this problem and instigated actions to prevent further occurrences.
- Following a serious incident involving a grade 3 pressure ulcer caused by a poorly fitting plaster cast the orthopaedic outpatient team carried out an investigation, developed staff education and patient information, amended assessment tools and established a direct line contact telephone number for patients. We observed a patient attending the new drop-in facility for this purpose and minor adjustments were made to ensure they were more comfortable and the risk of a pressure ulcer was significantly reduced.
- It had been suggested that outpatient staff could reduce the level of life support training to basic life support (BLS) but following a cardiac arrest in the outpatient department, a team brief was held and staff were given the opportunity to reflect on their involvement, what went well, what could have been done differently and identified training requirements, as a result of this intermediate life support (ILS) training for all staff had continued.
- There had been six radiological incidents reported under ionising radiation medical exposure IR(ME)R in the previous year. All of these were low level and included two incidents of imaging the incorrect body part, two incidents of incorrect patient demographics, one incident of previous history checks not being carried out and one incident of a previous scan not being documented so the procedure was repeated unnecessarily. Trusts are required to report any unnecessary exposure of radiation to patients. There was evidence that these had each been investigated, clear actions had been taken and appropriate action plans implemented as a result of learning. A standard operating procedure (SOP) was being developed for staff to follow and all staff who requested x-rays had been given the opportunity to shadow radiographers to understand radiology requirements as part of their training and medical staff in the accident and emergency department had been reminded that they must log in to the radiology requesting form correctly to ensure that the correct referrer details were shown.

- Radiology discrepancy incidents were discussed by case review with radiologists and referring clinicians. Medical staff took the opportunity to learn, work as a multidisciplinary team and exercise the primary stage of duty of candour when agreeing that a patient should be informed of a reporting error.
- Staff told us that safety and security did not cause concerns for staff. Diagnostic imaging staff had access to CCTV images of department entrances out of hours.
- Staff were aware of their responsibilities in terms of the recently introduced Duty of Candour regulations and all staff described an open and honest culture. We saw evidence of telephone call logs and letters to patients offering an apology and information regarding incidents and complaints.

Cleanliness, infection control and hygiene

- Nursing staff undertook a daily rounding system where cleanliness of the environment, hand hygiene and compliance with checklists and signatures were checked.
- The infection control nurse team for the trust carried out regular hand-washing audits. Compliance varied between 86% and 100% across all departments with the most recent all achieving 100%. Results were fed back to staff at staff meetings and collated for Infection Control. The results were displayed on the department notice boards.
- Personal protective equipment (PPE) such as gloves and aprons was used appropriately in most areas and available for use throughout the departments and, once used, was disposed of safely and correctly. We observed PPE being worn when treating patients and during cleaning or decontamination procedures. All areas had stocks of hand gel and paper towels.
- Staff in phlebotomy (taking blood for laboratory testing) chose not to wear gloves during venepuncture interventions. Trust PPE protocol allowed staff to choose whether or not to wear gloves but suggested it was safe practice to do so and that gloves must be worn if patients had suspected blood borne infections such as hepatitis. The phlebotomy staff had no access to patient records and therefore did not know what conditions a patient might have. The practice of wearing gloves is recommended by the World Health Organisation in the WHO Guidelines on Drawing Blood: best practices in phlebotomy (2010) which state, “wear non-sterile, disposable gloves for performing venepuncture, change gloves after contact with each patient. After use remove gloves promptly and discard”. Phlebotomy staff did however follow appropriate hand hygiene practices of washing hands between each patient.
- We saw, and patients reported, that staff washed their hands regularly before attending to each patient.
- PLACE (patient led assessment of the care environment) audit had been completed in February 2015. Scores for main outpatients were 97% for cleanliness, 75% for privacy, dignity and wellbeing and 100% for condition, appearance and maintenance. There were a number of actions identified within the outpatients and diagnostic imaging departments. During our inspection, we saw that these actions had been carried out but no actions had been completed on the action logs. The diagnostic imaging department, outpatient areas and clinic rooms were clean, tidy and uncluttered, and we saw staff maintaining the hygiene of the areas by cleaning equipment in between patient use, reducing the risk of cross-infection or contamination.
- Patient waiting and private changing areas were clean and tidy. Single sex and disabled toilet facilities were available and these areas were visibly clean.
- We saw that treatment rooms and equipment in outpatients were cleaned regularly. Diagnostic imaging equipment was cleaned and checked regularly. Rooms used for diagnostic imaging were decontaminated and cleaned after use. Processes were in place to ensure that equipment and clinical areas were cleaned and checked regularly. The trust conducted unannounced cleaning audits to ensure that all areas had been checked and signed off clean. Decontamination audits had been carried out in all outpatients departments in 2014 and recommendations had been made to improve safety and cleanliness.

Environment and equipment

- Equipment throughout the departments was calibrated, maintained and maintenance contracts were managed by the medical engineering department.
- Most areas we inspected were clean, well maintained and most areas were spacious and bright. Consulting, treatment and testing rooms were well stocked and equipment labelled as clean was clean. However the phlebotomy room was cluttered and untidy. We were

told that the room was cleaned after the last patient at night but no cleaning, for example, damp dusting of treatment surfaces was done in preparation before the first patient each morning.

- Resuscitation trolleys for adults and children, and equipment including suction and oxygen lines were all checked and cleaned daily and checklists were signed and found to be up to date. Trolleys were locked and tagged and staff made regular checks of contents and their expiry dates.
- Reception areas were open plan and spacious. There was sufficient seating and most clinical areas we saw had very few patients waiting for consultations. Seating was in good condition.
- Although waiting times were short, the diagnostic imaging department had no areas orientated towards young patients. Staff told us that there had been some toys to distract and entertain children in the past but these had been removed because they were considered to be an infection control risk. This showed a lack of consistency in approach to infection prevention and control since the main outpatients department had some toys. There was also a small waiting area orientated towards children attending with adults or those attending fracture clinics. The children's outpatient department was located separately on the main hospital site.
- We saw, and staff confirmed that, there was sufficient equipment to meet the needs of patients within the outpatients and diagnostic imaging departments.
- A report on the diagnostic imaging equipment across all trust diagnostic imaging departments carried out by the Radiation Protection Advisor for 2014 had identified that some pieces of equipment required replacement and a programme had been put in place to manage this. There were no other concerns about the diagnostic imaging departments across the trust.
- During our observations we saw that there was clear and appropriate signage regarding radiological hazards in the diagnostic imaging department.
- Staff wore dosimeters and lead aprons in diagnostic imaging areas. This was to ensure that they were not exposed to high levels of radiation and dosimeter audits were used to collate and check results. Results were lower (better) than the previous year, but not significantly different, and within the acceptable range.
- In diagnostic imaging, quality assurance (QA) checks were in place for equipment. These were mandatory checks based on the ionising regulations 1999 and the ionising radiation (medical exposure) regulations (IR(ME)R) 2000. These protected patients against unnecessary exposure to harmful radiation.
- Risk assessments were carried out with ongoing safety indicators for all radiological equipment, processes and procedures. These were easily accessible to all diagnostic imaging staff.
- Staff in diagnostic imaging were able to demonstrate safety mechanisms to ensure patient doses for radiation were recorded.
- The design of the environment kept people safe. Waiting and clinical areas were clean. There were radiation warning signs outside any areas that were used for diagnostic imaging. Illuminated imaging treatment room no entry signs were clearly visible and in use throughout the departments at the time of our inspection.
- Specialised personal protective equipment was available for use by staff within radiation areas and some new flexible radiation guarding equipment was being trialled for interventional procedures. A forehead dosimeter had been used to measure exposure to operators' eyes and this was found to be within safe levels.

Medicines

- We checked the storage and management of medicines and found effective systems in place. No controlled drugs were stored in the outpatients department. Small supplies of regularly prescribed medicines were stored in locked cupboards and where appropriate, locked fridges. We saw the record charts for the fridges which showed that the temperature checks were carried out daily and that temperatures were maintained within the acceptable range. All medicines we checked were in date.
- There had been a medicines management audit carried out in some departments with results disseminated to staff and an action plan had been drawn up. However, we were told that no formal drugs audits or stock checks were carried out in outpatients by staff or the pharmacist although the trust told us they were planning to put these in place.
- Medicines management training figures were 100% for registered nurses across the outpatients and diagnostic imaging departments.

- In the diagnostic imaging department some interventional procedures required sedation and pain relief and these included controlled drugs. These medicines were prescribed by the consultant radiologist carrying out the procedure and administered by the specialist radiology nurse in attendance. All medication used was documented and a controlled drugs book was kept with patients during procedures. Two nurses carried out monthly controlled drugs checks and the pharmacist audited every 3 months (including updates and training). Monthly stock checks were made and expiry dates were checked. We saw evidence of dated and signed checklists.
- PGDs (patient group directions) for drugs used in the outpatients and diagnostic imaging departments were in place and had been reviewed appropriately.

Records

- Records in the outpatient department were a mixture of paper based and electronic. Within the diagnostic imaging department, records were digitised and available to be viewed across the trust.
- Records contained patient-specific information relating to the patient's previous medical history, presenting condition, demographic information and medical, nursing and allied healthcare professional interventions.
- Records management and preparation for clinics in outpatients was complicated due to the use of several different processes. Some records contained only information relevant to the actual appointment with electronic information available via a computer terminal in each consulting room and some were totally paper based. Records were transported to and from the department in trollies and transferred to department trollies before each clinic.
- Staff told us that some patients' medical records were unavailable for clinics and that this was reflected in their incident reporting if a whole clinic's notes did not turn up. At University Hospital of North Tees 95.2% of records were available for outpatient clinics. Some letters and discharge summaries were stored electronically through the electronic document portal and provided back up when patients' notes were unavailable. Staff agreed that a patient would always be seen as long as there was some information about them available and temporary notes would be created for the episode and merged with main records when available.
- Staff reported as an incident if all of the records for an entire clinic were missing, but would not report an incident if a single set of records was missing from a clinic.
- Medical records were stored in lockable trollies for each clinic in the main outpatients department. This ensured records were safe and confidential until the point of need. However, in other outpatient areas there was not sufficient room for lockable trollies and records were kept at reception desks until patients arrived.
- Patients were required to place their clinic letter into an open box on the wall in each clinic area. The staff used this system to show that a patient was waiting to be seen. We noted problems with this system; letters were open and anybody could have read the patient details and confidential information; we noticed on more than one occasion patients waiting a long time and staff had to remind them to hand over their letters. When we asked staff whether they thought the system was confidential and effective we were told it worked well.
- For appointments that were conducted by doctors from another trust, there was an efficient system in place where the files were sent over from the host trust a day or two before each clinic. The reception staff kept the files so that they could contact the patients if the clinic was cancelled at short notice. If there was a secretary coming from the other trust, they would bring the files on the day.
- We reviewed 16 patient records which were completed with no obvious omissions. Nursing assessments of blood pressure, weight, height and pulse were routinely completed. We observed these checks being undertaken during our inspection.
- Diagnostic imaging and reports were stored electronically and available to clinicians via PACS (Picture Archiving and Communications System).

Safeguarding

- All staff we spoke to were aware of safeguarding policies and procedures and knew how to report a concern. They knew that support was available if they needed it or they had a query. Staff in the diagnostic imaging department had made a safeguarding alert about suspected abuse and had received feedback on the outcome.

- According to information provided by the trust, 100% of applicable staff had undergone safeguarding adults Level 1 (alerter) and 100% had completed safeguarding children level two training.
- Patient details for patients who did not attend appointments were checked by staff for any issues of concern. Patients were followed up after failing to attend and referrers were informed. The Child DNA process had been reviewed with the development of operational guidelines in the form of a SOP following a recent incident in orthopaedic outpatients. The vulnerable adult DNA process had been reviewed within the department and managers were developing operational guidelines in the form of a SOP which would be rolled out in orthopaedics and main outpatient departments.

Mandatory training

- The outpatient and diagnostic imaging departments had systems and processes provided by the trust to ensure staff training was monitored although the inspection team found this information difficult to interpret. Trust standards for mandatory training were identified and compliance against those was recorded.
- The trust told us that staff were allowed sufficient time to attend face-to-face training and to work through workbooks.
- Monthly red, amber and green (RAG) reports on mandatory training were produced and distributed by Training and Development. Departmental managers monitor compliance regularly and ensured that all staff were up to date with reviews. Time out was provided for staff to work through workbooks and attend face-to-face training as required.
- Mandatory training compliance for outpatients across all sites varied slightly between staff groups. The trust did not meet its own compliance standard for patient handling which was 75% for plaster room staff.
- Mandatory training compliance for diagnostic imaging varied between staff groups and the rates were collated across the whole Trust because staff were managed centrally and many rotated across sites. Fire Safety training compliance ranged between 71% and 100% and patient handling was 43% for allied health professionals

Assessing and responding to patient risk

- There were emergency assistance call bells in all patient areas, including consultation rooms, treatment rooms and diagnostic imaging areas. Staff confirmed that, when emergency call bells were activated, they were answered immediately.
- Staff were aware of actions to take if a patient's condition deteriorated while in each department and explained how they could call for help, access the paediatric and adult cardiac arrest teams and the process for transferring a patient to the Accident and Emergency Department. There were also a number of resuscitation trolleys and defibrillators across outpatients and diagnostic imaging departments which were available.
- There were policies and procedures in the diagnostic imaging department to ensure that the risks to patients from exposure to harmful substances was managed and minimised.
- The Radiation Protection Adviser report from March 2014 highlighted that all new equipment had been risk-assessed to ensure the safety of staff and patients.
- Diagnostic imaging policies and procedures were written in line with the Ionising Radiation (Medical Exposure) 2000 regulations. IR(ME)R
- There were named certified Radiation Protection Supervisors to give advice when needed and to ensure patient safety at all times. The trust had radiation protection supervisors (RPS) and liaised with the Radiation Protection Advisor (RPA).
- Two senior radiologistswere Administration of Radioactive Substances Advisory Committee **(**ARSAC) certificate holders for diagnostic imaging. They led on the development, implementation, monitoring and review of the policy and procedures to comply with Ionising Radiation (Medical Exposure) 2000 regulations. IR(ME)R.
- Arrangements were in place for radiation risks and incidents defined within the comprehensive local rules. Local rules are the way diagnostics and diagnostic imaging work to national guidance and vary depending on the setting. Policies and processes were in place to identify and deal with risks. This was in accordance with (IR(ME)R 2000).
- Staff asked patients if they were or may be pregnant in the privacy of the x-ray room therefore preserving the privacy and dignity of the patient. This was in accordance with the radiation protection requirements

and identified risks to an unborn foetus. We saw different procedures were in place for patients who were pregnant and those who were not. For example patients who were pregnant underwent extra checks.
- Outpatients and diagnostic imaging used early warning scores to monitor and manage patient risk. Patients were assessed and given scores which directed how the patient was then managed and treated.
- The outpatients and diagnostic imaging departments utilised risk assessments for patient management including; a risk assessment for plaster cast application and management and the World Health Organisation (WHO) checklist for invasive procedures. Staff were trialling an adaptation of the WHO checklist in an outpatient setting and had previously used a local format within the department. Diagnostic imaging and endoscopy departments used the WHO safer surgical checklist for all interventional procedures.

Nursing and allied health professional staffing

- We looked at the staffing levels in each of the outpatient and diagnostic imaging departments. There were very few vacancies and managers told us that staff retention was high. All department managers told us that staff were flexible to be able to ensure cover was available. Staff told us there were sufficient staff to meet service and patient needs and that they had time to give to patients.
- Managers told us they were able to adjust the number of staff covering clinics to accommodate those that were busy or where patients had greater needs. Rotas were compiled based upon activity within the departments.
- Within the diagnostic imaging departments, there were sufficient radiography and nursing staff to ensure that patients were treated safely. There were current vacancies; however, these were being recruited to
- Planned and actual numbers of staff on shift were displayed and matched demand.
- There was liaison across main and orthopaedic outpatients services and across sites for staffing with areas supporting each other where possible.
- Managers told us that staff sickness was monitored and that rates were consistently very low. Sickness rates for staff within the departments for the period between April 2014 and March 2015 ranged between 0% and 21% with the highest levels occurring in January 2015. The average sickness rate for the period between October 2014 and March 2015 was 7% in outpatients and 3% in radiology.

Medical staffing

- Medical staffing was provided to the outpatient department by the various specialties which ran clinics. Medical staff undertaking clinics were of all grades; however, we saw that there were consultants available to support lower grade staff when clinics were running.
- There was a national shortage of radiologists and the trust had had three vacancies in the previous 12 months, two of which had recently been recruited to, leaving just one to be filled. We were told that the trust seemed to find it easier to recruit radiologists than other local trusts. At the time of our inspection, there were sufficient staff to provide a safe and effective service. There were 10 consultant radiologists, one breast specialist radiologist (plus one vacancy as above); one long-term locum and two consultants who had recently retired from the trust provided additional support. 2.5 WTE specialist radiology registrars rotated through trusts in the northeast and were supernumerary.
- Some diagnostic imaging reporting was outsourced at times of need such as summer holidays and the Christmas period. There was a service level agreement and contract in place for this. At other times, medical staff undertook additional reporting and on-call work with locally agreed trust overtime arrangements.

Major incident awareness and training

- There was a major incident policy and staff were aware of their roles in the case of an incident. Staff contact lists were checked every 6 months to ensure up to date details were available.
- There were business continuity plans to make sure that specific departments were able to continue to provide the best and safest service in the case of a major incident. Staff were aware of these and able to explain how they put them into practice.

Are outpatient and diagnostic imaging services effective?

Organisation of clinics in main outpatients lacked robust management and staff working in the department had lost

focus and motivation. Information about which clinics would run on behalf of other trust specialties was regularly missing and staff were unable to plan resources effectively. Recording of actions completed following audits and checks within the outpatients department lacked rigour. Action plans were minimal and documentation was not completed to show if actions had been carried out.

Staff understood about consent although no staff had received Mental Capacity Act training. There were no established models of regular nursing clinical supervision in outpatients and staff received different types and frequency of informal supervision depending on their area of work.

Referral to treatment times met national targets. Outpatient clinics ran every weekday and a trauma clinic was held each Saturday morning. Care and treatment was evidence-based and targets were met consistently. The staff in the departments were competent and there was evidence of multidisciplinary working across teams and local networks in some specialities.

Diagnostic imaging services for inpatients were available seven days a week and service availability was increasing and continuously improving. Diagnostic imaging staff undertook regular departmental and clinical audits to check practice against national standards and action plans were put in place and monitored to make improvements when necessary.

Evidence-based care and treatment

- We saw reviews against IR(ME)R regulations and learning disseminated to staff through team meetings and training.
- The trust had a radiation safety policy in accordance with national guidance and legislation. The purpose of the policy was to set down the responsibilities and duties of designated committees and individuals. This was to ensure the work with Ionising Radiation undertaken in the Trust was safe as reasonably practicable.
- The trust had radiation protection supervisors for each modality to Lead on the development, implementation, monitoring and review of the policy and procedures to comply with Ionising Radiation (Medical Exposure) 2000 regulations. IR(ME)R.
- National Institute for Health and Care Excellence (NICE) guidance was disseminated to departments. Staff we spoke with were aware of NICE and other specialist guidance that affected their practice. For instance, radiology specialist nurses had implemented research-based practice using NICE guidance. and had developed standard operating procedures for new work within the department, for example a clinic for patients to receive an injection used in prostate cancer treatment.
- Procedures were in place to ensure the diagnostic imaging department were following appropriate NICE guidance regarding the prevention of contrast induced acute kidney injury and evidence based recovery documentation was completed following interventional procedures which included NEWS (national early warning system) forms.
- The departments were adhering to local policies and procedures. Staff we spoke with were aware of the impact they had on patient care.
- The diagnostic imaging department carried out quality control checks on images to ensure that the service met expected standards.

Pain relief

- Simple pain relief medication was administered if required by staff in the outpatients department. Records were maintained to show medication given to each patient.
- Patients we spoke with had not needed pain relief during their attendance at the outpatient departments.
- Diagnostic imaging staff carried out pre-assessment checks on patients prior to carrying out interventional procedures. Pain relief for procedures such as biopsies was prescribed by radiologists and administered safely as required.

Nutrition and hydration

- Water fountains were provided for patients' use and there were shops and a large hospital café where people could purchase drinks, snacks and meals.

Patient outcomes

- The trust provided us with information about the previous 11 months appointments which showed that the trust outpatient departments saw 141,213 patients. Of these, 55,918 were new appointments and 85,295 were review appointments.
- According to information supplied by the trust, the percentage of appointments cancelled by the trust was

consistently low with an average over the previous four months of 0.68% which was much better than the England average of 6%. The main reasons given for cancellations were annual leave, on-call changes and sickness.

- The percentage of patients waiting over 30 minutes to see a clinician data was not regularly collected by the Trust but a snapshot taken in March 2015 revealed that delays affected 5.5% of all surgical patients and 2.5% of orthopaedic outpatients. Staff did inform patients about delays and the reasons for them.
- After receiving care and treatment, patients were either given another appointment or provided with information about the follow-up appointment process (for example six monthly or yearly reviews) when they would be sent an appointment letter.
- All diagnostic images were quality checked by radiographers before the patient left the department. National audits and quality standards were followed in relation to radiology activity and compliance levels were consistently high.
- Safety and workflow audits had been carried out to establish diagnostic imaging requirements and patient waiting times during orthopaedic clinics. We saw results and action plans regarding the outcomes of these audits.
- Dermatology nurses carried out outcomes for psoriasis following light treatment; initial assessment was completed prior to treatment and patients were assessed after treatment. Staff were able to demonstrate a great improvement in outcomes.

Competent staff

- There were systems within departments to make sure that staff received an annual appraisal.
- In diagnostic imaging and outpatients 100% of all staff had taken part in appraisals within the last 12 months. In all departments staff were encouraged to discuss development needs at appraisal and as opportunities arose.
- Advanced practitioner and leadership strategy courses had been undertaken and more staff identified to attend for the year ahead.
- Staff in Radiology and outpatients completed trust and local induction which was specific to their roles.
- Radiology preceptorship competencies and medical devices training was monitored and well documented and staff undertook clinical peer support and one to one supervision meetings. Staff were supported to carry out continuous professional development activities, complete mandatory training, appraisal and specific modality training. Students were welcomed in all departments. Radiography students came for 12-month placements and two radiographer students were interviewed as part of the inspection. They both felt supported and enjoyed working within the department.
- There were no established models of regular nursing clinical supervision in use in outpatients and staff received different types and frequency of informal supervision depending on their area of work. Although the trust Clinical Supervision Strategy stated that "Clinical supervision is mandatory for prescribing nurses / health visitors and non- medical prescribers working within North Tees and Hartlepool Foundation Trust. Clinical supervision sessions provide an opportunity for reflection in prescribing, as well as other aspects of practice".
- Therapists took part in peer reviews.
- Radiologists working in interventional roles were trained in specialist areas by the clinical leads, for example in breast clinics, fluoroscopy and angiography.
- Nominated key staff were identified to attend and feedback information on medical devices, Infection control, tissue viability, Safeguarding, dementia, vulnerable adults, sensory loss and health promotion.
- Medical revalidation was carried out by the trust. There was a process to ensure that all consultants were up to date with the revalidation process.
- Outpatients staff were encouraged to question practice if they had any concerns. Local protocols and competencies had been agreed. Competency packs for staff were held within the departments and staff were encouraged to attend courses to update their skills and knowledge where appropriate; All new staff were allocated a mentor within the departments who would support staff to achieve competencies. Staff would not work unsupervised in an area that they were not deemed competent.
- Recruitment and selection procedures were followed to ensure staff were appropriately skilled and had relevant knowledge.

Multidisciplinary working

- Outpatient clinics, run by other Trusts were hosted by the outpatients department. Staff told us that they were able to raise issues directly with them. However,

managers told us that a general lack of communication between teams often prevented information being passed on and therefore staff and patients were sometimes not informed that clinics were cancelled.
- There was evidence of multidisciplinary working in the outpatients and diagnostic imaging department. For example, nurses and medical staff ran joint clinics and staff communicated with other departments such as diagnostic imaging and community staff when this was in the interest of patients.
- Specialist nurses ran clinics alongside consultant-led clinics.
- We saw that the departments had links with other departments and organisations involved in patient journeys such as GPs, support services and therapies.
- A range of clinical and non-clinical staff worked within the outpatients department. Staff were observed working in partnership with a range of staff from other teams and disciplines, including radiographers, physiotherapists, nurses, booking staff, and consultant surgeons.
- Staff were seen to be working towards common goals, asked questions and supported each other to provide the best care and experience for the patient.
- Managers or senior staff in all outpatient and diagnostic imaging departments held daily staff meetings. All members of the multidisciplinary team attended and staff reported that they were a good method to communicate important information to the whole team.
- Specialty MDT meetings were attended by staff from the specialist clinical areas and outpatients department including nurses, physiologists, consultant leads and radiologists. These meetings were held weekly and the teams discussed management plans as well as case reviews and sharing of best practice.
- MDT work took place in specialist clinics including respiratory, dermatology, vascular and plastics. Physiotherapy clinics were provided alongside the trauma clinics and extended scope physiotherapists and ultrasonographers worked alongside some consultant clinics.
- Staff were able to refer to the intermediate care team who were based in accident and emergency.
- The plaster room service received referrals from podiatry and physiotherapy. Plaster technicians also attended accident and emergency and theatres as required.

Seven-day services

- Diagnostic imaging provided services seven days a week. Outpatient services were available Monday – Friday with trauma clinics on Saturdays and bank holidays. Additional clinics could be added to ensure that the trust met their waiting list targets.
- The diagnostic imaging department provided general radiography, CT, ultrasound scanning and fluoroscopy services for outpatients and inpatients every day. There was a rota to cover evenings and weekends so that patients could access diagnostic imaging services when they needed to.
- Magnetic resonance imaging (MRI) was provided by a private organisation 12 hours a day, seven days a week with emergency cover for the remaining times.

Access to information

- All staff had access to the trust intranet to gain information relating to policies, procedures, NICE guidance and e-learning.
- Staff were able to access patient information such as diagnostic imaging records and reports, medical records and physiotherapy records appropriately through electronic records. Systems and processes were in place if patient records were not available at the time of appointment.
- Diagnostic imaging departments used picture archive communication system (PACS) to store and share images, radiation dose information and patient reports. Staff were trained to use these systems and were able to access patient information quickly and easily. Systems were used to check outstanding reports and staff were able to prioritise reporting so that internal and regulator standards were met. There were no breaches of standards for reporting times.
- The diagnostic imaging department kept an electronic list of approved referrers and practitioners. This ensured that all staff, both internal and external, could be vetted against the protocol for the type of requests they were authorised to make.
- Orthopaedic surgeons used image intensifiers in theatres with automatic reporting facilities with protocol in place to support and monitor these. Radiologists advised surgeons on safe practices regarding IR(ME)R regulations.

- There were systems in place to flag up urgent unexpected findings to GPs and consultants. This was in accordance with the Royal College of Radiologist guidelines.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- Nursing, diagnostic imaging, therapy and medical staff understood their roles and responsibility regarding consent and were aware of how to obtain consent from patients. They were able to describe to us the various ways they would do so. Staff told us that, , consent was usually obtained verbally although consent for any interventional radiology was obtained in writing prior to attending the diagnostic imaging department.
- Staff in outpatients and diagnostic imaging services had undertaken Mental Capacity Act Training and Deprivation of Liberty Safeguards training as part of adult safeguarding training and they told us that if any queries arose in the outpatient setting they would contact the named leads within the trust for advice. The trust told us that procedure specific formal consent protocols were being introduced into both the main outpatient and orthopaedic outpatients departments and that Mental Capacity Act and Deprivation of Liberty Safeguards information was kept in each department.
- Patients told us that staff were very good at explaining what was happening to them prior to asking for consent to carry out procedures or examinations.

Are outpatient and diagnostic imaging services caring?

Good

During the inspection, we saw and were told by patients, that the staff working in the outpatient and diagnostic imaging departments were kind, caring and compassionate at every stage of their journey and patients were given sufficient time for explanations about their care and were encouraged to ask questions. People were treated respectfully and their privacy was maintained in person and through actions of staff to maintain confidentiality and dignity. We raised concerns with staff about confidentiality of written information when patient letters were stored in open boxes in clinic corridors. There were services to emotionally support patients and their families. Patients were kept up to date and involved in discussing and planning their treatment and were able to make informed decisions about the treatment they received.

Compassionate care

- Staff in outpatients and diagnostic imaging were caring and compassionate to patients. We observed positive interactions with patients. Staff approached patients and introduced themselves, smiling and putting patients at ease.
- Clinic names were not displayed in order to maintain privacy and confidentiality.
- Patients' privacy and dignity was respected by staff. Consultation and treatment rooms had solid doors and patients could get changed before seeing a clinician. Staff were observed to knock on doors before entering and doors closed when patients were in treatment areas.
- We spoke with 19 patients and 5 people close to them and all said that staff were friendly with a caring attitude. There were no negative aspects highlighted to us.
- We observed staff behaving in a caring manner towards patients they were treating and communicating with and respecting patients' privacy and dignity throughout their visit to the department.
- The Friends and Family Test (FFT) had been rolled out fully in outpatients and managers told us that feedback through FFT demonstrated that outpatients staff in main and orthopaedic outpatients were caring. Results from the previous 4 months' results were consistent and the most recent results from June 2015 showed that 93% of outpatients and 86% of orthopaedic outpatients would recommend the service (the England average was 92%) and 2% of patients would not recommend it (better than the England average of 3%).
- Therapists carried out comprehensive patient feedback audits. We saw information collected and results had been published. Most audits carried out in the previous 12 months showed 100% patient satisfaction with the care they had received

Understanding and involvement of patients and those close to them

- Patients told us that they were involved in their treatment and care. Those close to patients said that they were kept informed and involved by nursing and

medical staff. All those we spoke with told us that they knew why they were attending their appointment and they had been kept up to date with their care and plans for future treatment.
- Outpatients and diagnostic imaging staff involved patients in their treatment and care. We saw staff explaining treatment.
- Staff told us that families were invited into the consulting room as long as the patient was agreeable.
- Patients and families were given time to ask questions.

Emotional support

- Patients told us that they felt supported by the staff in the departments. They reported that, if they had any concerns, they were give the time to ask questions.
- Staff made sure that people understood any information given to them before they left the departments. Emotional support for patients was available. For example, specialist nurses and psychologists worked with the clinical teams in the breast services department and were present for extra support when patients received bad news.

Are outpatient and diagnostic imaging services responsive?

Good

We found that outpatient and diagnostic services were responsive to the needs of patients who used the services. Extra clinics and scanning sessions were added to meet demand. Waiting times were within acceptable timescales, with outpatient DNA (did not attend) rates worse than the average for Trusts in England. Patients were able to be seen quickly for urgent appointments if required.

Clinics and related services were organised so that patients were only required to make one visit for investigations and their consultation. Some patients' conditions were monitored remotely which reduced the need for some very frequent or urgent appointments. New appointments were rarely cancelled but review appointments were often changed.

There were mechanisms to ensure that services were able to meet the individual needs, such as for people living with dementia, a learning disability or physical disability, or those whose first language was not English. There were also systems to record concerns and complaints raised within the department, review these and take action to improve patients' experience.

Service planning and delivery to meet the needs of local people

- The outpatients department flexed capacity and staffing to meet demand. Extra clinics were added to ensure provision met demand for example an increased referral pattern was noticed for general surgery so two extra clinics had been scheduled. Capacity issues were discussed with heads of departments at Patient Tracking Line meetings every two weeks for each specialty and with the clinicians.
- Clinics were organised to meet patients' needs. Specialist clinics were organised so that all investigations and consultations happened on the same day. Joint assessments and treatment were carried out by clinicians, nurses and therapists and a regular Saturday morning fracture clinic was scheduled.
- A phlebotomist was located within the outpatients department and patients took their own request forms with printed identification labels to be attached to blood samples.
- Management teams in outpatients and diagnostic imaging had noted a significant increase in demand for respiratory and CT services. The teams anticipated a 7-10% overall increase in activity in the coming year and they had calculated that two additional respiratory physicians and two new radiologists would be required. Recruitment to these posts was underway.
- Staff meetings were held first thing in the morning to plan for the day ahead. They discussed each clinic taking place, previous performance in terms of appointment utilisation and over runs and highlighted concerns such as patient numbers or cancellations. They discussed the previous day's activity such as late starts and overruns.
- The diagnostic imaging department had good processes in place and the capacity to deal with urgent referrals and additional scanning sessions were arranged to meet patient and service needs.
- Digital dictation had been introduced in diagnostic imaging to enable a swift turnaround for reports and

letters. Diagnostic imaging reporting and record-keeping was electronic and paperless methods were used to reduce time and administration requirements.
- Turnaround times for urgent radiology reports were 60 minutes for general scans and 30 minutes for suspected stroke patients.
- Managers told us that the trust were exploring moving more outpatient sessions from the hospital to community to bring care closer to the patient's home. Staff were aware that this system used a considerable amount of trust resources in terms of finance and staffing but this was a specific request from commissioners.
- There had been a recent introduction of telephone assessment for fracture patients, which aimed to improve the service for patients as well as reduce the number of DNAs.
- Both main and orthopaedic outpatients departments were responsive to additional clinic requests from clinicians to accommodate 2 week rules and short notice additional clinics.
- The trust told us that a recent patient survey had demonstrated that communication had been an issue, which led to the reinforcement of Customer Care Charter to staff.

Access and flow

- Referral to treatment times (RTT), diagnostic waiting times, cancer waiting or diagnosis times were all better than, or close to national targets. The percentage of people seen by a specialist within two weeks of an urgent GP referral was slightly worse than the England average (at 94% against the England average of 95%). However the percentage of people waiting less than 31 days from diagnosis to first definitive treatment for all cancers was consistently slightly better (87% against the England average of 84%).
- The percentage of Non admitted patients seen within 18 weeks of referral was consistently over 98% and higher (better) than the England operational standard of 95%. The percentage of patients with incomplete care pathways who started their consultant-led treatment ranged between 96 and 98%. The operational standard in England is 92%.
- Guidelines state that 95% of patients should start consultant-led treatment within 18 weeks of referral. The rate for this trust was consistently more than 98% of patients seen within 18 weeks of referral, for patients not admitted. This was consistently better than the England average.
- The trust was performing above and better than the England average for patients with all cancers being seen urgently within two weeks.
- The trust was performing consistently similar to or slightly worse than the England average for the percentage of people waiting less than 62 days from urgent GP referral to first definitive treatment for all cancers. 82% of patients were seen within 62 days for Quarter 1 of 2014/15 but this rose rapidly to better than average at 87% in Quarter 2.
- There were no review appointment waiting lists and no backlog of non-RTT patients.
- The trust used the 'Choose and Book' system. Choose and Book is a national electronic referral service which gives patients a choice of place, date and time for their first outpatient appointment in a hospital or clinic. The majority of patients used this system to make appointments and the team estimated they received an average of 250 calls per day. For other patients, booking staff made appointments then telephoned the patient to check it was suitable.
- The rates of patient non-attendance for the outpatients department for the 12 months between July 2013 and June 2014 (DNA rate) for the Trust, across all sites, averaged out at 8%. This was slightly worse than the national average of 7%. We saw there were policies in place for DNAs. Booking and reception staff were able to tell us the procedure for managing DNAs. Adults who had previously missed an appointment were telephoned the day before to remind them to attend.
- The trust's 'new to review' rate (the ratio of new appointments to follow-up) was 1:2.6. There was disparity between the two main hospital sites with University Hospital of North Tees performing at 1:2.2 (in line with the England average of 1:2.24) whilst University Hospital of Hartlepool was consistently higher than the England average at 1:3.2.
- Staff told us that staff toilets in main outpatients were not fit for purpose, because there were only two for all staff to use. The PLACE audit records showed that at one point in the previous year there had only been one staff toilet in working order.
- It was trust policy not to cancel clinics within six weeks of when they were due to run. Some were cancelled

within the six-week range but the percentage of all cancellations was 0.73% or less for every month from December 2014 to March 2015. In most cases clinics would be reduced rather than cancelled and patients told us that their review appointments were often changed and sometimes this happened more than once. We asked whether patients complained if their appointment was cancelled and staff told us "We don't get as many as we think".

- Patients were informed if clinics were running late. Patients were informed of the reason for the delay and approximate time they would be seen. If the patient could not wait a new appointment would be made. We saw staff inform patients, apologise and explain why clinics were running late. This information was also written on white boards in each clinic area. The longest wait during our inspection was one hour.
- Waits in diagnostic imaging were much shorter and patients told us they waited no more than 10-15 minutes. Staff had developed a coordination system in conjunction with the portering service where an identified radiographer controlled all patient traffic through the department to avoid delays and extended waits and to ensure best use of equipment and staff time.
- In diagnostic imaging we were told that all waiting time targets for patients following their arrival at the department were met and the most recent diagnostic imaging department dashboard confirmed this. The arrival time of the patient into the department was recorded and any unexpected delays were explained to individuals.
- The bookings team received referral letters by post and electronically. These were checked within 24 hours of receipt and forwarded to consultants for triage, to be returned within 5 days.
- Diagnostic imaging waiting times for all departments and from all urgent and non-urgent referrals met national targets. The trust was better than the England average for diagnostic waiting times. This performance declined in October 2014 due to a medical staff vacancy within cardiology but following a pathway management programme had since consistently achieved the 99% standard since that period.
- Staff carried out a continuous review of planned diagnostic imaging sessions in relation to demand and 7-day working arrangements. They organised additional inpatient CT sessions to accommodate urgent diagnostic imaging requests as necessary.
- In the diagnostic imaging department, reporting times for urgent and non-urgent procedures consistently met or were better than national and trust targets for all scans and x-rays for inpatients and outpatients.
- Patients who cancelled diagnostic imaging appointments were all re-booked to attend within the national target of six weeks of their original appointment date.

Meeting people's individual needs

- Staff could access private areas to hold confidential conversations with patients if necessary and receptionists informed staff quickly if patients had communication difficulties. .
- Staff within the main outpatient and orthopaedic department developed their own outpatient charter based upon the 6'c's (An NHS England initiative around Compassion in Practice; Care, Compassion, Competence, Communication, Courage, and Commitment) which was then rolled out to all staff within the department. Posters of the outpatient charter were displayed in all outpatient waiting areas.
- Breast and respiratory services offered a one-stop-shop approach to appointments where all investigations and consultations were carried out on the same day and patients left with a diagnosis and treatment plan. Patients we spoke with liked this approach. The service also offered interventional radiology treatments on the same day of a referral if required. This was corroborated by the consultant radiologists.
- Domiciliary visits were undertaken by orthopaedic outpatient staff to patients who were frail and vulnerable to prevent the disruption of attending hospital such as patients in nursing homes or those with terminal illnesses.
- Patients who were required to be at the hospital for long periods of time, for example those with multiple appointments or waiting for ambulances, were offered food or a snack and regular drinks by staff.
- Prisoners with escorts used separate areas of the departments for their dignity and to respect the anxieties of others.

- Bariatric furniture and equipment was available and accessible.
- Patients with learning difficulties were given the opportunity to look around the department prior to their appointment, providing a quiet room for the patient and carers to wait in or staff could reschedule an appointment to the beginning of the clinic or end of the clinic. A buzzer system could be offered to patients who may find it distressing to wait in the outpatient department main waiting area. This allowed them to leave the department and be called back immediately prior to the consultation. Staff were aware of how to support people living with dementia and had accessed the trust training programme in order to understand the condition and how to be able to help patients experiencing dementia. However, they had to rely on referrers or those accompanying patients to inform them if a patient required extra support.
- Departments were able to accommodate patients in wheelchairs or who needed specialist equipment. There was sufficient space to manoeuvre and position a person using a wheelchair in a safe and sociable manner.
- Patients had access to a wide range of information. Information was available on notice boards and leaflets.
- The bookings teams organised interpreter services for patients who did not speak or understand English. Staff told us that they experienced no difficulties in accessing interpreters. However booking staff had to rely on GPs and hospital referrers ensuring that the trust were aware of a patient's requirements. Staff told us that interpreters were preferable to friends and family to ensure that clinical messages were put across correctly and also to maintain patient confidentiality.
- There were separate toilets and waiting areas for patients who had received radioactive injections. This reduced the risk of radioactive exposure to visitors and ensured compliance with correct waste procedures.
- A daily rounding by a senior member of staff enabled patients and those close to them to express concerns and allowed staff opportunities to meet individual needs.

Learning from complaints and concerns

- Staff in all departments told us complaints were few and that the main issues were waiting times and cancelled clinics. The patient safety coordinator discussed these with the core service lead. Patterns and themes were identified and the lessons learned were shared with the team and the referring service. There were 36, concerns raised and 14 complaints documented. The majority of complaints were around clinical decisions and only 2 were about appointments.
- Staff were aware of the local complaints procedure and were confident in dealing with concerns and complaints as they arose. Managers and staff told us that complaints, comments and concerns were discussed at local team meetings, actions agreed and any learning was shared.
- None of the patients we spoke with had ever wanted or needed to make a formal complaint. Some had raised concerns during their attendance. They told us that their concerns had been dealt with professionally and, where possible, action taken to address the concern. On the whole they were happy with the experience they received from the departments.
- The complaints policy was accessible on the Trust web site. .
- Complaints were managed effectively in diagnostic imaging and we were shown actions taken to address concerns and complaints and their outcomes. A log of telephone calls was kept to show how complaints were dealt with.
- Patients had complained about the seating in all outpatient departments, and higher chairs had been purchased.

Are outpatient and diagnostic imaging services well-led?

Requires improvement

We rated well-led as requires improvement. Senior managers were familiar with the trust's vision for the future of the outpatients department and were aware of the risks and challenges. However staff told us they felt the service was fragmented and changes to meet current and future departmental needs could not be considered because there was no clear departmental strategy following a pause in plans for a new hospital at Stockton. It was not always possible to see from the risk register which risks had been managed and which were still waiting to be actioned. The expected implementation of an electronic booking system that was due in September 2015 was not identified as a risk at the time of inspection and was not included in the

departmental or trust risk registers. The diagnostic imaging department had good leadership and management and staff told us they were kept informed and involved in strategic working and plans for the future.

Local managers were active, available and approachable to staff. Business continuity plans had been developed to manage incidents, accidents and risks and these were simple to implement and effective but written action plans were not revisited to check that actions had been taken.

Regular daily meetings took place where service was planned and anticipated problems were discussed. There was an open and supportive culture where incidents and complaints were discussed, lessons learned and practice changed. Staff felt proud to work for the trust and felt they provided a good service to patients. The diagnostic imaging department was supportive of staff who wanted to work more efficiently and were able to develop to improve their practice, be innovative and try new services and treatments.

Vision and strategy for this service

- Senior managers told us that although plans to build a new hospital had been paused, the trust vision and strategy were well embedded and discussed at staff meetings. Staff told us that senior managers were approachable to ask questions or discuss their concerns but that the outpatients service was “procedures driven” and that there was no senior management or estates investment into the department. Operational staff told us they were unable to function effectively and required a new direction. .
- Managers told us that they were working with the transforming programme as part of the trust transformation strategy, looking at clinic allocations, clinic efficiency, room allocations and care closer to home and that they had a clear outpatient transformation project plan which was corporately led. However, this did not appear to be understood by staff at ground level. Staff told us that there was no overall strategy for outpatients; that discussions were taking place but they did not know what they were about.
- Staff told us that they did not have a room utilisation plan and had no control over estates so they could not make decisions on how to use resources. They felt that they provided a fragmented service and that this was often caused by lack of communication.
- The diagnostic imaging department had good leadership and management and staff told us they were kept informed and involved in strategic working and plans for the future
- The trust had a strategy for the introduction and continued use of more efficient and effective working using information technology such as electronic, records and digital dictation systems.
- A new electronic patient booking system was due to be implemented two months following our inspection which all staff were anticipating. However, it was not clear how much planning had been done and what had been achieved to date.

Governance, risk management and quality measurement

- Serious incidents were discussed at patient safety and quality meetings, led by the deputy director of patient safety. Clinical directors attended and if trends were identified such as patient falls then the training and development staff would attend to deliver training on “hot spots”.
- Following serious incidents regarding grade 3 pressure ulcers in orthopaedic patients with plaster casts, a risk assessment document was communicated through the orthopaedic clinical governance session in April 2015 and an SOP (standard operating procedure) was developed for full contact plaster casts with information cards for patients. The documents were approved at Health Records Committee and were awaiting approval prior to printing.
- Risk registers were held and controlled by Heads of Departments and staff were able to influence what risks were included. Risks were discussed by the patient safety team and learning was shared across the organisation via newsletters, regular dissemination meetings, team brief and staff communication emails.
- Actions taken by teams following root cause analysis were not well recorded and it was not always possible to see from the risk register which risks had been managed and which were still waiting to be actioned.
- The outpatient patient safety coordinator reported on risk, incidents and complaints. They told us that these issues informed each other. Staff in main outpatients told us that one outpatient department risk regarding leaking pipes in the plaster room ceiling had been escalated to the trust-wide risk register. There was a departmental risk register that was reviewed at weekly

team meetings where the team worked through risks and actions. The risk regarding confidentiality of medical records had been on the risk register for nine months before lockable notes trollies were introduced in main outpatients.

- The expected implementation of an electronic booking system that was due in September 2015 had not been identified as a risk at the time of inspection and was not included in the departmental or trust risk registers.
- Senior staff told us that a new risk manager had recently been appointed and that they intended to review the risk management processes and the risk register including current risks.
- Department managers carried out investigations of incidents and reported back to teams. The patient safety team monitored Datix reports, carried out trends analysis and sent out a trust-wide bulletin on incidents, trends and learning was shared from directorate to directorate. The trust-wide serious untoward incident (SUI) panel met on a weekly basis. The trust told us the directorate risk register was updated frequently and amber coded risks were assigned to specific staff who updated any actions and revised the risk assessment as required. However, the risk register we were presented with showed very few revisions or actions. Risks were reviewed at directorate meetings and where appropriate the outpatient staff would liaise with directorates.
- Diagnostic imaging had a separate risk management group consisting of modality (specialist diagnostic imaging services for example CT and MRI) leads, radiology risk assessors and radiology protection specialists.
- We saw minutes of the radiology protection working group where radiation protection supervisors (RPS), from specialties within the department and across all sites, raised, discussed and actioned risks identified within the department and agreed higher level risks to be forwarded to the patient safety manager.
- The organisation had systems to appraise NICE guidance and ensure that any relevant guidance was implemented in practice. In diagnostic imaging these included radiology related stroke thrombolysis and non-thrombolysis imaging times.
- Within the diagnostic imaging department, there were examples of audits taking place to ensure that NICE and other guidance was being adhered to. For example, a new flash CT scanner had been purchased following regional quality assurance group work to find out why cardiac and colon screening required higher doses of radiation than at other centres in the region. Doses and image quality improvements had been noted for lung CT, head scans and cardiac CT. CT urograms had replaced IVUs (intravenous urograms) following a national audit on the prevention of contrast induced acute kidney injury.
- The trust had introduced services to reduce the need for patients to attend as inpatients and to improve efficiency within the departments such as: the recent introduction of a designated trial removal of catheter clinic in the outpatient setting, preventing ward attendance, delays in treatment and long waits for the patient. In addition, Prostap injection clinics had been introduced each Friday afternoon. Initially patients had attended for injections at any time or any date. By providing a designated clinic staff were able to plan and provide timed appointments for patients to reduce waiting times. Transfer of traditional day case procedures into the outpatient setting; foam sclerotherapy for varicose veins, ESSure and other gynaecological procedures.

Leadership of service

- Staff found the managers of the service to be approachable and supportive. All the staff we spoke with told us they were content in their role and many staff we spoke with told us that they had worked at the hospital for many years. Staff felt that they could approach managers with concerns but did not always feel listened to, or confident that action would be taken when possible. We observed good, positive and friendly interactions between staff and managers.
- Staff felt that managers communicated well with them and kept them informed about the day to day running of the departments but outpatients managers could not consider changes to meet current and future departmental needs because there was no clear departmental strategy.
- Diagnostic imaging department leadership was positive and proactive. Staff told us that they knew what was expected of staff and the department and that positive changes were planned and some had already taken place.

Outpatients and diagnostic imaging

- There were no established models of regular nursing clinical supervision in outpatients and staff received different types and frequency of informal supervision depending on their area of work.
- Staff told us that they had annual appraisals and were encouraged to manage their own personal development. Staff were able to access training and development provided by the trust and external courses were funded by the trust.
- Outpatient matrons for main outpatients and orthopaedic outpatients carried out peer review on each department. They attended the monthly senior matron meetings for surgery and orthopaedics to maintain links and awareness. Monthly tripartite meetings had been set up to support staff and plan for the inspection process. Both departmental Matrons had completed leadership development programmes which had been rolled out to other staff.
- A joint board to board meeting had taken place with a neighbouring trust to discuss pathology collaboration and following this a board to board development day had been reported as successful in bringing the trust together to discuss future working

Culture within the service

- Staff were encouraged to report incidents and complaints and felt that these would be investigated fairly.
- Managers told us that they were constantly trying to raise the profile of the department and would have liked to see all outpatients together in one place within the hospital but since plans for a new hospital had been paused staff felt this was unlikely to happen.
- Staff were proud to work at the hospital. They were passionate about their patients and felt that they did a good job.
- Diagnostic imaging staff told us that they felt there was a culture of staff development and support for each other. Staff were open to ideas, willing to change and were able to question practice within their individual modalities and suggest changes.
- We were told by outpatients and diagnostic imaging staff that there was a good working relationship between all levels of staff. In diagnostic imaging we saw that there was a positive, friendly but professional working relationship between consultants, nurses, radiographers and support staff.

Public engagement

- The Friends and Family Test had been rolled out fully in outpatients and positive feedback had been received by the departments. Staff were able to give us working examples of changes that had been made following patient comments.
- We were told that intentional rounding allowed senior staff to speak to patients on a daily basis, solve any potential problems or issues at the time.
- The hospital user group (HUG) visited the departments and carried out surveys which were fed back to departments regarding patient experience and measures that could be taken to improve it.

Staff engagement

- Orthopaedic outpatient staff had recently instigated a weekly team brief which was held to ascertain what has gone well, and what could have been improved in the previous week. This meeting is documented. Staff told us they participated in team meetings and were confident to talk about ideas and sharing of good news as well as issues occurring the previous day or anticipated problems for the day ahead. Staff survey results for the whole Trust showed that 78% of staff felt satisfied with the quality of work and patient care they were able to deliver. Outpatients and diagnostic imaging staff told us that they enjoyed working for the trust and we interviewed several people who had been employed for 20 years or more. Staff were proud of the service they provided and felt they worked in highly skilled teams. Staff told us that they would be proud if members of their family were cared for by staff in the department.
- Policies and procedures were available to staff via the trust intranet.
- The trust told us that staff were keen to work with consultants to develop new practices, including the introduction of new drugs and procedures. Departmental staff liaised with visiting specialists to keep updated with new practices and developments to ensure that services offered were in line with current practice and effective.
- Staff shared their achievements with the rest of the trust in the trust magazine Anthem which was published and available via the intranet.

Innovation, improvement and sustainability

Outpatients and diagnostic imaging

- Staff had produced posters and delivered presentations at the International society of Orthopaedic and Trauma nurses on the development of virtual fracture clinics and on the roles of speciality nurses.
- The trust told us that a number of staff within the department had completed modules on service improvement and that one current project was working to improve the staff engagement and sustainability in clinical supervision.
- Staff had worked on development of health promotion packs within main out patients which would be rolled out within the orthopaedic department as a pilot to explore how this can be sustained.
- There was a plan to explore the transfer of radio frequency ablation of varicose veins into an outpatient setting.
- The lead consultant radiologist for the specialist procedure known as CTPA (CT pulmonary angiography) was asked to present the experiences of staff and patient outcomes to a panel at a major CT equipment manufacturer.

Outstanding practice and areas for improvement

Outstanding practice

Good Practice

- The development of advanced nurse practitioners had enabled the hospital to respond to patients' needs appropriately and mitigated difficulties in recruiting junior doctors.
- The bariatric service had been developed as part of a consortium arrangement with neighbouring NHS trusts to ensure the local population had access to this service.
- A training suite had been set up to simulate procedures within surgery and enabled staff to practice and upskill in a safe environment.
- The critical care team achieved a network award, which recognised excellent work in relation to "target" training. The team had also achieved recognition for their work related to critical care competencies, difficult airway and skills drills.
- The critical care team achieved 58% for its consideration of patients for tissue donation. The team were the second highest achiever for corneal donations. Overall the team's approach to tissue and organ donation was impressive, demonstrating a compassionate and sensitive approach to patients and relatives.
- The paediatric and neonatal departments participated in a number of national and local research studies and were involved in a large number of clinical trials. The management team and several other staff told us the department had recently obtained a £3.5 million grant for an 'OSCAR study.' This study is for high frequency OSCillation in Acute Respiratory distress syndrome, comparing conventional positive pressure ventilation with high frequency oscillatory ventilation.
- The neonatal unit had implemented the 'Small Wonders' initiative for premature babies; this was designed by the charity Best Beginnings. Small Wonders supports parents in their baby's care in ways shown to improve health outcomes for their babies.
- Staff in the maternity day assessment unit attended training on Gestation Related Optimal Weight (GROW) software which aims to reduce the number of stillbirths by using customised growth charts.
- 'NIPE Smart' had recently been implemented within the maternity directorate. This is an information technology screening management system which has a system of capturing data on newborn and infant screening examinations with the aim of reducing the number of babies diagnosed with a medical congenital condition at a late stage.
- Outpatient department staff produced posters and delivered presentations at the international conference for the International Society of Orthopaedic and Trauma Nursing on the development of virtual fracture clinics and on the roles of speciality nurses.
- A number of staff within the outpatients department completed modules on service improvement including one current project to improve the staff engagement and sustainability in clinical supervision.
- Staff worked on the development of health promotion packs within main outpatients to be rolled out within the orthopaedic department as a pilot to explore how this can be sustained.
- The lead consultant radiologist for the specialist procedure known as CTPA (CT pulmonary angiography) presented the experiences of staff and patient outcomes to a panel at a major CT equipment manufacturer.

Areas for improvement

Action the hospital MUST take to improve

- Ensure there are systems and processes in place to minimise the likelihood of risks by completing the 5 Steps to Safer Surgery checklist.
- Ensure staff follow trust policies and procedures for managing medicines, including controlled drugs. Ensure that medicines are stored according to storage requirements to maintain their efficacy in maternity services.

Outstanding practice and areas for improvement

- Ensure that risk assessments are documented along with personal care and support needs and evidence that a capacity assessment has been carried out where required.
- Ensure pain in children and young people is assessed and managed effectively.
- Ensure that the competency criteria for staff who are triaging patients are clearly documented and include recognised competency–based triage training.
- Ensure that infection control procedures are followed in relation to hand hygiene and use of personal protective equipment.
- Ensure that resuscitation and emergency equipment is checked on a daily basis in line with trust guidelines.
- Ensure cleanliness standards are maintained.
- Ensure effective systems are in place which enable staff to assess, monitor and mitigate risks relating to the health, safety and welfare of people who use the service.
- Ensure that all policies and procedures in the In-Hospital care directorate are reviewed and brought up to date.
- Midwifery policies, guidelines and procedural documents must be up to date and evidence based.
- Ensure there are always sufficient numbers of suitably qualified, skilled and experienced staff to deliver safe care in a timely manner.
- Ensure that all annual reviews for midwives take place on a timely basis.
- Ensure all staff attend the relevant resuscitation training.

Action the hospital SHOULD take to improve

- Consider strengthening the senior nurse capacity in the A&E department.
- Consider reviewing the system for documenting the follow-up of admitted head injury patients by the A&E department.
- Consider a system in A&E to enable patients with allergies to be recognised quickly and easily without the presence of medical records.
- Ensure that staff are following the correct procedure when dispensing medication using the Omnicell including checking the prescription at the time of dispensing.
- Consider a continuous audit of all MCA and DoLs assessments and referrals and share lessons learned.
- Consider assessing the access to the emergency resuscitation trolley on the haematology day unit.
- Consider putting engaged notices on toilet doors to protect dignity if the door is kept unlocked for staff to gain access to vulnerable patients.
- Send electronic communication to the patient's GP on discharge from the critical care unit.
- Ensure handover meetings are held in a private and confidential area in children's services.
- Ensure that all patient documentation remains confidential during patient visits to the outpatients department.
- Ensure that all outpatient treatment rooms are cleaned before use.
- Ensure that formal drugs audits and stock checks carried out regularly in outpatients.
- Ensure that medicines are stored appropriately to ensure their quality is maintained.
- Ensure that overall communication, outpatient clinic planning, room utilisation and staffing is formally managed and controlled, including clinics involving staff from other trusts.
- Ensure that patients in the children's outpatient department are afforded privacy when speaking with reception staff.
- Update the risk assessment related to paediatric resuscitation in the children's outpatient department.
- Ensure that some clean and safe methods for entertaining or distracting children are provided within the diagnostic imaging department.
- Ensure that staff adhere to the coding system for recording on medication charts
- Ensure that staff fully adhere to infection control policies and close doors on side rooms where patients are being barrier nursed.
- Ensure the processes and documentation used for appraisal of non-medical staff monitors their performance and meets their personal development needs.
- Review the process for storage of post-transfusion blood bags while retained on ward areas.
- Review whether documentation for patients living with dementia are completed and comprehensive.
- Ensure that within outpatient services, action plans from audits, risk registers and meetings are maintained, regularly revisited and amended to show where actions have been completed or remain outstanding.

Outstanding practice and areas for improvement

- Ensure that established models of regular nursing clinical supervision are implemented for all staff involved in patient care in outpatient services.
- Ensure that patients and staff are informed if clinics are cancelled, including those involving clinicians and staff from other trusts.
- Ensure that strategy and management plans regarding transforming the outpatients departments are communicated to all staff.
- Consider recording decision made at the evening medical ward rounds on the critical care unit.
- Consider how the critical outreach service will be maintained.
- Review the recruitment of medical staff, particularly junior doctors in the surgical unit.
- File maternity healthcare documentation according to the trust records management policy to avoid loss or misplacement of information
- Indicate benchmark data on the maternity performance dashboard to measure performance.
- Ensure that 'fresh eyes' checks are recorded when undertaken.
- Review the senior midwifery structure and experience resource to ensure that all the midwifery roles needed for coordination and oversight of each service are appropriately covered.
- Monitor and internally report the level of provision of 1:1 maternity care
- Hold staff handovers in maternity services in an environment that reduces the possibility of distraction and interruption.
- Have a competency based framework in place for all grades of midwives.
- Have systems in place to achieve the nationally recommended ratio of 1:15 for supervision of midwives.
- Consider safety briefings as part of daily communication with staff in maternity services.
- Include describing the reporting arrangements for Supervisors of Midwives following investigations, audits or reviews in the maternity services risk management strategy.
- Provide simulation training exercises to prevent the abduction of an infant

This section is primarily information for the provider

Requirement notices

Action we have told the provider to take

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

Regulated activity	Regulation
Treatment of disease, disorder or injury	Regulation 9 HSCA (RA) Regulations 2014 Person-centred care **Regulation 9(3)(a)** • Ensure pain in children and young people is assessed and managed effectively. • Ensure there are systems and processes in place to minimise the likelihood of risks by completing the 5 Steps to Safer Surgery checklist.

Regulated activity	Regulation
Treatment of disease, disorder or injury	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment **Regulation 12(2)(c)(e)(g)(h)** • Ensure that the competency criteria for staff who are triaging patients are clearly documented and include a recognised competency–based triage training. • Ensure staff follow trust policies and procedures for managing medicines, including controlled drugs. Ensure that medicines are stored according to storage requirements to maintain their efficacy in maternity services. • Ensure that infection control procedures are followed in relation to hand hygiene and use of personal protective equipment. • Ensure that resuscitation and emergency equipment is checked on a daily basis in line with trust guidelines. • Ensure that risk assessments are documented along with personal care and support needs and evidence that a capacity assessment has been carried out where required. • Ensure cleanliness standards are maintained.

This section is primarily information for the provider

Requirement notices

Regulated activity	Regulation
Treatment of disease, disorder or injury	Regulation 17 HSCA (RA) Regulations 2014 Good governance **Regulation 17(2)(a)** • Ensure that all policies and procedures in the In-Hospital care directorate be reviewed and brought up to date. • Midwifery policies, guidelines and procedural documents must be up to date and evidence based.

Regulated activity	Regulation
Treatment of disease, disorder or injury	Regulation 18 HSCA (RA) Regulations 2014 Staffing **Regulation 18(1),18(2)(a)** • Ensure effective systems are in place which enable staff to assess, monitor and mitigate risks relating to the health, safety and welfare of people who use the service. • Ensure there are always sufficient numbers of suitably qualified, skilled and experienced staff to deliver safe care in a timely manner. • Ensure that all annual reviews for midwives take place on a timely basis. • Ensure all staff attend the relevant resuscitation training.