

Northumbria Healthcare NHS Foundation Trust North Tyneside General Hospital

Quality Report

Rake Lane,
North Shields,
NE29 8NH

Tel: 0344 811 8111

Website: www.northumbria.nhs.uk

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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	Outstanding	☆
Urgent and emergency services	Good	●
Medical care (including older people's care)	Outstanding	☆
Surgery	Outstanding	☆
Maternity and gynaecology	Good	●
End of life care	Outstanding	☆
Outpatients and diagnostic imaging	Outstanding	☆

Summary of findings

Letter from the Chief Inspector of Hospitals

North Tyneside General Hospital is one of the acute hospitals providing care as part of Northumbria Healthcare NHS Foundation Trust. This hospital provides emergency care from an emergency care centre, medical and surgical services, midwifery led with no obstetric intervention maternity services, mental health care for older people, end of life care and a range of outpatient and diagnostic imaging services. North Tyneside General Hospital does not provide critical care and children and young people services. Services had been reconfigured in June 2015 when the Northumbria Specialist Emergency Care Hospital (NSECH) opened. The opening of NSECH had resulted in a new model of care and different patient pathways in emergency, medical and surgical care and maternity services.

Northumbria Healthcare NHS Foundation trust provides services for around 500,000 people across Northumberland and North Tyneside with 999 beds. The trust has operated as a foundation trust since 1 August 2006. North Tyneside General Hospital has 307 beds.

We inspected North Tyneside General Hospital as part of the comprehensive inspection of Northumbria Healthcare NHS Foundation Trust, which included this hospital, Hexham General Hospital, Wansbeck General Hospital, Northumbria Specialist Emergency Care Hospital, and community services. We inspected North Tyneside General Hospital between 9 and 13 November 2015.

Overall, we rated North Tyneside General Hospital as outstanding. We rated it outstanding for being caring, responsive and well-led, and good in providing safe and effective care.

We rated medical care, surgery, outpatient and diagnostic imaging services and end of life services as outstanding. Urgent and emergency services, maternity and gynaecology and the service for older people with mental health problems we rated as good.

Our key findings were as follows:

- The opening of NSECH had resulted in a new model of care and different patient pathways in emergency, maternity and medical and surgical care at this hospital. This had resulted in different ways of working for some staff.
- Staff felt fully informed about all the changes which had taken place and were proud of the hospital and the care it provided to the local community and beyond.
- Strong governance structures were in place across the hospital and there was a systematic approach to considering risk and quality management. Senior and site level leadership was visible and accessible to staff. Leadership was encouraged at all levels and staff supported to try new initiatives.
- Managers at all levels understood the challenges of the new model of care and were actively addressing any issues that this had presented, specifically around nursing and medical staffing and patient acuity.
- Staff and patient engagement was seen as a priority with several systems in place to obtain feedback.
- The “Northumbria Way”, which incorporates the trust’s values, behaviours and culture, was evident when we spoke with managers and staff throughout the hospital.
- Staff delivered compassionate care, which was polite and respectful and went out of their way to overcome obstacles to ensure this. All patient feedback was extremely positive.
- There were processes to ensure patients were cared for in the right place at the right time. Patient flow was a priority, and the hospital proactively managed this.
- For all performance measures relating to the flow of patients the hospital was performing the same or better than the England average.
- The transfer of patients between NSECH and the ‘base’ hospitals was still being embedded at the time of inspection and staff were working flexibly to accommodate patient needs.
- The hospital had infection prevention and control policies in place, which were accessible, understood and used by staff.

Summary of findings

- Patients received care in a clean, hygienic and suitably maintained environment.
- There was adequate personal protective equipment (PPE) such as aprons and masks available to staff. We routinely saw staff using this equipment during our inspection. Patients told us that staff washed their hands and used gloves and aprons.
- The hospital routinely monitored staff hand hygiene procedures and compliance, at the time of inspection, was high.
- Between April and September 2015 there had been no cases of methicillin resistant staphylococcus aureus (MRSA) at this trust and five cases of c-difficile. No cases were reported in surgery at this hospital.
- Nurse staffing was maintained at safe levels in most areas. The hospital had implemented a 'Safer Nursing Care Tool' (SNCT) to assess the staffing requirements across wards.
- The ratio of consultants was better than the England average at this hospital.
- The hospital utilised advance nurse practitioners to support doctors.
- Mortality and morbidity meetings were held at least monthly and were attended by representatives from teams within the clinical business units.
- Patients were assessed regarding their nutritional needs using the Malnutrition Universal Screening Tool (MUST).
- Nutritional assistants were employed to provide patients with eating and drinking assistance if required.
- Most wards followed the 'well organised ward' model to ensure that equipment storage was standardised and consistent across the trust.

We saw several areas of outstanding practice including:

In medical care:

- The joint working by the falls team, which has raised the profile of falls and engaged staff, patients and their relatives in trying to reduce falls.
- The role of nutritional assistants and the focus on the nutritional needs of patients which had improved the patient experience.
- The 'real time' data collected on patient experience to assess how each ward is performing.
- The inclusion of a psychological assessment for patients who require isolation for infection prevention reasons.
- The development of comfort care packs for relatives.

In surgery services:

- North Tyneside General Hospital is rated in the top five hospitals in the country for the treatment of emergency hip fractures.
- North Tyneside General Hospital was recently recognised by the General Medical Council as the best in the country for the quality of training for orthopaedic surgeons of the future.
- The service had developed a day case mastectomy service. This was proposed to save 201 bed days each year. Average length of stay had also reduced to between 2.7 and 4.2 days (depending on patient risk at the time of surgery). This compared to a national average of around 4.8 days.

In end of life care:

- The model of end of life care services saw that dedicated palliative care beds were operated alongside a specialist palliative in-reach service to general ward areas. This meant that specialist staff worked alongside general staff to deliver effective, coordinated care within a holistic approach.
- Services worked across both acute and community settings with a strong multi-disciplinary ethos.
- The trust had adopted an innovative approach to providing an integrated person-centred pathway of care in partnership to provide services that were flexible, focused on individual patient choice and ensured continuity of care.
- The trust had taken positive action to increase the number of patients who were dying in their usual place of residence.

Summary of findings

- The trust was supporting increasing numbers of non-cancer patients.
- Partnership working with Marie Curie and joint management and nursing posts enabled the trust to provide prompt support and continuity of care for patients being discharged to their preferred place of care in the community.
- The leadership, governance and culture were used to drive and improve the delivery of high quality person-centred care through collaboration and partnership working. The trust had clear leadership for end of life care services that was supported at the top of the organisation.
- Investment in end of life and palliative care services was apparent and staff we spoke with consistently told us they felt that end of life care was a priority for the trust.
- Innovations were seen in relation to a focus on spiritual support and an assessment model that aimed to increase staff understanding of spirituality and confidence around assessment.
- The Palliative Care service had won the Quality Award for 2014 for their commitment to improvement and the excellent patient experience feedback received.
- The development of a tool for the assessment of patients' spiritual needs that focused on providing staff with prompts that would make it easier for them to have this discussion with patients. The tool also helped staff to engage in a clearer way to ensure patients understood.

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

Importantly, the trust must:

- Complete a comprehensive gap analysis against the recommendation made for the University Hospitals of Morecambe Bay NHS Foundation Trust.
- Ensure that the maternity and gynaecology dashboard is fit for purpose, robust and open to scrutiny.

In addition the trust should:

- Ensure that levels of staff training continue to improve in the hospital so that the hospital meets the trust target by 31st March 2016.

In the Emergency Care Centre:

- Consider circulating guidance to staff about when to stop using the 'see and treat' model when the department is busy and revert to the triage model, to ensure patient safety and improve responsiveness.
- Consider training for reception staff to help identify patients who may need to be brought to the attention of clinical staff more quickly.
- Consider increasing the number of independent nurse prescribers to enable more flexibility in prescribing of medication in the ECC when there are no doctors available.

In maternity and gynaecology:

- Ensure that the clinical strategy for maternity and gynaecology services which is embedded within the Emergency Surgery and Elective Care Annual Plan, sets out the priorities for the service with full details about how the service is to achieve its priorities, so that staff understand their role in achieving those priorities.
- Consider the provision of separate accommodation for women undergoing pregnancy loss and termination of pregnancy.

In outpatient's and diagnostic imaging:

- Ensure waiting time targets in ultrasound in diagnostic imaging continue to improve as more staff are appointed.

In wards for older people with mental health problems:

- The provider should ensure that all steps are taken to maintain the safety, privacy and dignity of patients on mixed sex wards until the wards move into new same sex accommodation.

Summary of findings

- The provider should ensure that a programme of formal supervision is rolled out following completion of a pilot project.
- The provider should ensure that ligature risk assessments are comprehensive and consistent across sites.
- The provider should look to develop service specific key performance indicators to aid performance monitoring.

Professor Sir Mike Richards

Chief Inspector of Hospitals

Summary of findings

Our judgements about each of the main services

Service

Urgent and emergency services

Rating

Good



Why have we given this rating?

We rated the emergency care centre as good because: We observed that staff followed policies and procedures. Safeguarding processes, to protect vulnerable adults and children, were in place and referrals were made in a timely manner when necessary. There were sufficient medical and nursing staff employed by the department and staffing levels were acceptable. There were some areas where the department was not meeting the trust expected compliance rate for mandatory training. Staff were up to date with annual appraisals.

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 seven-day service. Staff understood their responsibilities in relation to taking consent from patients and the principles of the Mental Capacity Act 2005.

The care given to patients by the department was very good. Privacy and dignity were maintained and people were dealt with in a kind and compassionate way. Staff ensured that patients received the care and support they needed. Patients and families were involved in decisions about their care and they had emotional support 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. Most patients were discharged within three hours of admission and four hour waiting time targets were met. The trust was performing better than the England average for a number of other performance measures relating to the flow of patients. Patient complaints were managed in line with the trust's policy and feedback was given to staff. Lessons were learned and where applicable, practice was changed to minimise the likelihood of recurrence.

Summary of findings

Staff were fully engaged in the future development of the department and the vision and strategy of the trust were embedded in practice.

There were robust governance, risk management and quality measurement processes in place to enhance patient outcomes. Patient voice was seen as important and there were a number of initiatives within the trust designed to ensure that the opinions of patients influenced the delivery of services.

Staff felt that there was good leadership not only in the department but also within the trust. There was an inclusive, learning and supportive culture in the department and staff felt valued and appreciated. Staff were encouraged and supported to be innovative and we saw examples of innovative ways of working within the department.

Medical care (including older people's care)

Outstanding



We rated medical care as outstanding because: Feedback from patients and visitors was overwhelmingly positive. Patients felt involved in their care and their physical needs were not the only consideration. Patients and relatives understood what their plan of care was and were able to be involved with this. Staff were committed to providing high quality patient focused care and took the time to meet the individual needs of patients and we were given examples of where staff had gone 'the extra mile' to make patients hospital stay a positive experience. The medical services were managed by an experienced and cohesive team who demonstrated a clear understanding of the challenges of providing high quality and safe care. The leadership team had a shared purpose to ensure that this was delivered. They had identified and implemented actions and strategies to manage this and this had been done with the involvement of frontline staff. This meant staff we spoke with felt valued and were engaged with the process. Staff felt valued and were encouraged to contribute to service development. Governance processes were embedded which allowed clear identification and monitoring of risk and we saw evidence of related progress and action plans as well as ongoing review of risks.

There were robust systems in place for reporting incidents and for feeding back learning from these. The trust was a high reporter of incidents. All staff demonstrated a good understanding of the duty of

Summary of findings

candour and safeguarding. There were clear guidelines in place to manage deteriorating patients and staff felt these worked well when they had to be implemented. The wards we visited were visibly clean and tidy and we observed good practice in relation to infection prevention. Nursing and medical staffing was at a safe level and following a safer staffing audit looking at patient acuity, we were assured ward establishments were being reviewed. We observed and found evidence of good practice in relation to medicines management and documentation was comprehensive and fully completed.

Policies were up to date and were evidence based. Patients were provided with pain relief as required and the nutritional needs of patients were viewed as a priority. The role of nutritional assistants had a positive impact on meeting nutritional needs of patients. We observed strong multidisciplinary team working to provide holistic care for patients which was confirmed by feedback from different staff groups. The opening of the new hospital and a different model of care meant patients were cared for on appropriate wards with a clear plan in place. There was ongoing engagement with external stakeholders to continue to develop and promote this model of care. There were good systems in place to manage patient flow and if patients condition deteriorated. Discharges were MDT focused to ensure all the needs of patients were met and discharges were safe. There was an open culture in relation to complaints and they were seen as a way of learning and improving services.

Surgery

Outstanding



We rated surgery services as outstanding because: There were consistently high levels of staff satisfaction and staff spoke strongly about the supportive and open culture at the trust; staff were proud to work for the service.

There was a clear vision for the service and the new model of care being delivered, with a clear focus on improving the quality of care and people's experiences. The change to the provision of emergency and high risk surgical services centred at NSECH ensured patients received the right care and treatment, support services, nursing and clinical staff at the appropriate time and location. The strategy clearly identified the new model of emergency and high-risk surgery provided at NSECH

Summary of findings

and the relationship between NSECH and the base hospitals. The new model was under constant review to determine the most effective site to undertake different procedures depending upon risk and safety.

Local communities had been engaged in the consultation and development of the strategy for the new model of care. This had a positive effect upon the feedback received from patients and relatives received during the inspection at NSECH and also at the base hospitals.

Senior leaders welcomed innovation and there was a continuing history of innovation being embraced and promoted amongst staff. Strong and robust governance structures were in place across the directorate and there was a systematic approach to considering risk and quality management. Senior and site level leadership was visible and accessible to staff. Staff spoke very positively about their immediate line managers and senior leaders. Comprehensive leadership strategies were in place to promote and ensure delivery of the desired culture. This included pilot initiatives such as the 'shared purpose' wards and value based recruitment. The surgical services at this hospital used various innovative ways to gather feedback from patients. There was evidence of innovative practice to improve patient outcomes.

Surgery services at NTGH were planned and delivered to meet the needs of local people in a timely way. The service was part of the wider hospital network and incorporated the NSECH emergency care model. This allowed patients access to elective care at North Tyneside Hospital and emergency support when needed. The service reported waiting times better than NHS averages and had been responsive in analysing, assessing and considering patient risk when identifying where best to care for high risk patients. Staff understood the different needs of individual patients and were able to take a tailored approach to meet their needs. This included dementia pain training, access to bariatric equipment, and an understanding of the support needed for some patients with learning disabilities. This included individual experiences for patients with learning disabilities to ensure a positive patient experience. Low levels of complaints had been received. When a complaint was made they were actively reviewed and taken seriously. Action was taken as a result with improvements to the service.

Summary of findings

The surgical services in this North Tyneside General Hospital received consistently positive feedback scores and comments through the NHS Friends and Family test. There were a number of approaches taken at the trust to gather feedback from people, the local '2 minutes of your time' survey, a real-time feedback process and a social media feedback approach managed by the Trust Communications and PALS team. All patients we spoke with in wards 7 and 8 and reported staff were friendly, professional and caring. Staff offered patients positive encouragement and challenge when mobilising following surgery. Patients told us this support and encouragement struck the right balance between encouraging them while respecting their limitations. We observed examples of staff compassion with patients and caring communication amongst staff and patients. Comments were consistently positive without exception during our discussions with patients in both surgical wards.

Performance over time showed a good track record with regard to patient safety. Staff were confident in the reporting of incidents and felt supported in doing so. In order to improve services, we saw governance processes were in place to ensure incidents were discussed, and lessons learned and communicated to staff. Staffing levels were appropriate for the service being delivered and recruitment was underway to fill additional posts. Planning for staffing had taken into account the strategic changes in services and the new model of care in Northumbria NHS Foundation Trust. There was a comprehensive understanding of patient risk and staff monitored, recorded and assessed this appropriately. The hospital environment was clean. Medicines were stored and administered safely. Records were appropriate, well completed and stored appropriately. Compliance with wider mandatory training was good and was on target to be completed by the trust's year end.

Staff used evidence based guidance to inform their practice and were encouraged to seek out new evidence-based techniques and technologies to support the delivery of high quality care. Appraisals were in place with rates above the trust target levels. Patients pain and nutritional needs were appropriately monitored and met by staff. Staff also had up to date training and sound knowledge of consent and mental capacity issues.

Summary of findings

Maternity and gynaecology

Good



We rated obstetrics and gynaecology services as good overall with the well-led domain rated as requires improvement because:

There were systems for reporting, investigating and acting on adverse events. The service routinely collected and reviewed standards and safety and shared it with staff. Medicines were stored correctly and checks on emergency equipment were in line with trust policy and were complete. Staff followed safety guidance for infection prevention and control. We found clear safeguarding processes in place; staff knew their responsibilities in reporting and monitoring safeguarding concerns. There were plans in place to ensure staff attended mandatory training. There was no medical staff present on the pregnancy assessment unit, however, support was provided from the antenatal clinic and staff had open access to the medical team based at NSECH.

We found the service used evidence-based guidelines to determine the care and treatment they provided. We reviewed the annual audit plan. Staff were involved in regular local audit. We found staff had the correct skills, knowledge and experience to do their role, however, we found that training had not been provided to support staff on ward 7 when gynaecology was relocated. Training ensured medical and midwifery staff could carry out their roles effectively. Competencies and professional development were maintained through supervision.

We found patients were respected and valued. Feedback from patients was positive about the care they experienced and were fully informed about what to expect. We observed patient care in the pregnancy assessment unit and antenatal clinic staff were supportive and compassionate.

The service had gone through a significant reconfiguration to a new model of care. Services were maintained at North Tyneside to support the local population. We found there were robust policies in place to ensure that patients were seen at the right place at the right time. We were informed of occasions where women experiencing miscarriage and termination of pregnancy were next to each other. The fertility control pathway provided an efficient and effective service to women in response to their respective needs, and was

Summary of findings

provided with choice in how they would like to dispose of pregnancy remains. Women using the service could raise a concern and be confident that concerns and complaints would be investigated and responded to. Although the senior management team were aware of the challenges to the service and had a vision for the future, the formal clinical strategy for maternity or gynaecology services which was contained within the surgical business unit annual plan was very generic in terms of outcomes and references to maternity and gynaecological services were minimal. This did not support identification of how the service was to achieve its priorities or support staff in understanding their role in achieving the services priorities. The risk register did not reflect the current concerns of the senior management team. We found there were risk and governance processes in place; however, we were concerned with the levels of scrutiny provided by the directorate with regard to the clinical dashboard. Risks were reported and monitored and action taken to improve quality.

End of life care

Outstanding



We rated end of life care as outstanding because: We found that the trust was providing high quality end of life care services using an innovative model of working and effective partnership working. There had been significant investment in palliative and end of life care services and the trust was responsive to addressing issues as they arose with flexibility in relation to staffing and resources. There was a clear vision, strategy and leadership at all levels of the organisation with a focus on good quality end of life care. The structure of the hospital liaison service that had been developed in partnership with Marie Curie provided additional flexibility to enable specialist palliative care staff to provide support to patients at the end of life irrespective of the complexities of their condition. This was sometimes in the form of supporting a rapid discharge to the patients preferred place of care in the community and as such involved a very hands on approach to ensuring as straightforward a transition as possible with hospital staff accompanying the patient in order to handover to community staff. We saw evidence of the use of national guidance and appropriate anticipatory prescribing of medicines at the end of life. Multidisciplinary working was apparent across services within the hospital and the community.

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The use of a dedicated palliative care unit and hospital liaison meant that there was a culture of understanding of palliative and end of life care that was integrated across disciplines and with other services. Patients and their families were involved in that care and we saw a number of initiatives in use to record patient wishes including advance care plans, emergency healthcare plans and treatment escalation plans. Feedback from patients and their relatives was positive about the way staff treated them with one person telling us that staff really care and go above and beyond what they would expect. There was a strong person-centred culture within the hospital and staff consistently appeared to be committed to providing compassionate care and promoting people's dignity. The trust performed in the top ten NHS trusts in England in the 2014 National Cancer Patient Experience Programme national survey, with 95% of respondents rating the care as being excellent or very good. Spiritual care was seen to be important with initiatives having been developed in supporting staff in the assessment of spiritual needs through training and the use of an internally designed assessment tool. Chaplaincy support saw multi-denominational ministers and faith leaders available for patients, relatives and staff. The leadership, governance and culture were used to drive and improve the delivery of high quality person-centred care through collaboration and partnership working. The trust had clear leadership for end of life care services that was supported at the top of the organisation. There was a clear proactive approach to seeking out and embedding new and more sustainable models of care. Staff we spoke with consistently told us they felt that end of life care was a priority for the trust.

Outpatients and diagnostic imaging

Outstanding



We rated North Tyneside General Hospital outpatients and diagnostic imaging services as outstanding because: Staff and managers had a clear vision for the future of the service. They knew the risks and challenges the service faced. Staff we spoke with at all levels felt supported by their line managers, who encouraged them to develop and improve their practice. Staff embraced change and there was a real focus on patient experience and leaders and managers drove this. There were well embedded systems and processes for

Summary of findings

gathering and responding to patient experiences and the results were well publicised throughout the departments. There were effective and comprehensive governance processes to identify, understand, monitor, and address current and future risks. These were proactively reviewed. There was an open, honest and supportive culture where staff discussed incidents and complaints, lessons learned and practice changed. All staff were encouraged to raise concerns. The departments supported staff who wanted to work more efficiently, be innovative, and try new services and treatments and ways of engaging with the public. Waiting times and cancellations were minimal and managed appropriately. Diagnostic image 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 emergency patients, inpatients, and outpatients. A radiographer discharge programme facilitated the discharge of patients having soft tissue injuries directly from radiology by suitably trained radiographers. Prior to emergency services moving to NSECH in June 2015, the radiology department had developed trauma image reporting, which was swift with an emphasis on “results within minutes” for emergency patients. This was the process that had been adopted at the new NSECH hospital and enabled medical teams to complete assessments and manage risks quickly. The department teams recorded concerns and complaints and used patient feedback proactively to prevent recurrence that might affect others. They reviewed and acted on problems quickly and demonstrated an open and transparent outlook with the aim to learn from them and improve patient experience. The hospital had good systems and processes in place to protect patients and maintain their safety. The departments were clean and hygiene standards were good. Medical records were stored and transported securely.

Patients were 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. Trust policies protected patients from the risk of harm by making sure they met any individual support needs. Staff demonstrated understanding of these policies and followed them.

North Tyneside General Hospital

Detailed findings

Services we looked at

Urgent and emergency services; Medical care (including older people's care); Surgery; Maternity and gynaecology; End of life care; Outpatients and diagnostic imaging.

Detailed findings

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Background to North Tyneside General Hospital

North Tyneside General Hospital is one of the acute hospitals providing care as part of Northumbria Healthcare NHS Foundation Trust. This hospital provides emergency care from an emergency care centre, medical and surgical services, midwifery led with no obstetric intervention maternity services, mental health care for older people, end of life care and a range of outpatient and diagnostic imaging services. North Tyneside General Hospital does not provide critical care and children and young people services. Services had been reconfigured in June 2015 when the Northumbria Specialist Emergency Care Hospital (NSECH) opened. The opening of NSECH had resulted in a new model of care and different patients pathways in emergency, medical and surgical care and maternity services.

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The emergency care centre (ECC) at North Tyneside General Hospital is situated in the former Accident and Emergency department of the hospital. In June 2015, the department ceased to be an A&E department and became an emergency care centre. Patients who should attend the emergency care centre are those with minor illnesses and injuries, such as broken bones, nosebleeds, sprains, strains, cuts and bites. Children's minor ailments are also managed within the department. The department may accept patients who attend by ambulance but only after prior agreement. More seriously ill or injured patients or those needing ambulance transport attend the Northumbria Specialist Emergency Care Hospital (NSECH) in Cramlington. Facilities at the North Tyneside Emergency Care Centre mean that patients who attend with more serious conditions are stabilised, kept safe and transferred by ambulance to NSECH.

Northumbria Healthcare NHS Foundation Trust provides medical care, including older people's care, across four sites including North Tyneside General Hospital. Northumbria Specialist Emergency Care Hospital opened on 16 June 2015 providing specialist emergency care for seriously ill and injured patients from across Northumberland and North Tyneside. The opening of this new hospital resulted in changes to North Tyneside General Hospital. Most medical admissions came from Northumbria Specialist Emergency Care Hospital and patients were then transferred out to "base" sites which

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included this hospital. It had eight medical wards and an ambulatory care unit. The medical wards covered various specialities, including elderly medicine, elderly rehabilitation, ortho-geriatrics, cardiology, gastroenterology, respiratory medicine and stroke.

North Tyneside General Hospital provides a range of surgical services for the population of Northumberland and the North East of England. It is part of the wider hospital network, incorporating the Northumbria Specialist Emergency Care Hospital (NSECH) care model. This allowed patients to access elective care at North Tyneside General Hospital while ensuring that emergency support, using NSECH, was also available. The hospital provides elective surgery for: colorectal and upper gastrointestinal surgery, breast, plastic and microsurgery, bariatric (weight loss) surgery, and urology and orthopaedic surgery. It has a 24 hour walk-in service, diagnostic services, 2 surgical wards, and a day treatment centre (where patients can attend for day surgery procedures) and a theatre suite.

Prior to June 2015 the maternity unit in North Tyneside General Hospital was midwifery led with no obstetric intervention. In June 2015 all intrapartum services was relocated to the Northumbria Specialist Emergency Care Hospital (NSECH). At the time of our inspection the service offered a limited number of maternity and obstetric services at North Tyneside, these included a pregnancy assessment unit, antenatal clinic, scan facilities, early pregnancy assessment and a pregnancy control service and elective gynaecology services. Between April 2014 and March 2015 there were 151 births at the unit, and at the time of inspection this had reduced to none. The service offered both medical and surgical termination of pregnancy. There was a children's day surgery unit at this hospital.

The hospital had a dedicated palliative care unit for patients with end of life and palliative care needs. Patients requiring end of life care would also be cared for in ward areas throughout the hospital with support from the hospital liaison palliative care team. Specialist palliative care was provided as part of an integrated service across the hospital and community teams and the palliative care service sat within the trust's community and social care business unit.

North Tyneside General Hospital provided a range of clinics covering the majority of clinical specialities including orthopaedics, gynaecology, rheumatology, urology and respiratory services. The department had around 46 consulting rooms plus treatment and audiology facilities. The clinics were allocated into six separate areas, the main department waiting area and a number of sub waiting areas.

Diagnostic imaging services were open 24 hours a day, 7 days a week. The department offered several imaging techniques including plain x-ray, CT scanning from 8am to 8pm with a service for head CT scans overnight, and diagnostic ultrasound from 8 am to 6 pm Monday to Friday, for mammography. A private company managed the MRI scanning department independently and provided a service from 8am to 5pm 7 days a week. Trust radiologists provided reports for MRI scans. There was a children's outpatients.

The hospital provided three wards for older people with mental health problems. Ash court was a 14 bed mixed sex ward providing assessment and admission for people over the age of 65 experiencing mental health problems. West View was a 10 bed male only ward. It offered care and treatment to individuals with dementia including those with challenging behaviour. Ward 19 was a 16 bed mixed sex ward. This was a dementia assessment and admission unit.

Our inspection team

Our inspection team was led by:

Chair: Dr Linda Patterson OBE, Consultant Physician.

Team Leader: Amanda Stanford, Head of Hospital Inspections, Care Quality Commission

The team included a CQC inspection manager, 23 CQC inspectors and a variety of specialists including: a non-executive director, Director of Nursing, consultant anaesthetist, consultant physician and gastroenterologist, consultant in obstetrics and gynaecology, consultant obstetrician and specialist on

Detailed findings

feto-maternal medicine, accident and emergency nurses, paramedic, nurse consultant in critical care, palliative care modernisation facilitator, head of midwifery, risk

midwife, infection control nurse, surgical nurse, matron, head of children's services and junior doctor. We also had experts by experience that had experience of using healthcare 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?

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 local clinical commissioning groups, NHS England, Monitor, Health Education England and Health watch.

We carried out an announced visit between 9 and 13 November 2015. We held focus groups with a range of hospital staff, including support workers, nurses, doctors (consultants and junior doctors), physiotherapists, occupational therapists and student nurses. We talked with patients and staff from all areas of the hospital, 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 held listening events on 22 October and 6 November 2015 in Alnwick, Hexham, Cramlington and Whitley Bay to hear people's views about care and treatment received at the hospitals. 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 events.

Facts and data about North Tyneside General Hospital

North Tyneside General Hospital is one of the acute hospitals providing care as part of Northumbria Healthcare NHS Foundation Trust. This trust provides services for around 500,000 people across Northumberland and North Tyneside with 999 beds. During 2014/15, the trust saw 71,000 patients on wards, carried out 36476 operations and is responsible for 1.4million appointments with patients outside of its hospitals.

The health of people in Northumberland is varied compared with the England average. Deprivation is lower than average, however about 17% (9,300) children live in poverty. Life expectancy for women is lower than the England average.

The health of people in North Tyneside is varied compared with the England average. Deprivation is higher than average and about 19% (6,800) children live in poverty. Life expectancy for both men and women is lower than the England average.

Detailed findings

Northumberland was ranked 135th and North Tyneside was ranked 113th most deprived out of the 326 local authorities across England in 2010.

Since the new configuration of the department as an emergency care centre, from June to October 2015, the department has seen 8501 adult patients and 2830 children.

From January to December 2014 North Tyneside General Hospital undertook 162,121 outpatient appointments.

Between April 2014 and March 2015 this hospital carried out 608 medical and 21 surgical termination of pregnancies.

Our ratings for this hospital




Our ratings for this hospital are:

	Safe	Effective	Caring	Responsive	Well-led	Overall
Urgent and emergency services	Good	Good	Good	Good	Good	Good
Medical care	Good	Good	★ Outstanding	Good	★ Outstanding	★ Outstanding
Surgery	Good	Good	★ Outstanding	★ Outstanding	★ Outstanding	★ Outstanding
Maternity and gynaecology	Good	Good	Good	Good	Requires improvement	Good
End of life care	Good	★ Outstanding	★ Outstanding	★ Outstanding	★ Outstanding	★ Outstanding
Outpatients and diagnostic imaging	Good	Not rated	Good	★ Outstanding	★ Outstanding	★ Outstanding
Overall	Good	Good	★ Outstanding	★ Outstanding	★ Outstanding	★ Outstanding

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

Information about the service

The emergency care centre (ECC) at North Tyneside General Hospital is situated in the former Accident and Emergency department of the hospital. In June 2015, the department ceased to be an A&E department and became an emergency care centre. Patients who should attend the emergency care centre are those with minor illnesses and injuries, such as broken bones, nosebleeds, sprains, strains, cuts and bites. Children's minor ailments are also managed within the department. The department may accept patients who attend by ambulance but only after prior agreement. More seriously ill or injured patients or those needing ambulance transport attend the Northumbria Specialist Emergency Care Hospital (NSECH) in Cramlington. Facilities at the North Tyneside Emergency Care Centre mean that patients who attend with more serious conditions are stabilised, kept safe and transferred by ambulance to NSECH.

The department is staffed by a combination of consultant and junior doctors and GPs, emergency nurse practitioners (ENP), nurses and health care assistants. There is consultant medical cover from 9am to 5pm, GP cover from 5pm to midnight, Monday to Friday and ENP cover seven days a week, 24 hours a day. On-call medical cover is accessible by using the on-call medical team working across the wider hospital.

Since the new configuration of the department as an emergency care centre, from July to October 2015, the department has seen 8501 adult patients and 2830 children. As the new reconfiguration of services had been in

place for four months at the time of our inspection, the staffing of the department and the number of patients attending had varied as the public became familiar with the new ways of working.

The ECC at North Tyneside General Hospital is part of the medicine directorate.

We spoke with staff including doctors, receptionists, nursing assistants, nurses of all grades, patients and their relatives. We looked at the records of seven patients and reviewed information about the service provided by external stakeholders and the trust.

Urgent and emergency services

Summary of findings

We rated the emergency care centre as good because:

We observed that staff followed policies and procedures. Safeguarding processes, to protect vulnerable adults and children, were in place and referrals were made in a timely manner when necessary. There were sufficient medical and nursing staff employed by the department and staffing levels were acceptable. There were some areas where the department was not meeting the trust expected compliance rate for mandatory training. Staff were up to date with annual appraisals.

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 seven-day service. Staff understood their responsibilities in relation to taking consent from patients and the principles of the Mental Capacity Act 2005.

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. Staff ensured that patients received the care and support they needed. Patients and families were involved in decisions about their care and they had emotional support 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. Most patients were discharged within three hours of admission and four hour waiting time targets were met. The trust was performing better than the England average for a number of other performance measures relating to the flow of patients. Patient complaints were managed in line with the trust's policy and feedback was given to staff. Lessons were learned and where applicable, practice was changed to minimise the likelihood of recurrence.

Staff were fully engaged in the future development of the department and the vision and strategy of the trust were embedded in practice.

There were robust governance, risk management and quality measurement processes in place to enhance patient outcomes. Patient voice was seen as important and there were a number of initiatives within the trust designed to ensure that the opinions of patients influenced the delivery of services.

Staff felt that there was good leadership not only in the department but also within the trust. There was an inclusive, learning and supportive culture in the department and staff felt valued and appreciated. Staff were encouraged and supported to be innovative and we saw examples of innovative ways of working within the department.

Urgent and emergency services

Are urgent and emergency services safe?

Good



We rated the safety of services as good because:

Cleanliness and hygiene were good and the environment was well maintained. Incident reporting was common practice throughout the department and there were examples that staff learnt from incidents, near misses and errors. There were adequate staffing levels to provide safe care to patients. Medication was stored and dispensed safely.

Records were stored securely. Information held within records was sufficiently detailed and subject to clinical audit. The department had processes in place for identifying patients at risk of harm and for monitoring and escalating the support of patients when they remained in the department for extended periods or if they began to deteriorate. Incident reporting was common practice throughout the department and there were examples that staff learnt from incidents, near misses and errors. Staff mandatory training was on target to be completed by April 2016.

The department used a 'See and treat' model. If the department was busy, there were no clear guidelines about when staff should switch from the see and treat model to the triage model.

Incidents

- Between June to September 2015, there were no serious incidents or never events reported by the department.
- There were 7 incidents in the Emergency Care Centre.
- Of the 7 incidents, 6 resulted in no harm and one in minor harm or damage.
- The most commonly reported category of incidents was Access, Appointment, Admission, Absconder, Transfer, and Discharge.
- There was evidence that the trust took action to learn lessons and informed patients when there had been errors or potential harm, for example, a new pathway had been introduced to deal with scaphoid wrist fractures. This demonstrated that staff were aware of duty of candour and actively informing patients or their relatives when required to.

- Mortality and Morbidity meetings took place regularly across the directorate and were attended by a member of staff from the ECC who reported back any findings or lessons learned at departmental meetings.

Cleanliness, infection control and hygiene

- Since the reconfiguration in June 2015 the trust reported that there had been no incidents of MRSA (methicillin resistant staphylococcus aureus) or clostridium difficile in the emergency care centre.
- When we visited the department, we found it to be visibly clean. Patient rooms were cleaned in between patients and waiting area floors and seating were in good order.
- Patient toilets were clean.
- Staff could call cleaners to the department 'out of hours' if required however, health care assistants were responsible for general cleaning and wiping of patient equipment such as blood pressure machines. We witnessed staff carrying out cleaning of equipment between patients.
- There was ample personal protective equipment (PPE) such as aprons and masks available to staff. We routinely saw staff using this equipment during our inspection. Patients also told us that staff washed their hands and used gloves and aprons.
- The trust routinely monitored staff hand hygiene procedures and informed us that compliance at the time of inspection was 100%.
- The department had a policy in place to ensure the safe isolation of patients who needed to be isolated. Patients who attended with potentially contagious conditions could be treated safely in cubicles that had solid walls and doors.
- We looked at the areas where equipment were cleaned and these were clean and there were cleaning schedules in place for all equipment, along with evidence that cleaning had taken place in line with the schedules.

Environment and equipment

- The waiting area used by patients was well lit and had ample seating.
- Consulting and treatment rooms were an acceptable size and contained the necessary patient equipment. Using curtains, privacy was maintained as well as possible.

Urgent and emergency services

- We found that equipment in the department had been safety tested. Most of the equipment we looked at had up to date tests however, we found an otoscope overdue a service from July 2015.
- As there were maintenance contracts in place, equipment was serviced and maintained in line with manufacturer's guidelines. The medical electronics team co-ordinated equipment servicing and repairs throughout the trust. To ensure accuracy, the medical electronics team also ensured that equipment was regularly calibrated.
- We checked the resuscitation trolley and found that this was checked daily in line with the trust's policy.
- We found some pieces of out of date equipment such as paediatric nasotubes, tegaderm dressings and bag valve masks.

Medicines

- Medicines management was part of mandatory training. Compliance was at less than the department target of 85% for medication management, drug history compilation and reducing harm from medicines. There was an action plan in place to ensure that the department met the trust target by April 2016.
- Medication was stored securely and fridge temperatures were regularly checked to ensure that drugs were stored at the correct temperatures. Medication was stored in an Omnicell directly linked to pharmacy who managed stock control.
- Patient group directives (PGDs - specific written instructions for the supply and administration of medicines to specific groups of patients) were used in the department. We saw that staff had signed to say that they understood them.
- None of the emergency nurse practitioners (ENP) we spoke with were nurse prescribers. This meant that they could only dispense medication in accordance with the PGDs. These were very specific and meant that sometimes staff could not prescribe medication when patients did not fit the criteria of the PDG. Staff reported that there were occasions when patients had to go to another service, such as A&E, to get a prescription for the medication they needed.

Records

- We looked at the clinical records of seven patients who had attended the ECC on the day of our inspection. Six

of the patients were in the department for longer than 60 minutes, one patient was in the department for 222 minutes and one patient was in the department for less than 60 minutes.

- We saw that there was clear information about the patients presenting condition in the records.
- Medication and pain scores were not always completed; however there were clear treatment and care plans.
- All of the records we looked at contained the necessary information about patients and we had no concerns about the standard of record keeping.
- 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.

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 of what to do.
- We saw evidence that referrals for vulnerable adults and children were regularly made and information was routinely sent to health visitors about all children who attended the department.
- Staff knew about specific safeguarding topics such as sexual exploitation, people trafficking and female genital mutilation (FGM).
- The IT system used by the department routinely displayed the number of attendances patients had made during the previous 12 months. Where there were concerns about a patients welfare, the system also displayed an alert to staff that gave specific details about any risks to the patient or to staff.
- All staff had undergone specialist training to treat children and used a specific tool to enable them to assess children and identify any specific concerns.
- Safeguarding training was overall below the trust expected standard of 85%. Training figures showed compliance as follows: Safeguarding adults level one

Urgent and emergency services

95%, safeguarding adults level two, 50%, safeguarding children level two, 95% and safeguarding children level three, 52%. There was an action plan in place to ensure that the department met the trust target by April 2016.

Mandatory training

- Staff told us they had no problems accessing mandatory training.
- The trust organised annual mandatory training days as well as using workbooks and e-learning to enable staff to complete mandatory training.
- Medical staff were not meeting the trust standard of training for 15 of 26 modules. They were not meeting the trust standard for the following modules: advanced paediatric life support, conflict resolution, blood safety, calculating drug doses for adults, drug history compilation, reducing harm from medicines, preparation and administration of parenteral medicines, deprivation of liberty, fire safety, health and safety, infection prevention and control, medical devices, Mental Capacity Act, and safeguarding children and young people level three.
- Nursing staff were not meeting the trust standard of training for 38 of 86 modules.
- We discussed levels of training with staff who informed us that there was an action plan in place to ensure that the department met the trust target by April 2016.

Assessing and responding to patient risk

- The department used a 'See and Treat' model of care. This meant that patients were not formally triaged on arrival. Clinical staff relied on information provided by patients to identify how unwell a patient was. Reception staff listened for trigger words and phrases to help with this however when we asked them, they said they had not received any formal training to assist them to do this. If reception staff identified a patient using a trigger phrase, this patient was brought to the attention of clinical staff so that clinical staff could make a decision about whether the patient should be seen more quickly. There was a risk that poorly patients would not be identified quickly and a risk that because initial observations were not carried out, that deteriorating patients were difficult to identify.
- The trust had identified that between 6pm and midnight, the department was too busy to safely run the see and treat model and had employed a nurse

specifically to triage patients. At other times, when the triage nurse was not working, if the department became busy, the triage model of care was used and one of the ENPs took on this role. There was no clear standard operation procedure or guidance about when to revert to the triage model. Staff told us, and during our inspection we saw, there were times when patients waited longer than 60 minutes before being seen by any clinician.

- Information sent by the trust shows that 95% of patients were treated and discharged within 192 minutes (three hours 12 minutes). The median time patients had to wait for treatment was 40 minutes.
- Staff reported that patients who were inappropriate to treat at the ECC regularly attended and had to be stabilised before being transferred to other services. The frequency of this was being recorded and the trust was carrying out a piece of work to analyse the impact of these occurrences.
- When patients were identified as needing to be transferred to another service, staff ensured that the patient remained safe and was stable. A standard operating procedure was in place and patients were transferred by ambulance to the most suitable service for them, such as NSECH. We saw this happen during our inspection. The organisation was monitoring the frequency of this.
- Staff were fully aware of the action they should take if patients deteriorated and there was a process in place for staff to follow. However, when the 'see and treat' model was in use, initial observations were not carried out; therefore it was difficult to identify if a patient had deteriorated since arriving to the department. Additionally, the waiting room was not within the direct eye line of clinical staff. There was a risk that deteriorating patients may be missed.
- There was emergency medical equipment in the department and staff had undergone life support training. This meant that patients could be stabilised while an ambulance was called to transfer them to NSECH.
- Using stickers, such as red triangles and hands, patient records clearly identified when patients needed assistance, or were at risk of falls, or of developing pressure damage.

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- We saw that known patient allergies were recorded in patient records and patients with allergies were given a red wristband to wear to ensure that they were easily identifiable.

Nursing staffing

- Although the department did not formally use an acuity tool, at the time of the introduction of the new configuration of the service, NICE recommendations for staffing levels had been adopted. Staff and managers told us that staffing levels were regularly monitored to ensure that staffing levels matched the demand for services.
- 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.
- We saw that staff effectively communicated the presenting symptoms and care needs of patients to colleagues starting the new shift or taking over responsibility for care.
- There were qualified members of the nursing team who worked in advanced roles as emergency nurse practitioners, treating patients with minor injuries and illnesses.
- The manager of the department told us that, after a successful recruitment campaign, there were currently no nursing vacancies in the department.
- Absences and annual leave were being managed using overtime and internal bank staff.
- Agency staff use in the department was very low. Between June and October 2015 only three shifts were covered by Agency staff.
- We saw that there was a local induction in place for all new staff including temporary staff.
- Between April 2014 and March 2015, there was a staff turnover rate of 11% (three staff) and 17% (three staff) for nursing and health care assistant (HCA) staff, respectively. Percentages were high because of the small numbers of staff involved.
- The sickness rate for nursing staff was 1.4% and for HCAs it was less than 1%.

Medical staffing

- Monday to Friday, the department was staffed by a consultant and junior doctor between 9am and 5pm and GPs with a background in A&E between 5pm and midnight. There was access to out of hours GP cover and the hospital on-call medical staff between midnight and 9am. Medical staff worked closely with local GPs to ensure cover.
- Overnight and weekend cover were provided by GPs who could be supported by consultants based at the main NSECH site if necessary.
- We observed doctors discussing patients and handing over relevant information to colleagues. We had no concerns about this process.
- There was limited locum use in the department and the locums who were used were used regularly and so were therefore familiar with the policies, procedures and organisation of the department.

Major incident awareness and training

- Staff in the department were aware of the role they would play if there was a major incident in the region. All staff told us that they would only accept patients with minor injuries.
- The department had a policy in place to manage patients presenting with suspected Ebola. There was sufficient equipment and a designated area of the department. Staff were aware of their roles and responsibilities in the event of a possible presentation.
- There was limited equipment available in the event of a major incident, such as hard hats, high visibility jackets, disposable body suits and washing equipment. These were stored in an area accessible to staff.
- The department had business continuity plans in place, in the event of system failures.
- Security staff were based on the site and were easily accessible if required.
- The department could be locked down easily to ensure the safety of patients should the need arise. Staff were aware of their roles and responsibilities.

Are urgent and emergency services effective?

(for example, treatment is effective)

Good



Urgent and emergency services

We rated effective as good because:

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. The hospital was taking part in local and national audits and monitoring patient outcomes. It was performing within acceptable standards.

Staff were able to access information about clinical guidelines. Information about patients such as test results were readily accessible.

Pain relief was offered to patients on arrival at the department and regularly during the duration of their attendance at the department. Patient and relative nutrition and hydration needs were managed and while we were inspecting the department, we saw patients being offered drinks and food. Relatives also confirmed that they had been offered food and drinks.

There was evidence of multi-disciplinary working throughout the department and the department offered a 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 looked at a reference tool available to staff and found that guidelines had been updated to reflect recent updates to NICE guidance.
- We saw evidence that the department followed NICE guidance for a number of conditions such as Sepsis, head injury and stroke. Where patients presented to the ECC with these conditions, pathways were commenced and arrangements made to transfer the patients to the most relevant A&E department.
- Care was provided in line with 'Clinical Standards for Emergency Departments' guidelines and there were audits in place to ensure compliance.
- Local audit activity took place within the department to measure staff compliance with departmental guidelines. For example, a new care bundle had been introduced to improve the care of patients with acquired kidney injury.

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.
- In the same survey, 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.
- A local patient survey for April to July 2015 showed that 83% of patients thought that staff had done everything they could to control pain.
- We saw that patients were being asked if they required pain relief and it was recorded 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.

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 while in the A&E Department.
- Staff told us (and we saw), that there were food packs available for patients 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.

Patient outcomes

- Between June 2015 and September 2015 the trust rate for unplanned re-attendance at A&E within seven days was 0.3% (better than the England average). The trust threshold rate was 5%.
- Departmental staff took part in CEM audits where they were applicable however due to changes in configuration of the department, only some aspects of the audit were applicable to the department. Managers told us that data was aggregated across the trust and submitted as one trust, rather than as individual locations. The available audit results related to audits carried out prior to reconfiguration of the services and therefore were no longer applicable to the service.
- The department had no CQUIN (Commissioning for quality and innovation) targets for 2014/2015 or for 2015/2016.

Urgent and emergency services

- During the inspection we saw that waiting times were displayed in the waiting area along with information about the last time the board had been updated.
- Trauma audit research network (TARN) information related to the department prior to its reconfiguration and was no longer applicable to the current configuration of the department as an emergency care centre.

Competent staff

- According to information provided by the trust, between April 2014 and March 2015, 81% of nursing and health care assistant staff underwent annual appraisals. In the same year, all of the medical staff underwent an annual appraisal. Staff told us they had regular appraisals and supervision sessions.
- We spoke with staff about whether they were able to access clinical supervision. Staff told us that clinical supervision took place. 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 44% of medical staff were not up to date with accredited advanced paediatric life support and 32% of nursing staff were overdue an update of paediatric life support training. 21% of nursing staff were overdue an update of immediate life support training.
- Health care assistants performed advanced roles such as taking blood. Among other duties staff were trained to put on plaster casts and take electrocardiograms (ECGs).
- Newly qualified staff were given preceptorship (mentoring and support) and newly employed staff shadowed existing staff prior to being counted as a member of the team for staffing purposes.
- 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.

Multidisciplinary working

- The ECC team worked effectively with other specialty teams within the trust for example by seeking advice and discussing patients, as well as making joint decisions about where patients should be admitted.
- There was good access to psychiatry clinicians within the department with 24 hour access by telephone to psychiatric liaison staff.
- There was a substance and alcohol misuse liaison team available by telephone to support patients and staff treating them.
- Allied health professionals attended 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 and other community services including social services, to ensure that patients were discharged with packages of care in place if this was required.
- The department worked closely with the ambulance trust, local GPs and the out of hours service 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 ECC offered a seven-day service, with consultant cover between 9am and 5pm during the week and ENP cover 24 hours a day, every day. There was also on-call consultant cover, by telephoning NSECH, so staff could seek advice if required.
- There was 24 hour seven day access to some diagnostic tests such as x-rays. Patients who needed more advanced testing were transferred to NSECH.

Access to information

- Staff were able to access patient information using the electronic system and using paper records. This included information such as previous clinic letters, test results and x-rays.
- Clinical guidelines and policies were available on the trust intranet.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

Urgent and emergency services

- We spoke with staff about the Mental Capacity Act (MCA) 2005 and deprivation of liberty safeguards (DoLs). Staff understood the basic principles of the Act and were able to explain how the principles worked in practice in the department.
- Training figures for MCA level two for medical staff were at 71% and for nurses, 55%. Doctors were 76% for DoLs. Nursing staff did not have to undertake DoLs training as part of their mandatory training.
- 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. We saw evidence of staff explaining procedures to patients and patients agreeing to them. Consent training was not indicated as mandatory training for staff working in the ECC.
- Parents of children attending the department told us that staff were understanding of their concerns and showed empathy towards them and their children.
- The trust scored about the same as other trusts in the 'CQC 2014 in-patient survey' for compassionate care.
- In the patient led assessment of the care environment survey, over the last three years, the trust scored 93% for privacy, dignity and wellbeing (national average 87%).
- The trust performed better than other trusts in eight of the 24 compassionate care questions in the 2014 Accident and Emergency survey. The trust scored 'about the same' as other trusts for the remaining 16 questions.
- The friends and family test showed that 94% of patients would recommend this trust's A&E/ ECC departments compared to a national average of 88%. However, response rates were low and the department carried out other patient engagement such as 'We're listening' and local satisfaction surveys. These all demonstrated positive feedback about the care and compassion patients received.

Are urgent and emergency services caring?

Good 

We rated caring as good because:

We witnessed patients being supported and receiving good treatment in the department. Patient feedback for the department was good.

Patients were involved in decisions about their care and treatment and diagnoses were explained in ways that patients could understand. There was a partnership relationship between patients and staff.

Emotional support was present for patients and wider support mechanisms were in place as required by patients and their relatives.

Compassionate care

- During our inspection, we spoke with six patients who described the care they received as caring and supportive. Patients described to us how staff treated them with dignity and respect.
- Survey results from the trust showed that 95% of patients thought they had enough privacy when discussing their symptoms and 96% thought they had enough privacy and dignity when being examined and treated.

Understanding and involvement of patients and those close to them

- According to patient feedback from April 2015 to July 2015, 92% of patients thought that staff had explained their condition or treatment in a way that they understood. 93% of patients thought that nurses and doctors listened to what they had to say and 81% of patients thought that staff addressed fears or worries they had. 91% of patients thought they were involved as much as they wanted to be in decisions about their care and treatment and 88% of patients had the results of tests explained to them in a language they could understand. 82% of patients were happy with the amount of information they received when visiting the department.
- During the inspection, we witnessed patients being given their diagnoses. Where fractures were involved, if patients wished to, they were shown their x-rays and breaks were pointed out and explained.
- 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 before they left the department. When patients needed to be transferred to another hospital, staff were seen explaining how this would happen and what would take place once the patient arrived at their new destination.

Urgent and emergency services

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.
- According to patients, staff offered support and gave information about support services if this was required.
- Staff could refer patients who presented with alcohol or drug problems (regardless of their age) to support services available under the 'Healthy Hospitals' campaign.
- Staff were observed delivering news in a sensitive and compassionate manner. To make sure patients felt supported, they took time to sit with them.

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

Good



We rated responsive as good because:

The configuration of the department and services around the region had been reconfigured to better meet the needs of the public. Patient pathways had been introduced to ensure that patients attended the most appropriate service to their needs. Since July 2015 the department had met the national four hour waiting time target and most patients were discharged within three hours of attendance. The trust was performing better than the England average for a number of other performance measures relating to the flow of patients.

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.

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 management of the department were aware of the changing demands on the department and worked

- closely with the local out of hours provider to manage demand, for example by identifying patients who had minor ailments and arranging for these patients to see a GP based in a department close by.
- 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 a different 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 for patients as well as having a service level agreement with the ambulance trust to transfer poorly patients.
- The department had acknowledged the mental health needs of the local population and had good access to mental health services.
- Children under the age of two could not be treated in the department between midnight and 9am. As new housing estates were being built around the hospital bringing the likelihood of younger families moving in to the area and more children, this was a concern.

Meeting people's individual needs

- The waiting room was 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 16. There was a dedicated paediatric waiting room and treatment rooms for children were separate from the adult treatment area. This meant that young people were away from the adult waiting and treatment rooms.
- 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.

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- There were private areas for relatives to wait while patients were being treated. Although there was no dedicated relatives' room, there was a private room where people who were recently bereaved were supported. They could wait in privacy. The room was comfortable and tastefully decorated. There were advice leaflets available for relatives.
 - 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 the patient or carer presented this at the department, staff used the information to assist them in making decisions about patient needs and wishes.
 - If patients had specific needs, alerts were put on to the electronic record system to alert staff. 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 of 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.
 - Information about expected waiting times was clearly visible and updated regularly, with the time of update noted. This meant that patients knew how long they could expect to be in the department.
 - For patients and relatives of all faiths, or none, there was 24 hour access to Chaplaincy services.
 - Patients with purely mental health needs often waited in the relatives' room if this was vacant.
- transfer or discharge them. Additionally, ambulance waiting times were too low to be statistically significant because only a very small number of patients were brought to the department by ambulance.
- Since June 2015, three patients had waited in the department for more than six hours before they were admitted, transferred or discharged. However, 95% of patients were in the department for less than 195 minutes (3 hours 15 minutes) before being admitted, transferred or discharged. Delays were due to patients waiting for ambulance transfer to NSECH.
 - The unplanned re-attendance rate for July 2015 to September 2015 was 0.3%. This was significantly better than the threshold of 5% set by the trust.
 - Only 3.2% of patients left the department before a clinician saw them. This was significantly better than the 5% standard set by the trust.
 - Between July 2015 and September 2015, 99% of patients who attended North Tyneside ECC were seen within four hours.
 - From our observations and discussions with patients and staff, patients were treated quickly. None of the people we spoke with expressed concerns about excessive waiting times.
 - Patients who needed to be transferred to NSECH occasionally experienced delays. Staff told us that this was because patients needed to be transferred by ambulance. Delays transferring patients were as a result of capacity issues within the local ambulance trust. The hospital trust and the local ambulance trust were working together to address capacity issues and possible delays. During our inspection, we saw that patients often had to wait more than 60 minutes for an ambulance to transfer them. We found that this did not have an adverse impact on patients as they were safe, stabilised and often receiving preliminary treatment. Where patients were identified as deteriorating, a more urgent ambulance transfer was requested.
 - Since the reconfiguration of the service, North Tyneside ECC had 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. This was because the hospital no longer accepted ambulance admissions other than by prior agreement.

Access and flow

- Due to the recent reconfiguration of the department in June 2015, from an Accident and Emergency department to an Emergency care centre, there was limited information about the length of time patients waited to be treated, or a decision was made to admit,

Learning from complaints and concerns

Urgent and emergency services

- 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.
- Between June 2015 and August 2015 there were 6 complaints received about the emergency care centre. Of these complaints, one related to attitude of staff and five related to all aspects of clinical treatment. There was evidence that complaints had been acknowledged and responded to in line with the trust's complaints policy. Feedback had been given to the staff involved and where appropriate, additional training had been given.

Are urgent and emergency services well-led?

Good



We rated well-led as good because:

Staff were engaged in the future development of the department and the vision and strategy of the trust were embedded in practice. There were governance, risk management and quality measurement processes in place to enhance patient outcomes. Staff felt that there was good leadership not only in the department but also within the trust. There was an inclusive, learning and supportive culture in the department and staff felt valued and appreciated.

Patient voice was seen as important and there were a number of initiatives within the trust designed to ensure that the opinions of patients influenced the delivery of services.

Staff were encouraged and supported to be innovative and we saw many examples of innovative ways of working within the department.

Vision and strategy for this service

- The trust had introduced a vision and five core values as well as three areas of focus for continuous improvement. Staff we spoke with demonstrated these values in the way they spoke about the department and the way they interacted with patients who attended. For example, staff told us that they felt part of a team and that everyone within the team was as important as each other.
- The trust had recently implemented a new way of working across the entire trust and in particular, in the way urgent and emergency care services were delivered. Staff and managers were able to describe the vision for urgent and emergency care. Staff were aware that the model was still evolving, developing and adapting to the new ways of working.
- Managers in the department were aware of the changing demands on the department and the types of patients accessing the department. Work was continually underway to ensure demand was managed appropriately and safely. Staffing numbers were continually reviewed and revised.

Governance, risk management and quality measurement

- There was a clinical governance system in place across the department. Staff worked across sites and were able to attend clinical governance, patient safety and clinical audit meetings. We saw that information was shared with all staff by those who attended the meetings, and to ensure that all staff were aware of the outcomes of the meetings, minutes were circulated around the department.
- There was a process in place to ensure that all relevant NICE guidance and drug alerts were implemented and that staff were aware of any changes.
- The staff we spoke with were clear about the challenges the department faced. They were involved in discussions about future developments in the department.
- A departmental risk register was available and was under regular review to ensure that the content of the register was reflective of the real-time risks within the department.
- The trust held regular Mortality and Morbidity (M&M) meetings and staff frequently attended and discussed relevant cases at team meetings.

Urgent and emergency services

- Each morning, the consultant working in the department that day, reviewed the clinical records of patients seen over night to ensure that all patients received the appropriate care and treatment.

Leadership of service

- We found that the leadership in the department was strong. During our inspection, we found that senior managers were visible within the department and readily available to support staff. Staff confirmed that this was the case.
- Staff told us that members of the executive team occasionally visited the department. Staff were complimentary about the senior management of the trust and a number expressed their disappointment that the chief executive was leaving. According to the NHS staff survey 2014, 87% of staff trust wide, knew who their senior managers were. This was better than the national average of 84%.
- Staff felt that their hard work was recognised and they felt appreciated. Trust wide, according to the staff survey, 70% of staff felt that their work was valued by their employer. This was better than the national average of 65%.
- 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 in a timely manner. They told us that the management team was open, approachable and provided good leadership.
- In the 'NHS 2014 staff survey', 56% of staff believed that staff who were involved in an incident, error or near miss were treated fairly. This was better than the national average of 48%.
- 57% of staff said they agreed or strongly agreed that they received feedback about changes made in response to incidents, errors, or near misses. The national average was 44%.
- 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

- The structure of the department and the way we saw staff interact with each other demonstrated that there was an open and respectful culture.

- Staff told us that staff supported each other to learn from incidents.
- The trust scored better than the national average for fairness and effectiveness of procedures for reporting errors, near misses and incidents at 3.67 (out of 5) compared to the national average of 3.54.
- According to the 2014 NHS staff survey, 77% of staff felt that they would be secure raising concerns about unsafe clinical practice. This was better than the national average.
- Staff told us that although patients were always at the centre of everything, they also felt important and valued by their colleagues, managers and the trust. The national NHS staff survey showed that 84% of staff believed that care of patients was the trust's top priority. This was better than the national average of 71%.
- Overall, staff told us they were proud to work for the hospital. The team appeared to be efficient, and teamwork was clear from our observations at the inspection. Staff worked well with each other.

Public engagement

- The trust took part in the national Friends and Family initiative and also carried out local surveys and questionnaires.
- Additionally, the trust had introduced an initiative called "We're Listening". This was a relatively new introduction however preliminary results provided suggestions from staff and the public about how services could be improved.

Staff engagement

- We saw that regular staff meetings took place every month for both medical and nursing staff.
- The national staff survey of 2014 showed that the trust as a whole scored better than other similar trusts for staff not working extra hours, staff not witnessing or experiencing bullying or harassment and staff not witnessing potentially harmful errors or near misses. There were no specific results for the emergency care centre.
- The national staff 2014 survey showed that the trust as a whole was performing better than other similar trusts in a number of areas such as: 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

Urgent and emergency services





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 emergency care centre.

- Staff told us that they were kept fully informed about changes to the configuration of the department and were given the option to work solely at North Tyneside General Hospital, or to work some shifts at NSECH. Staff we spoke with were happy to work across both sites to enable them to maintain their skills in dealing with more serious conditions that were treated at NSECH.

Innovation, improvement and sustainability

- The configuration of emergency care services delivered by the trust was in itself innovative. There were three emergency care centres (North Tyneside General Hospital being one of them) and NSECH which cared for patients with greater emergency health needs.
- There were clear pathways in place for patients to ensure that they attended to most appropriate hospital to meet their needs, with ambulance patients taken to NSECH.
- The staff in ECC were able to speak to consultants using a video phone so the specialist clinician could see the patient. This meant that specialist advice was also based on visual information as well as verbal information.
- There is a hospital admissions avoidance team in place. They will arrange home visits from physiotherapy and occupational therapy to ensure patients are safe in their homes and avoid being admitted.
- As long as patient safety remained paramount, staff told us that the trust encouraged innovation and was supportive of staff who wanted to try new ways of working.

Medical care (including older people's care)

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

Information about the service

Northumbria Healthcare NHS Foundation Trust provides medical care, including older people's care, across four sites including North Tyneside General Hospital. Northumbria Specialist Emergency Care Hospital opened on 16 June 2015 providing specialist emergency care for seriously ill and injured patients from across Northumberland and North Tyneside. The opening of this new hospital resulted in changes to North Tyneside General Hospital. Most medical admissions came from Northumbria Specialist Emergency Care Hospital and patients were transferred from there out to "base" sites which included this hospital. It had eight medical wards and an ambulatory care unit. The medical wards covered various specialities, including elderly medicine, elderly rehabilitation, ortho-geriatrics, cardiology, gastroenterology, respiratory medicine and stroke.

We spoke with 24 patients and visitors, 25 staff members including the management team, doctors, nurses, specialist nurses, therapy staff, health care assistants, and domestic and administration staff. We reviewed 16 sets of patient records. We visited eight wards and the ambulatory care unit, where we observed care and the environment. We observed meals being provided to patients, nursing handover and a multidisciplinary team meeting. Prior to the inspection we reviewed the hospital's performance data.

Summary of findings

We rated medical care as outstanding because:

Feedback from patients and visitors was overwhelmingly positive. Patients felt involved in their care and their physical needs were not the only consideration. Patients and relatives understood what their plan of care was and were able to be involved with this. All staff were committed to providing high quality patient focused care and took the time to meet the individual needs of patients and we were given examples of where staff had gone 'the extra mile' to make patients hospital stay a positive experience.

The medical services were managed by an experienced and cohesive team who demonstrated a clear understanding of the challenges of providing high quality and safe care. The leadership team had a shared purpose to ensure that this was delivered. They had identified and implemented actions and strategies to manage this and this had been done with the involvement of frontline staff. This meant staff we spoke with felt valued and were engaged with the process. Staff felt valued and were encouraged to contribute to service development. Governance processes were embedded which allowed clear identification and monitoring of risk and we saw evidence of related progress and action plans as well as ongoing review of risks. Innovation was encouraged. Diabetes research, in particular the long term self-management of diabetes, was at the forefront of medical research within the medical directorate.

Medical care (including older people's care)

There were robust systems in place for reporting incidents and for feeding back learning from these. The trust was a high reporter of incidents. All staff demonstrated a good understanding of the duty of candour and safeguarding. There were clear guidelines in place to manage deteriorating patients and staff felt these worked well when they had to be implemented. The wards we visited were visibly clean and tidy and we observed good practice in relation to infection prevention. Nursing and medical staffing was at a safe level and following a safer staffing audit looking at patient acuity, we were assured ward establishments were being reviewed. We observed and found evidence of good practice in relation to medicines management and documentation was comprehensive and fully completed.

Policies were up to date and were evidence based. Patients were provided with pain relief as required and the nutritional needs of patients were viewed as a priority. The role of nutritional assistants had a positive impact on meeting nutritional needs of patients. We observed strong multidisciplinary team working to provide holistic care for patients which was confirmed by feedback from different staff groups.

The opening of the new hospital and a different model of care meant patients were cared for on appropriate wards with a clear plan in place. There was ongoing engagement with external stakeholders to continue to develop and promote this model of care. There were good systems in place to manage patient flow and if a patient's condition deteriorated. Discharges were MDT focused to ensure all the needs of patients were met and discharges were safe. There was an open culture in relation to complaints and they were seen as a way of learning and improving services.

Are medical care services safe?

Good



We rated safe as good because:

There were robust systems in place for reporting incidents and for feeding back learning from these. The trust was a high reporter of incidents. All staff demonstrated a good understanding of the duty of candour and safeguarding. There were clear guidelines in place to manage deteriorating patients and staff felt these worked well when they had to be implemented.

The wards we visited were visibly clean and tidy and we observed good practice in relation to infection prevention.

We observed and found evidence of good practice in relation to medicines management and documentation was comprehensive and fully completed.

Nursing and medical staffing was at a safe level and following a safer staffing audit looking at patient acuity, we were assured ward establishments were being reviewed.

There were some gaps in mandatory training particularly basic life support, however plans were in place to ensure training had been completed by the end of the training year.

Incidents

- Trust policies for reporting incidents, near misses and adverse events were embedded within the medical service. Incidents were reported on the trust's electronic reporting system. Staff we spoke with, of various roles and grades, could tell us how they would report an incident and many could describe the process for a recent incident they had reported.
- There were no reported never events reported for North Tyneside General Hospital medical services for 2014/2015. Never events are serious, wholly preventable patient safety incidents which should not occur if proper preventative measures are taken.
- Between January 2015 and July 2015 there were 992 incidents reported on the medical wards at North Tyneside General Hospital. 650 were categorised as no harm, 300 as minor harm and 42 as moderate harm.

Medical care (including older people's care)

Themes of incidents were falls and pressure ulcers. This was reflected in the feedback from staff who told us themes of incidents were pressure ulcers and falls and that any patient with a grade two or above pressure ulcer was referred to the tissue viability nurse.

- Between February 2015 and July 2015 there were 14 serious untoward incidents and one serious learning event reported within medical services at North Tyneside General Hospital. Ten of these related to falls resulting in a fracture.
- We reviewed a copy of a root cause analysis (RCA) produced following a patient fall resulting in a fracture. This was comprehensive. Staff signed a sheet to indicate they had read it.
- We spoke with the falls team who received a copy of every incident form which related to a patient fall and they reviewed the patient. The falls team also attended weekly meetings regarding incidents and serious incidents and offered input around management of falls and complex patients.
- During our inspection we attended the weekly incident reporting meeting (IR1). At this meeting all incidents that had been reported during the previous week were discussed. Matrons and ward managers from all medical wards attended to discuss the incidents for their areas of responsibility and described the actions that had been implemented. Matrons advised of any further requirements, tracked any ongoing incidents and provided updates. This information was shared with all ward staff at monthly team meetings.
- Therapy staff told us their monthly team meetings always included the discussion of incidents and any actions taken.
- If an action plan was devised as a result of a single incident (or themes in incidents) a copy was sent to all ward staff as well as having a paper copy available on the ward.
- We saw evidence that the hospital held a mortality and outcomes data group meeting where mortality and morbidity were discussed. Mortality rates were also discussed at the Medicine and Emergency Care Business Unit Governance Group (BUGG) meeting.
- The duty of candour is a regulatory duty that relates to openness and transparency and requires providers of health and social care services to notify patients (or other relevant persons) of certain 'notifiable safety incidents' and provide reasonable support to that

person. This regulation applied to all NHS trusts from November 2014. Most of the staff we spoke with were aware of the duty of candour and spoke about being open and honest.

- We were provided with examples where the duty of candour had been applied when information was given about a patient to a non-family member and a meeting was held with a family when a patient fell sustaining a fracture.

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 measures 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.
- On each ward that we visited we saw that safety thermometer data was displayed.
- We reviewed safety thermometer data for the medical wards at North Tyneside General Hospital. The percentage of harm free care from October 2014 to September 2015 was between 83% and 100%. The England average for 'harm free care' is 95%.
- The percentage of completed VTE risk assessments was between 92% and 100% with the exception of one ward which, in July 2015, was 69% and in September 2015 was 76%.

Cleanliness, infection control and hygiene

- From April 2015 to September 2015 there were two cases of clostridium difficile within the medical service. Both cases were reported in September 2015.
- Between April 2015 and September 2015 there were no cases of methicillin resistant staphylococcus aureus (MRSA) infection. There had been one case in February 2015 on ward 12 which was investigated as a serious untoward incident.
- As a reminder, one ward put the date of when the next MRSA screen was due on the board above patients beds.
- Hand hygiene audits were completed monthly by each ward and the data was displayed on the ward. We reviewed audit data from April 2015 to September 2015. Hand hygiene compliance on the medical wards at North Tyneside General Hospital was between 80% and 100% with some wards consistently scoring 100%.

Medical care (including older people's care)

- Observations during our inspection confirmed the availability of alcohol gel and hand washing facilities in each bay and single side room. At entrances to clinical areas alcohol gel was available.
- Staff were observed using personal protective equipment (PPE) as required. We observed hand hygiene from all disciplines of staff while on the medical wards, and 'bare below the elbows' guidance was adhered to. The patients we spoke with said they saw staff washing their hands and using alcohol gel when attending to them.
- We reviewed attendance rates for infection prevention mandatory training. The trust target was 85%. One medical ward at North Tyneside General Hospital had achieved 96%, while the rest were below the target, with two wards only achieving 38% attendance. However, plans were in place to ensure staff completed training by the end of the training year which was March 2016.
- Single rooms were available on each ward if patients needed to be isolated. We were told if a single room was not available a risk assessment would be completed and a patient may be 'barrier nursed' within a bay as appropriate.
- Domestic staff told us they would be informed of any patients with an infection risk on the ward or those requiring barrier nursing. Domestic staff were managed by the domestic supervisor and provided seven day cover on the wards.
- Any patients from outside the trust were automatically screened for MRSA. An electronic system showed when screening was done and a positive screen led to infection precautions being used for ten days.

Environment and equipment

- The wards we visited were visibly clean and tidy. Care of the elderly wards were dementia friendly with adaptations and equipment such as clocks and signage.
 - All the beds were electric profiling beds. The falls team told us the trust owned 700 low beds. If any other beds, such as ones which go right to the floor were needed, these could be obtained within four hours.
 - We observed a variety of equipment to help prevent falls and keep patients safe. For example, to make it more difficult for patients to stand unaided and so prevent falls, there were chairs in use with a slight tilt. Ward staff told us these could only be used for certain patients. To try and stop patients slipping from chairs, one way glide sheets were also used. The falls team told us about trailing a new type of 'single use' glide sheet which could then go home with the patient. Also, to allow patients to sit with both feet on the floor, they were looking at investing in smaller chairs.
- The falls team also told us that they were in discussions with other trusts about moving away from using chair and bed sensors. The team felt the noise of the sensors could be very distressing for patients (particularly those with dementia) and described how some patients had pulled them apart leaving exposed wires. We were told a paper about reducing the use of them had been sent to the senior management team.
 - We checked equipment for evidence of safety testing. 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 on the medical wards and all had evidence of in date safety testing.
 - Staff told us they would contact estates for broken / non-functioning equipment and that they could loan equipment from other areas if needed and have done this, for example, with blood pressure machines.
 - Within ward areas they had access to bariatric commodes and beds could be hired when needed.
 - On the medical wards we reviewed checks of resuscitation equipment and did not find any gaps. Hypo kits for the management of hypoglycaemia (low blood sugar levels) were also seen on some of the wards with a log of when it was used.

Medicines

- The main pharmacy department was located at North Tyneside General Hospital and operated 7 days a week with a dispensing service at weekends to NSECH.
- The trust had up to date policies for the storage and administration of medicines and staff could access these on the intranet.
- Mandatory training for qualified nursing staff included medicines management level two, calculating drug doses for adults and drug history compilation. The trust target for this was 85%. Attendance figures for this were extremely variable between wards, ranging from 0% to 100% however plans were in place to address this and the training year did not finish until March 2016.
- On each ward the pharmacy team carried out three monthly controlled drugs checks but stock checks were

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completed by the ward nurses. On ward 5 we looked at two sets of controlled drugs documentation, selected randomly, and found the relevant checks and documentation to be correct.

- Ward sisters told us their wards scored lowest on their in-patient experience data for medication information on discharge and we saw evidence of this in the information sent to us from the trust. To address this the medical wards were working with families and the pharmacy team to improve information relating to medicines on discharge.
- We reviewed 16 medication charts across five different wards. We found them to be completed to a good standard with patient details fully recorded and any reasons for omissions documented.
- If a patient had a fall while in hospital we saw evidence of medications being reviewed.
- It had been identified that there were a number of risks associated with the administration of methotrexate. We reviewed data of an audit on correct prescribing and administration of this drug. The audit of ten patients revealed standards were adhered to in all cases. There were plans to do a further retrospective audit. The audit data did not specify which hospital at the trust it had been collected from.
- An audit performed by the pharmacy team looked at a number of National Patient Safety Agency (NPSA) medicine alerts and related actions and assurances of compliance. For example, the update about promoting safer use of injectable medicines and actions that made anticoagulant therapy safer. The audit concluded that the current policies, procedures and training were in line with the requirement of the NPSA. To provide ongoing assurance there were plans to repeat the audit in 2016/2017.
- Data was collected by the trust on medicines reconciliation. The target was 90% reconciliation of medicines within 24 hours of admission (which was a stretch target as opposed to a minimum standard). For the period January and June 2015 data for North Tyneside General Hospital showed the figures were between 82% and 91%.

Records

- We reviewed 16 sets of records across five of the medical wards. We found them to be completed appropriately and each contained completed risk assessments on topics such as: Malnutrition Universal Screening Tool (MUST); skin integrity; and falls.
- We saw care plans in place for those patients at risk of falls as well as stickers to clearly identify those patients at risk of falling or who had fallen. We saw various other documents which were completed in all the records we reviewed. For example the Skin Integrity Pathway (SKIP) and cannula care plans.
- There was evidence of patient and multidisciplinary involvement in care planning.

Safeguarding

- Mandatory training at the trust included adults safeguarding levels one and two and childrens safeguarding level two. We reviewed data on mandatory training attendance figures for nursing staff. The trust had set a target of 85% for adult safeguarding level one. Six of the eight wards had achieved this, and the other two had training attendance rates of 62% and 71%. All but one ward had achieved the target for safeguarding children and young people level two. Adults safeguarding level two was variable on the medial wards with figures between 0% and 93%.
- The trust had policies relating to adult and children and young people's safeguarding and staff could access these on the intranet. On the wards, information was also held in folders.
- All staff we spoke with had a good understanding of safeguarding and their role and responsibilities within this. The level of knowledge and understanding was appropriate to the different grades of staff we spoke with. Staff knew who they could contact if further information or advice was needed, including safeguarding leads and the safeguarding team.
- One member of staff gave an example of a safeguarding concern from the previous day and told us they completed a PROTECT form and a meeting was held with the health care team.
- We observed two nursing handovers and a multidisciplinary team meeting at which safeguarding concerns were highlighted and discussed.

Mandatory training

- The trust provided information on mandatory training compliance rates within medicine. There was a

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comprehensive list of training included within this the majority of which was mandatory. This included areas such as: infection prevention; blood transfusion; moving and handling; and conflict resolution.

- The staff we spoke with on the wards all told us they were up to date with mandatory training and that access to training was not an issue.
- The trust target for each training course was 85%, with the exception of childrens level two safeguarding which was 66%. Ward 3 compliance figures for basic life support were 57% and ward 2 was 50%. There were only three wards which had a percentage of more than 85%. It was identified that at the point of inspection the trust was part way through the allocated 12 months for mandatory training, so higher rates of completion was not expected until March 2016, which would account for some of the percentages seen.

Assessing and responding to patient risk

- To ensure deterioration in a patients condition was measured and (where required) medical review provided, all the notes we reviewed had a national early warning score (NEWS) chart in place. The scores on the charts were completed correctly.
- We reviewed data on an audit of NEWS scoring for medicine at North Tyneside General Hospital. From February 2015 to November 2015 96-100% of NEWS scores had been calculated correctly, although the audit did not state how many records had been included. The audit also looked at whether the medical responder was appropriate. Figures for this were variable. In July 2015 it was 100% but this fell to 43% in August, in September and October this rose to 100% but fell to 56% in November.
- In June 2015 the Northumbria Specialist Emergency Care Hospital (NSECH) was opened and this changed the way in which deteriorating patients were managed. Each area had a large poster displayed showing the transfer criteria for a deteriorating patient and actions to take when there was clinical concern for a patient. All staff we spoke with were aware of this. Many had experience of using it and said it had worked well.
- There was a cardiac arrest team on site and at least one member of the cardiac arrest team was trained in Advanced Life Support (ALS).

- Due to their medical condition, many patients had Treatment Escalation Plans (TEP) which clearly outlined ceilings of care and the treatments which would and would not be used if a patient deteriorated as well as a repatriation option to NSECH.
- Staff told us they used handover and handover sheets to be pro-active in identifying potential risks. They would use high visibility beds if a patient was at risk of falls or they were becoming unwell. If information given to them from NSECH identified a risk, the ward would make a bed available in a high visibility area before they arrived.
- To enable prompt treatment a tool was used designed to identify sepsis (a life threatening infection) and we saw posters about the sepsis 6 bundle (a bundle of medical therapies designed to reduce the mortality of patients with sepsis).
- The resuscitation team did not include an anaesthetist but the use of airways that did not require intubation had been introduced and this practice conformed to guidelines issued by the Resuscitation Council.

Nursing staffing

- The National Institute for Health and Care Excellence (NICE) state that, when making decisions about safe nursing staff requirements for adult inpatient wards in acute hospitals, assessing the nursing needs of individual patients is paramount. The service had implemented a 'Safer Nursing Care Tool' (SNCT) to assess the staffing requirements across wards.
- Planned and actual numbers of staff were displayed in each ward area and at the time of our inspection actual staffing levels were achieved. The ward managers we spoke with told us staffing establishments were not quite right but they felt assured that a recent acuity audit using the safer nursing care tool should address this. In the interim period wards have been working above their establishment. This was achieved by using bank staff and overtime and further support was available at night for staff from clinical practitioners. Initially some staff felt requesting more staff was questioned, but more recently, as there was more information and understanding around the numbers and acuity of patients, there were no issues in getting additional staff. Staff felt management valued the importance of the right staffing number and skills mix. This was reflected in discussions with the senior

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management team who identified nurse staff as their top risk. We were told recruitment was ongoing and that the focus had been on staffing recruitment within the base units when NSECH was being opened.

- We reviewed information provided on staffing vacancies which showed these were at 0% for the medical wards at North Tyneside General Hospital.
- Qualified nursing turnover rates were between 0% and 17%. The data showed there were some vacancies for health care assistants and these figures were between 7% and 40%.
- When NSECH opened the medical wards at North Tyneside General Hospital reduced their number of beds to 21 with three additional beds for escalation. At the time of our inspection five out of the eight medical wards had over 21 patients. However, we saw the staffing escalation flowchart (which was visible on all the wards) being followed and staff were moved from other areas to support.
- We observed handover on two of the wards which was very comprehensive. The patients clinical condition and any ongoing treatment and plans were clearly described. Patients due to be discharged were prioritised and risks and any deteriorating patients were highlighted.

Medical staffing

- The ratio of consultants was better than the England average. The trust showed 35% consultant cover compared to the 34% England average. Registrars were slightly below at 37% compared to the 39% England average. In the medical division, staff ratios were comparable to the average national data, although there was a slight increase to the percentage of junior doctors employed by the trust. A review of staffing had increased the number of junior medical staff.
- Orthopaedic doctors were also available in the fracture clinic if advice was needed.
- It had been identified that NSECH would impact upon training for junior doctors at this site as there would not be acute admissions. To enable them to widen their learning experience they were given, each month, two days protected time at NSECH.
- The junior doctors we spoke with said they felt very well supported and could always contact a senior doctor when needed. We observed a consultant leaving their mobile number for junior doctors to contact them if they had any concerns.

Major incident awareness and training

- The trust was part of the North East Escalation Plan (NEEP). Throughout the winter NHS organisations in the North East report the level of activity they are having to deal with and the level of resources available (surge and capacity).
- The NEEP is based on six levels of escalation ranging from 1: normal working (white alert), to 6: potential service failure (black alert). All of the alerts have agreed triggers and actions whereby staff review individual systems and escalate command and control accordingly within their respective organisation. During our inspection, the trust was at a NEEP level 2.
- The wards we visited each had escalation beds but many of these were already in use and because of this senior staff on the wards were unsure of plans in terms of winter pressure. At a governance meeting the possibility of opening another ward had been discussed but due to staffing concerns it had been decided not to do this. Although not all staff could describe the major incident plan, they knew where to access the information and that they would be guided by senior staff. We saw a copy of the major incident plan on one of the wards which had been recently updated. There had recently been a table top major incident exercise which senior staff had attended.

Are medical care services effective?

Good



We rated effective as good because:

Policies were up to date and were evidence based.

Patients were provided with pain relief as required and the nutritional needs of patients were viewed as a priority. The role of nutritional assistants had a positive impact on meeting nutritional needs of patients.

We observed strong multidisciplinary team working to provide holistic care for patients which was confirmed by feedback from different staff groups.

Staff demonstrated a good knowledge of MCA and DoLs. Not all staff had received their annual appraisals although actions had been implemented to address this.

Medical care (including older people's care)

The Summary Hospital-level Mortality Indicator (SHMI) remained within the expected levels.

Evidence-based care and treatment

- Staff used both the National Institute for Health and Care Excellence (NICE) and Royal College guidelines to determine the treatment they provided. Local policies were written in line with this.
- We reviewed policies during our inspection and found them to be relevant and validated. Policies could easily be accessed on the trust intranet.
- There was a programme of audit activity within medicine. Many of these were completed by the ward sisters, for example, NEWS and 'Position Right to Outsmart Pneumonia' (PROP) which was audited monthly and data was uploaded electronically. We were told the use of PROP on the medical wards had reduced the incidence of hospital acquired pneumonia and raised awareness with staff and patients about positioning.
- We were told link staff for infection prevention completed weekly hand hygiene and commode cleaning audits. Emails were sent if these were not completed. Any actions resulting from this were followed up and results displayed on ward areas.
- Changes in practice had occurred as a result of data collected, for example, the use of the falls bundle and support and feedback from the falls team.
- Diabetes research, in particular the long term self-management of diabetes, was at the forefront of medical research within the medical directorate.

Pain relief

- Pain relief was provided as prescribed and there were systems in place to make sure additional pain relief could be accessed by medical staff if required. In the records we reviewed we saw pain scores completed for patients. Patient records included the management of pain relief and it was incorporated into the elements of care. This included the management of pain and checks were recorded as required.
- Patients told us that they were asked about their pain and whether they required any pain relief. Patients we spoke with had no concerns about how their pain was managed.
- Staff told us they have access to the pain team who assessed patients quickly and there was never a delay in them attending.

Nutrition and hydration

- Patients were assessed regarding their nutritional needs using the Malnutrition Universal Screening Tool (MUST). In the 16 sets of records we reviewed this was found to be completed.
- To provide patients with eating and drinking assistance nutritional assistants were employed. Staff on the wards felt they were a valuable addition to the team. They had time to spend encouraging patients to eat and could ensure regular snacks and drinks were taken by patients. The nutritional assistant completed a board indicating which patients required assistance with meals. We saw that ward 5 had obtained 100% on a nutrition audit.
- An audit in April 2015 looked at the impact nutritional assistants had on weight loss in elderly patients. The audit took place on ward 3 and 23 and concluded that the wards with a nutritional assistant in post had a statistically significant improvement in weight gain. An unexpected effect of this was a trend towards reduced length of stay. To continue to promote the importance of nutrition, a further recommendation was that all elderly care wards should consider employing a full-time nutritional assistant.
- We found that fluid balance charts were particularly well completed. Staff we spoke with felt that the nutritional assistant played a significant part in this.
- We observed mealtimes which were protected although family could visit to encourage or assist patients with meals. All staff were seen to help with providing meals for patients, and so meal times ran as smoothly as possible one person was allocated to answer bells and take people to the toilet.
- We observed patients being sat up ready for meals, family members present to assist and staff assisting patients who required it and checking on those able to feed themselves.
- We observed all patients had fresh water available and appropriate crockery at hand. Patients were seen being offered hot drinks and mid-morning snacks.
- Patients reported a good choice in meals.
- One lady told us she had been able to visit outside of visiting times to support with meals as 'mum is a fussy eater'.

Patient outcomes

Medical care (including older people's care)

- The Sentinel Stroke National Audit Programme (SSNAP) is a programme of work that aims to improve the quality of stroke care by auditing stroke services against evidence based standards. In the SSNAP results for 2015, North Tyneside General Hospital was rated A. This is the highest score possible. We visited ward 22 which provided stroke and rehabilitation care, and we observed patients receiving therapy support.
- North Tyneside General Hospital scored in patient care better than the England average on 3 measures of the 4 in the 2014 Heart Failure Audit.
- The Myocardial Ischemia National Audit Project (MINAP) showed that North Tyneside General Hospital has improved in three and worsened in one of the four measures when comparing data from 2012/2013 and 2013/2014. This hospital was below the England average in two measures and above in two measures.
- The standardised relative risk of re-admission rate for elective general medicine was lower (better) than the England average of 63 compared to a national average of 100. In non-elective general medicine it was also better at 87 compared to a national average of 100.
- Physiotherapy staff told us about Fast track protocols for early mobilisation which aimed to reduce length of stay.
- There was in-service training for physiotherapists particularly when starting a new rotation, for example, on dementia, Parkinson's disease or stroke and the particular challenges these conditions may present when mobilising patients.
- We spoke with bank staff who told us they had induction shifts when they first started where they were additional to the actual staffing numbers, and then a buddying system was used when they started.
- All staff on the respiratory ward were trained to care for patients who required non-invasive ventilation.
- Some junior doctors (Core Medical Trainees) stated that they did not find their experience adequate at this hospital in terms of medical care, in that it did not give exposure to patients in the acute phase of their illness (which was all concentrated on NSECH).
- The consultants and managers recognised this and were actively working on ways to improve the experience. Foundation Doctors (FY1's and FY2's) did get some time at NSECH as did Registrars (Specialist Trainees).
- Medical education was a standing item agenda.

Competent staff

- We reviewed appraisal rates for nursing staff on the medical wards. Figures for April 2014 to March 2015 were variable. The trust target was 85%; four of the eight wards had achieved this. Appraisal rates for ward 2 were 33% however we were informed this back log had been inherited and permission has been given to book bank staff to free people up to have their appraisal.
- As many of the wards had changed speciality, additional training had been provided. For example, ward 5 which had previously been a medical ward now took orthopaedic patients for rehabilitation. Specific moving and handling training had been provided by the physiotherapists and training on wound care. Physiotherapy staff told us there were plans to supply informal training for nursing staff on equipment and how to get people out of bed and to promote independence.
- A comprehensive preceptorship programme was in place for newly qualified staff.
- In all areas we visited we observed multidisciplinary working. The practice of working together with different staff groups was embedded and ensured holistic care for patients.
- On the wards a brief handover took place with the physiotherapist and occupational therapist each morning, Monday to Friday. A full multidisciplinary team (MDT) meeting took place weekly with a consultant present.
- We observed a MDT meeting attended by a social worker, physiotherapist, occupational therapist, doctor and nurse. Short and long term patient treatment plans were discussed. Social workers were present on the ward four days a week. On complex discharges ward staff told us they would liaise with community matrons.
- We spoke with the 'hospital to home team' who told us: 'this was a combined team consisting of social workers, occupational therapists, care managers and nurses.' The aim of the team was: 'to provide safe prompt discharges and provide short and long term care packages in the community as well as signposting patients to other health services'.

Medical care (including older people's care)

- The physiotherapists told us they had good working relationships with the nurses and health care assistants. They worked together to look at how to solve any problems.
- The falls team had a link nurse on each ward, who met monthly and in May 2015 had an away day. To improve learning in falls practice they invited guest speakers to their away day. One such speaker was an ophthalmologist, who explained it can take several weeks for people's eyes to adjust to a new prescription. As a result, falls nurses were advised not just to note that the patient 'wore reading glasses' but note instead whether the patient had a new prescription.
- To engage families with falls prevention the falls team told us they spoke with families.
- The falls team were looking at integrating more with community falls work and development of a falls passport. The matron was involved with this project.
- We saw anti-coagulant specialist nurses visiting the medical wards to check appropriate medication was prescribed and offer advice.
- We were told specialist nurses responded promptly, for example, once a referral had been sent, the diabetes team came the next day. Staff told us if they needed urgent advice this would be given over the phone.
- Junior doctors told us they had cared for a number of dying patients and the palliative care team were very supportive. The medical staff told us they also had good links with old age psychiatry.

Seven-day services

- Consultant cover was available Monday – Friday for the medical wards with a geriatrician available at NSECH at the weekend and during the night.
- Ward rounds took place in the morning with the medical team.
- Staff we spoke to told us that there was access to on-call physiotherapists, radiologists, pharmacists and chaplaincy.
- Physiotherapy was available five days each week with on-call cover available at weekends. Occupational therapy provided a Monday to Friday service.
- The 'Hospital to home team' worked Monday- Friday; however in the future there were plans to extend this service to cover the weekend.
- The trust provided seven day services for all emergency attendances and admissions from NSECH. It met all ten

national standards for seven day working. A comprehensive transfer plan was in place for deteriorating patients to access emergency care seven days a week.

Access to information

- Nursing and medical staff told us they could easily access policies and guidance on the intranet. On the wards paper copies of regularly used documents were also available.
- Every three months the falls team produced a link worker newsletter which contained details of any new ideas or learning, which was sent to all the wards.
- Handover sheets contained relevant information on patients medical condition, past medical history, ongoing treatment and any identified risks.

Consent, Mental Capacity Act (MCA) and Deprivation of Liberty Safeguards (DoLS)

- The trust had a policy in place to cover DoLS. This included details of the appropriate process and contacts for when DoLS applications were required. The policies were accessed from the trust intranet and paper copies were also available, so staff could easily refer to them.
- We reviewed data relating to MCA and DoLS training for the medical wards at North Tyneside General Hospital. DoLS training data supplied for 5 out of 8 wards showed training between 0-100%.
- MCA training rates were between 25%-100%. As mentioned previously the training year ended in March 2016, which gave time for training to be completed.
- Patients were asked for their consent to procedures appropriately and correctly. When helping patients with personal care we saw staff obtaining verbal consent.
- Staff told us that Information on DoLS and the MCA was contained within an easy access folder.
- Staff we spoke with were confident in identifying any issues in regard to mental capacity and in accordance with trust guidance, knew how to escalate concerns.
- We observed a DoLS which was in progress with a gentleman who had been admitted. He had been seen by a psychiatrist. His next of kin had been present during a 'best interests' meeting. It was explained that, to protect the patient in the short term, a DoLS would be applied if agreed, and if required discussion was to be held with an independent mental capacity advocate (IMCA).

Medical care (including older people's care)

Are medical care services caring?

Outstanding



We rated caring as outstanding because:

Feedback from patients and visitors was overwhelmingly positive.

Patients felt involved in their care and their physical needs were not the only consideration. Patients and relatives understood what their plan of care was and were able to be involved with this.

All staff were committed to providing high quality patient focused care. Wards felt very calm despite being busy and taking into account the dependency of the patients. Staff took the time to meet the individual needs of patients and we were given examples of where staff had gone 'the extra mile' to make patients hospital stay a positive experience. Patients on every ward had all they needed within reach and the nutritional assistants ensured drinks and snacks were available throughout the day. Relatives we spoke with praised the staff and the care their relatives had received.

Compassionate care

- As part of our inspection we visited all the medical wards and observed care. This involved observing staff speaking with patients and relatives in person and on the telephone. To understand how patients found their experience of being on a medical ward we spoke with 24 patients and visitors across the medical wards.
- All of the patients and visitors we spoke with were extremely positive about the care they had received. We did not receive a single negative comment. Patients felt safe and one said staff are vigilant with regards to people coming on the ward.
- One patient told us: 'all you have to do is ring and they are at your bedside' and another said: 'nothing is too much trouble'. On all the wards we visited buzzers were observed to be answered quickly and all patients were seen to have call bells within reach.
- Several patients and visitors spoke about staff being very approachable and flexible around visiting times.

This meant family members who may not have been able to visit were able to as they could arrange to come with a time that was convenient for a friend or family member to bring them.

- Patients spoke very positively about the nursing and medical staff in relation to keeping them informed of what was happening. Communication was said to be very good and a particular patient said: 'they had been provided with lots of information from the medical staff and that they feel very safe, more so than at other hospitals they had been to'. Another patient said: 'staff always explain what they are doing while maintaining privacy and dignity', and: 'they always make sure you are ok before leaving the room'.
- Patients said they were encouraged to be independent and we observed two therapy staff spending twenty minutes gently encouraging and trying to motivate a patient to mobilise.
- We were given examples from patients who felt other aspects of care had been considered which had a positive impact. For example, one lady described a 'lovely bubble bath and having her hair washed'. Another patient said: 'many more things have been done for me on this ward, they got me a splint for my wrist which is not the reason I came into hospital'.
- We were also told about a party which was arranged in the dayroom as it was a patients birthday and wedding anniversary. 32 members of the family attended and nothing was too much trouble.
- Several patients made reference to other hospitals they have been in and how this one was so much better.
- The comments from patients were reflected in the Family and Friends Test (FFT) data which showed between August and October 2015 75% to 100% would recommend the service. These results were specific to the medical wards at North Tyneside General Hospital.
- The medical wards also collected monthly real time data on patient experience, which looked at ten areas, including: respect and dignity; kindness and compassion; and involvement. Results of these were seen displayed on each ward with each domain given a score out of ten. We reviewed data specific to North Tyneside General Hospital for October 2015, which showed an average score of 9.51 against the trust recommendation of 9.53.

Understanding and involvement of patients and those close to them

Medical care (including older people's care)

- We observed staff talking with patients and relatives about their care. Patients told us they felt involved in their care and decision making. They could tell us about their plan of care and estimated discharge date. One patient who was due to be discharged later could clearly describe that he had to go to the discharge lounge and await his medication before leaving.
- We observed an explanation being given to a patient prior to intravenous antibiotics being administered.
- We observed multidisciplinary team meetings which were holistic because they took into account the wishes of patients and their relatives. We observed staff knowing and understanding their patients. For example, at one meeting we observed, it was highlighted that a carer of a patient seemed 'stressed', and an action was noted to follow this up.

Emotional support

- To look at the emotional needs of patients the medical service had strong links with the psychiatry old age service. They could be accessed as required.
- Clinical nurse specialists were available for support and advice, for example in relation to diabetes or for respiratory conditions.
- Feedback from patients was that they felt supported and informed about their care. We were told: 'the ward have looked at more than just my mothers physical needs'.

Are medical care services responsive?

Good



We rated responsive as good because:

The opening of the new hospital and a different model of care meant patients were cared for on appropriate wards with a clear plan in place. There was ongoing engagement with external stakeholders to continue to develop and promote this model of care.

There were good systems in place to manage patient flow and if a patients condition deteriorated. Discharges were MDT focused to ensure all the needs of patients were met and discharges were safe.

There was an open culture in relation to complaints and they were seen as a way of learning and improving services.

Service planning and delivery to meet the needs of local people

- Following several years of discussion, planning and widespread public engagement, NSECH was developed and subsequently opened in June 2015. NSECH is the first purpose built hospital of its kind in England, dedicated to providing specialist emergency care. Although the impact of this resulted in the transfer of all complex emergency care services from North Tyneside General Hospital, the opening of NSECH replaced these services with a state of the art emergency care department in Cramlington.
- There was ongoing engagement with external stakeholders such as Northumberland County Council, health and well-being boards, and clinical commissioning groups. We saw evidence of quarterly forum minutes and bulletins.

Access and flow

- Following initial assessment patients were usually admitted from NSECH. The bed management team would transfer patients coming from NSECH and ward staff would be contacted with relevant patient details. If a patient significantly deteriorated and did not have a TEP in place, or required surgery, they would be transferred back to NSECH.
- Staff on ward 5 could recall that there were four transfers back to NSECH due to wound problems.
- The criteria would be followed for a deteriorating patient and feedback from nursing and medical staff said this system worked well and many staff had experience of using it.
- Since NSECH had opened, data provided by the trust showed a significant decline in the number of medical patients on surgical wards ('boarders'), meaning more patients were being cared for on the appropriate ward. In April 2015 there had been 58 boarders and 53 in May. This had reduced to four in August 2015 and 11 in September. Also, staff told us that there had been less bed moves for patients. Without reducing their bed base, ward 12 had space to accommodate bariatric patients.
- The 18-week referral to treatment (RTT) performance between April 2013 and May 2015 was consistently

Medical care (including older people's care)

better than the England average and above the national standard. For example, in May 2015 the England average rate was 94%; however the trust was below 98% for the same period.

- We reviewed data in relation to bed occupancy on the medical wards at North Tyneside General Hospital. This data was red, amber, green (RAG) rated. Figures for general medical, cardiology and elderly medicine wards between April and September 2015 fluctuated with percentages between 98% and 75%.
- The hospital has a dedicated bed management team. The modern matrons held the bleep for this and there were daily team telephone calls three times each day to look at pressures across the medical directorate. Also, bed data was captured at 09.30 and 16.00 each day. The nurse practitioner within urgent care at NSECH held the bed management responsibility out of hours. This arrangement was in place seven days a week.
- As many discharges were complex they were MDT focused. We saw discussions regarding discharge at handover and comprehensive discussions at MDT meetings to ensure timely and safe discharges.
- The hospital to home team could be utilised to facilitate quick discharges.

Meeting people's individual needs

- It was identified by all of the staff we spoke with that since the opening of NSECH many of the patients being cared for on the medical wards had very complex needs. Comprehensive risk assessment and multidisciplinary care planning enabled the complex needs of patients to be met. For example, physiotherapy staff identified that due to many patients having fluctuating levels of delirium it can make mobilising patients difficult. To address this and to ensure the safety of patients and staff is maintained, we were told the mobility plan will always be based on more difficult times, which ensured that staff have equipment ready should they require it. We were informed they will always advise nursing staff to go with the safest option for mobilising.
- For patients who required it, isolation risk assessment was used, which also considered the psychological impact of being isolated. This meant that a holistic approach was taken to isolation because the emotional and physical needs of the patient were taken into consideration.
- Wards were dementia friendly with appropriate signage and equipment. The day room on ward 23 was

completely focused around the needs of patients. It was very welcoming with a large screen TV, music, dining table, pictures and books. There were dementia champions on many of the wards.

- The hospital has a learning disabilities link nurse. The involvement of carers was encouraged and patient passports were used.
- One ward told us, to make a patient with learning difficulties stay less stressful, they made arrangements for the patients mother to stay overnight.
- Junior doctors we spoke to said that end of life care at the hospital was extremely good. It was accessible and they were often involved in the care of these patients. They also told us that a care of the dying pathway was in use for these patients.
- Staff told us they could access translation services if they had patients who did not speak English.
- Bariatric equipment was available and additional equipment could be ordered when needed. To try and have it in place before they arrived this could be identified prior to patients transferring from NSECH.

Learning from complaints and concerns

- 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.
- Staff were aware of the trust's complaints policy and would follow this. All staff said they would try to resolve any concerns at ward level rather than simply referring patients or relatives to the Patient Advice and Liaison Service (PALS).
- Between 2014 and 2015 there were 51 complaints for medical services at North Tyneside General Hospital. These clearly outlined outcomes and actions taken. For example, following a complaint when a ward was particularly busy and the needs of a patient were not met, the induction for new staff and band and agency staff was reviewed.
- The trust welcomed the views of patients and visitors so complaints were viewed as a way of learning and improving. Complaints were discussed at all levels and at monthly governance meetings.
- We were given examples of two recent complaints about the hygiene and cleanliness of a ward and communication. These had been shared with the staff.

Medical care (including older people's care)

For example, for the communication complaint, an action plan had been devised which asked staff to reflect on the feedback and look at their attitudes and behaviour.

Are medical care services well-led?

Outstanding



We rated well-led as outstanding because:

The medical services were managed by an experienced and cohesive team who demonstrated a clear understanding of the challenges of providing high quality and safe care. The leadership team had a shared purpose to ensure that this was delivered. They had identified and implemented actions and strategies to manage this and this had been done with the involvement of frontline staff. This meant staff we spoke with felt valued and were engaged with the process.

Staff felt valued and were encouraged to contribute to service development.

Governance processes were embedded which allowed clear identification and monitoring of risk and we saw evidence of related progress and action plans as well as ongoing review of risks.

We observed a positive open culture with all staff focused on providing high quality and safe patient care.

Staff and patient engagement was seen as a priority with several systems in place to obtain feedback. Innovation was encouraged. Diabetes research, in particular the long term self-management of diabetes, was at the forefront of medical research within the medical directorate.

Vision and strategy for this service

- The opening of NSECH in June 2015 was a result of several years of planning and consultation. This was the first hospital in England to be built using a new model of care to optimise operational efficiency and improve patient experience and outcomes. The service had implemented its long term strategy with the opening of the new hospital and reconfiguring services at North Tyneside General Hospital. There were short term strategies to manage situations which had arisen as a result of the changes, for example a safer staffing review

and a focus on recruitment. We were told about plans to relocate two wards within the hospital to areas where the environment would be more suitable for the patients they were caring for.

- There was a very clear vision of delivering the highest standards of patient care with quality and safety as a key focus. Staff from all areas we visited were aware of the vision of promoting safe and effective care to improve patient experience. This was reflected in the 2014 NHS staff survey results as 84% of staff said that care of patients was 'my organisations top priority'. The national average for this was 70%.
- We were told the change had to be supported and led by consultants so a lot of time was spent building those relationships. In addition, the recruitment process for new consultants had helped to recruit the right people by having a mixed interview panel of different grades of staff to gain a wider perspective.

Governance, risk management and quality measurement

- There was a well-defined structure for risk management and governance. We reviewed minutes of the clinical governance meetings which took place every two months. There were systems in place to share with staff information from these meetings. The senior management team were continually reviewing risk to reflect the changing needs of care.
- The senior management team highlighted their top risk as nurse staffing. The wards we visited told the inspection team about the safer staffing tool which had been used to gather data between September and October 2015. This reassured staff that this would demonstrate the increased acuity of the patients they were caring for and help inform a review of ward establishments.
- The senior management team saw demand and volume as their other risk. The new way of working with NSECH opening had transformed the way healthcare was being delivered and it was acknowledged that some systems and processes were still developing and being adapted. In particular, the complexities of patients were greater than expected, so there was ongoing work with patient pathways.
- We reviewed the departmental risk register which was reviewed at the clinical governance meeting. This was separated into sub business units with a designated officer for each. We reviewed the information on the risk

Medical care (including older people's care)

register and found it was in alignment with what staff felt was the biggest risk or 'worry' to the service. There were action plans, review dates and completion dates attached to each risk. For example, the difficulty in recruiting qualified nurses in to elderly medicine.

- Most of the staff we spoke with could talk about the duty of candour and we were provided with examples of when this had been used. We observed an open culture in relation to incident reporting and complaints and associated learning.
- We saw evidence of robust clinical internal audit activity covering a wide range of topics, including sepsis, hand hygiene and nutrition. Much of this data was displayed in public areas and action plans were seen where improvement was required.

Leadership of service

- We saw evidence of strong leadership and clinical engagement. Leadership was encouraged at all levels and staff were supported to try new initiatives. For example, due to flexible working, to give continuity of care, physiotherapy staff within the hospital were able to provide follow up at home for some patients. This was seen in the 2014 NHS staff survey results which showed 76% of staff reporting they felt able to contribute to improvements at work. This was higher than the national average of 68%.
- The management team demonstrated a clear understanding of the challenge of providing high quality and safe medical care with the reconfiguration of services and ongoing review of patient activity and acuity.
- Staff told us the executive team were visible and senior managers supportive. This was particularly mentioned by senior nurses we spoke with as many were relatively new to the post.
- Staff told us there were good relationships with line managers and comments such as: 'my manager is exceptionally supportive and knowledgeable' were made. This was reflected in the NHS 2014 staff survey results which showed a score of 3.89 for staff being supported by immediate managers. This was higher than the national average of 3.65.
- We observed matrons in clinical areas during our inspection who demonstrated a good awareness of activity for that day and any risks within their service.

Culture within the service

- We were told by the senior management team a lot of energy was placed on the culture of the trust particularly in relation to the new hospital opening. This was evident throughout our inspection and although staff had gone through a significant period of change they were very positive.
- The senior management team told us the good relationships between doctors, nurses and management had helped support meaningful change.
- Staff told us they were given the freedom to make decisions and all staff were on an equal footing. Staff referred to 'The Northumbria Way' which brought together all the programmes of work within the trust. Senior management told us there had been occasions where staff had not been recruited if they were not supportive of this way of working.
- We observed strong multidisciplinary team working which was patient focused. Staff of all grades told us they felt valued and respected, and junior doctors commented: 'it is the best trust I've ever worked in'. As a staff group they told us they were listened to if they raised concerns.
- Results from the 2014 NHS staff survey indicated 77% of staff felt that they would be secure raising concerns about unsafe clinical practice. This was better than the national average.

Public engagement

- There was evidence of extensive engagement with patients and the public and the trust actively sought their views and opinions.
- The patient experience team visited the medical wards monthly and collected data from patients. Findings were fed back the following day to ward sisters. Comments from patients were also displayed on notice boards within each ward area.
- Data relating to inpatient experience was displayed on each ward and covered several areas such as: dignity and respect; involvement; and pain control. Each was given a score out of ten. Data was reviewed from the medical business unit for North Tyneside General Hospital for October 2015 and scores were between 8.05 and 9.92. All the wards we spoke with said they scored lowest for medicines and that this was largely due to the types of patient they cared for. The questions asked were around understanding of medications the patient had to take and some patients found it difficult to retain

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this type of information and relied on relatives/carers. We were told work was in place to try and address this by involving relatives in discussion on medication and working with the pharmacy team.

- Two minutes of your time feedback was also collected on discharge. This asked six key questions about the care patients received during their in-patient stay.
- The service actively promoted projects relating to patient experience. An example of this was the 15 steps challenge. This is a series of toolkits which are part of the productive ward work stream. It was developed by various staff groups, patients and volunteers to help capture what good quality care looks, feels and sounds like. We reviewed 15 steps analysis of two medical wards at North Tyneside General Hospital which took place in August and October 2015. They used the care Quality Commission five domains as a framework and looked at all aspects of care and the environment. Areas for improvement were identified and an action plan produced.
- We were told about quarterly engagement forums with voluntary and community groups.
- We saw written patient information leaflets available on all wards we visited during our inspection. These included information on: the Patient advice and liaison service; MRSA; Infection prevention and control; falls; protected mealtimes; hospital chaplaincy; carer's information; alcohol consumption; smoking cessation; and delirium.

Staff engagement







- We saw evidence of regular monthly staff meetings and the staff we spoke with felt engaged with the service and senior management.
- Results of the 2014 NHS staff survey showed a score for staff engagement of 3.93 which was higher than the national average of 3.74.
- North Tyneside General Hospital and its staff had experienced significant change as a result of NSECH opening in June. Staff told us they had felt involved in discussions and kept informed of any changes.
- Frontline staff told us they felt fully informed about all the changes which had taken place and the

management team told us they were: 'enormously proud of how the staff had coped with the massive changes, particularly in areas where two wards had merged'.

Innovation, improvement and sustainability

- Diabetes research, in particular the long term self-management of diabetes, was at the forefront of medical research within the medical directorate.
- The diabetes service was involved in Year of Care Partnerships (YoCP), exploring the role of care planning in diabetes care. The trust hosted the YoCP which supported numerous organisations locally, regionally and nationally to implement care planning in diabetes, other long term conditions and various other settings.
- The trust has a significant national profile and influence as a result, including research papers on person centred care in long term conditions.
- The trust, in partnership with West End Family Health and Health WORKS in Newcastle, Deakin University in Australia were focusing on people with long-term conditions in primary and specialist care, using a 'Optimising Health Literacy and Access' approach to identify and address strengths and weaknesses in the healthcare system. (Health literacy describes how people find out about health, and understand and use that information to achieve better health). The project team focussed on parallel settings in primary and specialist care, initially the Czech-Roma population in the West End of Newcastle and also people with chronic lung disease attending specialist clinics in North Tyneside General Hospital. This enabled clinicians and community members to co-produce innovative, locally relevant service redesign and improvements.
- One ward was looking at recreational activities for patients and discussions have taken place with volunteers who are going to support this.
- Comfort care packs have been developed for relatives who were staying for long periods of time or visiting for prolonged periods.

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

Information about the service

North Tyneside General Hospital provides a range of surgical services for the population of Northumberland and the North East of England. It is part of the wider hospital network, incorporating the Northumbria Specialist Emergency Care Hospital (NSECH) emergency model of care. This gives patients access to elective care at North Tyneside General Hospital while ensuring that emergency support, using NSECH, was also available.

Following the opening of the Northumbria Specialist Emergency Care Hospital (NSECH) on 16 June 2015, all patients requiring specialist emergency care are admitted to NSECH directly or transferred from there to North Tyneside Hospital, one of the three 'base' hospitals. Planned surgery considered high-risk is also carried out at NSECH and patients are transferred from North Tyneside Hospital when required.

Patients who no longer required emergency treatment at NSECH were discharged to home or to North Tyneside Hospital for further rehabilitation, care and treatment. The transfer of patients between NSECH and the 'base' hospitals was being managed well by staff across sites and at the time of inspection staff were working flexibly to accommodate patient needs and assessment of risk.

North Tyneside General Hospital provides elective surgery for patients who need colorectal and upper gastrointestinal surgery, breast, plastic and microsurgery, bariatric (weight loss) surgery, urology and orthopaedic surgery. It has a 24 hour walk-in service, diagnostic services, 2 surgical wards, a day treatment centre and a theatre suite.

During this inspection we visited surgical ward 7 (general surgery), ward 8, (orthopaedic), the day treatment centre and we visited all 8 theatres on site, although 6 were operational.

We spoke with 10 members of staff, and 11 patients and relatives. We reviewed 9 care records and we observed care and treatment of patients.

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Summary of findings

We rated surgery services as outstanding because:

There was a clear vision for the service and the new model of care being delivered, with a clear focus on improving the quality of care and people's experiences. Senior leaders welcomed innovation and there was a continuing history of innovation being embraced and promoted amongst staff. Strong and robust governance structures were in place across the directorate and there was a systematic approach to considering risk and quality management. There were consistently high levels of staff satisfaction and staff spoke strongly about the supportive and open culture at the trust. Staff consistently told inspectors that they were proud to work for the trust.

Senior and site level leadership was visible and accessible to staff. Staff spoke very positively about their immediate line managers and senior leaders. Comprehensive leadership strategies were in place to promote and ensure delivery of the desired culture. This included pilot initiatives such as the 'shared purpose' wards and value based recruitment. The surgical services at this hospital used various innovative ways to gather feedback from patients. There was evidence of innovative practice to improve patient outcomes.

Surgery services at North Tyneside General Hospital were planned and delivered to meet the needs of local people in a timely way. The service was part of the wider hospital network and incorporated the NSECH emergency care model. This allowed patients access to elective care at North Tyneside Hospital and emergency support when needed.

The service reported waiting times better than NHS averages and had been responsive in analysing, assessing and considering patient risk when identifying where best to care for high risk patients. Staff understood the different needs of individual patients and were able to take a tailored approach to meet their needs. This included dementia pain training, access to bariatric equipment, and an understanding of the

support needed for some patients with learning disabilities. We also noted individual experiences for patients with learning disabilities that supported a positive patient experience.

Low levels of complaints had been received in surgery at the North Tyneside Hospital. When a complaint was made they were actively reviewed and taken seriously. An apology was made and action was taken as a result of the complaint, with improvements made to the service.

The surgical services in North Tyneside General Hospital received consistently positive feedback scores and comments through the NHS Friends and Family test. There were a number of approaches taken at the trust to gather feedback from people, the local '2 minutes of your time' survey, a real-time feedback process and a social media feedback approach managed by the Trust Communications and PALS team. All patients we spoke with in wards 7 and 8 reported staff were friendly, professional and caring. Staff offered patients positive encouragement and challenge when mobilising following surgery. Patients told us this support and encouragement struck the right balance between encouraging them while respecting their limitations. We observed examples of staff compassion with patients and caring communication amongst staff and patients. Comments were consistently positive without exception during our discussions with patient in both surgical wards.

Performance over time showed a good track record with regard to patient safety. Staff were confident in the reporting of incidents and felt supported in doing so. In order to improve services, we saw governance processes were in place to ensure incidents were discussed, and lessons learned and communicated to staff. Staffing levels were appropriate for the service being delivered and recruitment was underway to fill additional posts. Planning for staffing had taken into account the strategic changes in services and the new model of care in Northumbria NHS Foundation Trust. There was a comprehensive understanding of patient risk and staff monitored, recorded and assessed this appropriately. The hospital environment was clean. Medicines were stored and administered safely. Records

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were appropriate, well completed and stored appropriately. Compliance with wider mandatory training was good and was on target to be completed by the trust's year end.

Staff used evidence based guidance to inform their practice and were encouraged to seek out new evidence-based techniques and technologies to support the delivery of high quality care. Appraisals were in place with rates above the trust target levels. Patients pain and nutritional needs were appropriately monitored and met by staff. Staff also had up to date training and sound knowledge of consent and mental capacity issues.

Are surgery services safe?

Good



We rated safe as good because:

Performance over time showed a good track record with regard to patient safety. Clear information was displayed for staff and patients to show safety thermometer data and very low numbers of incidences of patient harm were recorded. Staff were confident in the reporting of incidents and felt supported in doing so. In order to improve services, we saw governance processes were in place to ensure incidents were discussed, and lessons learned and communicated to staff.

Staffing levels were appropriate for the service being delivered and recruitment was underway to fill additional posts. Planning for staffing had taken into account the strategic changes in services and the new emergency model of care in Northumbria NHS Foundation Trust. The changes in staffing levels had been anticipated and planned for the opening of NSECH. The closure of beds at the North Tyneside Hospital site had allowed for planned re-deployment of staff and to keep patients safe, appropriate levels of staffing and skill mix had been agreed and managed.

There was a comprehensive understanding of patient risk and staff monitored, recorded and assessed this appropriately. The hospital environment was clean and we saw evidence of regular audits with regard to infection control measures. Medicines were stored and administered safely.

Care records were inconsistently completed by staff and we observed examples of inappropriate storage and access to care records in wards and the day treatment centre.

The trust had a safeguarding policy and staff had a good understanding of safeguarding issues, although, at the time of our visit, compliance with formal safeguarding training was variable. Compliance with wider mandatory training was good and was on target to be completed by the trust's year end.

Incidents

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- Staff at North Tyneside General Hospital understood and fulfilled their responsibilities to raise concerns and report incidents and near misses. Staff were fully supported, and attended regular meetings where feedback was shared and learning was encouraged.
- Between July 2014 and July 2015, North Tyneside General Hospital recorded 914 incidents.
- The majority of the incidents (677) were recorded as causing 'no harm' to the patient. The most common incidents recorded at North Tyneside were falls (174 incidents). Four of these falls resulted in a fracture and in surgery there were 2 incidents of preventable pressure ulcers.
- Staff we spoke with were aware of how to report incidents on the electronic system and at team meetings received feedback on incidents. We saw minutes of team meetings confirming this.
- The trust had monthly mortality and morbidity case review meetings that were well attended. Due to changes in job plans and team locations the meeting had been recently re-organised and re-scheduled. In the absence of formal meetings during this period of change across the trust, interim measures had been in place to review mortality and concerns. We were told that the new meeting structure was now in place in surgery.
- Staff on Ward 7 and 8 had knowledge of their responsibilities about the Duty of Candour although at the time of the inspection they could not share any experience or learning. Staff had attended training across wards, theatres and the day treatment centre.

Safety thermometer

- As part of the system to monitor and analyse patient 'harm free' care, the NHS Safety Thermometer data was clearly displayed on wards 7 and 8. We saw information displayed for the past year for the monthly incidence of hospital acquired pressure ulcers, patient falls and urine infections associated with catheter insertion and prevention of blood clots (venous thromboembolism or VTE).
- From October 2014 to October 2015, Ward 7 had provided 100% harm free care, with nil to record on their safety thermometer display. The thermometer showed 85% compliance with risk assessment for blood clots and 85% of patients at risk received appropriate treatment.

- In April 2015, Ward 8 had one preventable harm incident of an avoidable pressure ulcer.
- Safety thermometer data was clearly displayed and visible to patients and visitors at the entrances to wards 7 and 8.

Cleanliness, infection control and hygiene

- The trust has an infection surveillance programme and an infection control team. Policies were available as paper copies and had current review dates and they were available for staff to access on the trust's intranet.
- Monthly reports were generated and reported for: clostridium difficile (C.difficile) infection and methicillin resistant Staphylococcus aureus (MRSA). Since April 2015, the trust reported zero incidences of MRSA and five cases of C difficile. The trust was on target to achieve less than 3 cases of MRSA and less than 30 cases of C difficile over the course of the year. No cases were reported in surgery at North Tyneside General Hospital.
- We saw evidence of infection control audits taking place. Data provided by the trust showed that between April and July 2015, all surgical areas at North Tyneside achieved 100% audit compliance, against a trust target of 98%.
- During our inspection we found the standard of environmental cleanliness to be good across wards 7, 8, theatres and the day treatment centre.
- We saw cleaning records for ward areas and surgical areas were completed appropriately by staff. To indicate that bed spaces were clean, a separate cleaning log sheet was used.
- We observed staff using appropriate hand washing techniques. In compliance with uniform and infection prevention and control policy we also observed all staff as 'bare below the elbow'.
- To prevent the spread of infection, a notice at the entrance to the ward discouraged visitors if they had been ill.
- We saw sharps bins were used and these were appropriately positioned and safe. Clinical waste bins had clear labelling for segregation of clinical and domestic waste and we saw staff disposing of clinical waste appropriately.
- The trust carried out quarterly audits of adherence to its antimicrobial prescribing care bundle. This included

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individual audits of eight elements identified in the care pack. Data from February 2014 to August 2015 showed that on average routine compliance was 99% across the trust.

- North Tyneside General Hospital achieved 100% compliance with submission of monthly audits for: staff hand hygiene, clean commodes, intravenous cannula and urinary catheter care.
- The rate of deep surgical site infections (June 2015) was in line the national target for both hip replacements (0.8% compared to 0.7%) and knee replacements (0.7% compare to 0.6%).
- The rate of infection for fractured neck of femur surgery was lower than the national average (1.3% compared to 1.4%).
- The rate of all recorded surgical site infections during this period was below the national average.

Environment and equipment

- Trust environmental audit data showed that the surgical areas audited were ward 8 (96%), ward 6 (now closed) (100%), and the surgical day and assessment unit (93%). They achieved an average score of 96%.
- Patient led assessment of the care environment (PLACE) assessed patients privacy and dignity, food, cleanliness and general building maintenance.
- In the most recent audit (2014), North Tyneside General Hospital scored 99% for cleanliness, 94% for food, 92% for privacy and dignity, and 97% for condition. The trust performed better than the England average in all categories.
- We inspected the day treatment centre and checked four pieces of equipment, observing for testing of theatre equipment. All 4 items of equipment were appropriately tested. In line with trust policies, staff had checked resuscitation equipment on the wards and the day treatment centre on a weekly basis.
- Ward staff had attended medical device equipment training. However, not all staff groups in all surgical departments at North Tyneside General Hospital met the 85% target for completion of the self-assessment competency component to the module.
- Wards were clean and spacious. The bathroom and toilet facilities on Ward 8 were old and worn and made some of the areas difficult to keep clean. Staff reported that ward bathrooms were part of a planned upgrade programme, which was reflected in a divisional action plan.

Medicines

- In wards 7 and 8, the day treatment centre and theatres, medicines were stored and locked away. In the day treatment centre, the main medicine cabinet was locked. A medicines cabinet in the treatment room, which was accessible to patients, was not locked. We brought this to the attention of the ward manager and it was locked immediately.
- A medicines audit carried out in the day surgery unit in October 2015 had also identified issues with an unlocked medicine cabinet.
- Medicine prescription charts were completed appropriately. Medicine administration was signed for, dosages were noted as correct, and drug allergies were specified. Medication rounds were conducted appropriately and wards had dedicated support from pharmacy.
- Staff explained that a fridge in the day surgery unit treatment room was used to stock medications when needed for specific clinics. Temperature checks were recorded when the fridge was used, rather than daily. When temperatures were recorded they were within an appropriate range.
- Controlled drugs and recording logbooks were stored in accordance with policy. We saw evidence of checks that were signed for by staff.
- We saw nursing staff prepare medication and leave an un-labelled syringe on a trolley un-supervised. Staff were unable to confirm for which patient this medication was intended. This concern was raised with the CQC pharmacy adviser and with the theatre manager and rectified immediately.
- Patient group directives (PGD's - written instructions for the supply or administration of medicines to groups of patients) were used in surgical wards and departments. These were in date and appropriately completed at North Tyneside General Hospital.

Records

- We checked nine sets of patient records whilst at North Tyneside General Hospital. The records we checked were clear and recorded appropriate information concerning patient management. All staff entries by the multidisciplinary team were appropriate and legible. Notes were well organised in wards and departments.
- The risk register for surgery identified inconsistencies in staff completing alert forms stored at the beginning of

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medical records. Six of the nine records had a completed alert form present. The forms gave prompts and the opportunity for staff to record information such as allergies, involvement in medical trials, or other associated risks to patients that staff needed to be aware of when delivering care.

- We also found that three records did not contain a completed falls assessment, one record did not contain a completed pain assessment, and one record contained a do not attempt cardiopulmonary resuscitation order (DNACPR) that had been signed by a junior medical officer rather than a consultant.
- In the day treatment centre and in ward areas records were stored in a lockable trolley located outside rooms and bays. On our visit, the trolleys were not locked.
- One of the available patient rooms in the day centre was being used to store a box of patient records and this was also unlocked. This presented a risk that patients or visitors could access confidential patient information.

Safeguarding

- The trust had a safeguarding strategy and monthly safeguarding board meetings were held. Minutes and action plans were in place and meetings were attended by senior staff from across the trust. This meeting provided a forum for staff to discuss safeguarding concerns and share learning across the trust. Local safeguarding leads had been appointed.
- Data provided by the trust in advance of our inspection showed that there were varying levels of compliance with the trust's targets for safeguarding training.
- All staff on ward 7 and theatres achieved the Trust target of 85% for level 1 for adults, and 80% of staff had attended on ward 8. A compliance training target of 85% for safeguarding children at level one and two was also in place but not achieved.
- Surgery averaged 90% compliance against a trust target of 85% for safeguarding adults training level 1. At the time of inspection only 35% compliance had been achieved for safeguarding adults level two training with only one of five relevant staff groups meeting the target across surgical services.
- The trust had up to date policies in place concerning adult and children safeguarding. Staff we spoke with were aware of the policies and guidance around safeguarding. They were able to explain how they could escalate any safeguarding concerns.

- A safeguarding folder had been made available to staff. This had quick reference guides for advice and relevant contact details for leads in: child and adult safeguarding and domestic violence, (which included reference to female genital sexual mutilation, honour based violence, forced marriage, human trafficking and sexual exploitation).
- Data provided by the trust showed 11 safeguarding incidents had been raised in the past year concerning surgical services at North Tyneside. All of these were rated as 'low' or 'very low risk' and in raising these concerns we saw that staff had followed appropriate policies.

Mandatory training

- The trust had a comprehensive package of mandatory training for staff. This included modules on topics such as: infection control, safeguarding, an 'essence of care' package focusing on eleven issues such as self-care and communication, and a module on conflict resolution.
- There were different trust targets for completion of training. The standard target was 85%. However, safeguarding adults level two training had a compliance target of 66% and information governance training had a compliance target of 95%.
- Most staff were compliant with the majority of training. The data available included wards that are now closed at North Tyneside and some staff included in the report had been re-deployed across sites. Surgery had an action plan in place to achieve the target by April 2016.
- The Trust overall compliance with staff attending and completing mandatory training in 2014/2015 was 91%. Across all departments in Surgery 88% compliance was calculated.
- Staff told us that many of the mandatory training modules were delivered online through eLearning and that they could access the system easily. The system also provided prompts to staff when training was due.
- We spoke with a newly qualified nurse and Occupational Therapist who had both attended a structured preceptorship programme and trust induction, which included mandatory modules. They told us that they felt very supported.
- Senior nursing staff and doctors we spoke with told us that training opportunities were good and staff development was valued.

Assessing and responding to patient risk

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- Data provided by the trust showed between April and July 2015, there was 100% compliance with the World Health Organisation (WHO) safer surgery checklist ('safe surgery saved lives'10 - this is a tool for clinical teams to improve the safety of surgery by reducing deaths and complications).
- In theatres and in wards 7 and 8 we observed the WHO checklist in practice.
- Staff knew how to highlight and escalate key risks that affected patient safety, such as staffing and patient assessment and screening. Ward Managers, Matrons and Operational Site Managers in surgical services were visible and involved in supporting staff and addressing issues, seven days a week.
- Staff were clear about the changes to the surgical programme at North Tyneside General Hospital and across the other sites. They told us that higher risk patients were assessed and admitted to NSECH for access to critical care facilities and 24/7 surgical cover.
- The records we checked included appropriate use of the National Early Warning Score (NEWS) observations. This included appropriate completion of falls risk assessments and pain assessments. Where risks were noted, we saw that appropriate care plans had been completed by staff.
- The trust had a clear escalation policy in place for care of the deteriorating patient. Departments we visited displayed escalation information prominently in nurse stations which set out clear instructions and staff contact details for 24/7 support.
- A dedicated area was available at the hospital where acutely unwell or deteriorating patients could be stabilised prior to transfer to NSECH and critical care out of hours.
- The trust used video communication for remote access to a consultant intensivist. This meant that the consultant could view the patient using video conferencing and make decisions on their care prior to transfer that could then be implemented by on-site medical staff.
- The trust also used a 'pick and retrieve' system, whereby an anaesthetist was on-call from NSECH and was able to attend base site hospitals immediately in emergencies to stabilise patients and transfer them to critical care facilities at NSECH.
- Patients were assessed for risks and this was documented in their notes. Care plans were completed where risks were identified. Care planning was individualised and the initial documentation gave prompts to assess patients for: falls, pressure ulcers, nutritional and swallow assessment, cognitive function and capacity assessment, resuscitation status and escalation of treatment plans.
- The trust assessed patients at risk of developing a blood clot or venous thromboembolism (VTE).
- Between April and July 2015 over 95% of eligible patients had received a VTE assessment, meeting the target for the assessment of VTE.
- Data provided by the trust showed that it met its target for identifying patients with dementia in July 2015 (95%). However, it did not meet the target for assessing these patients (75%).
- Patients at risk of falls were identified on admission and an individualised plan of care was put into place by staff. We observed examples of planned and delivered care, for example: 1:1 nursing or close observation, safety rails on beds, falls stockings, a nurse call system being in reach and, to identify risk, placing of stickers on display boards.
- The Sepsis Six initiative had been implemented across the trust as a key priority to reduce sepsis related deaths by 30% over the next two years by improving timely recognition of sepsis and delivery of specific steps in treatment.
- At the time of our inspection, since April 2015, ward 7 had maintained 100% compliance with the sepsis six bundle. Ward 8 recorded 100% compliance at the beginning of its reporting period in May 2015.
- The sepsis pathway team monitored this information and zero cases of missed sepsis were recorded on the safety boards visible at North Tyneside.
- Patient toilets in all departments had emergency call bells in place, but in some male/female toilets they were above the height of the cistern and in one it was tied to the hand rail.

Nursing staffing

- The National Institute for Health and Care Excellence (NICE) states that assessing the nursing needs of individual patients is paramount when making decisions about safe nursing staff requirements for adult inpatient wards in acute hospitals.

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- The Director of Nursing had implemented a Safer Nursing Care Tool (SNCT) to assess the staffing requirements across wards. At the time of the inspection this tool was not applied to every ward. A roll out of Stage 2 of this programme was planned.
- Data provided by the trust showed that it employed 112 whole time equivalent (w.t.e.) nursing staff in surgical areas within the hospital and 46 w.t.e. health care assistants. The day surgery unit had no vacancies, while wards 7 and 8 had one vacancy each (6%). Theatres had six vacancies for nursing staff (11%). Sickness rates on the wards were below 2%, sickness in theatres 4%, and sickness in the day surgery unit 14%.
- Ward 7 was using SNCT and as a result staffing ratios of 1:8 patients during the day shifts and 1:10 on night duty was recommended. No specific acuity tool was used to plan daily staffing on ward 8, the day surgery unit, or in theatres.
- Numbers of staff on duty was displayed clearly at ward entrances. Planned staffing levels were 3 registered nurses (RNs) and 2 nursing assistants (NAs) on day shift and 2 RN's and 1 NA on night shift for a maximum of 21 patients. On the day of inspection this level of staff was in place.
- Staff told us staffing levels were safe and appropriate and adjusted to the variation in activity since the ward changes and opening of NSECH. Staffing on the day surgery unit was within safe limits, with only one nurse short of planned establishment for the day. The ward manager said there was sufficient staff available for the unit.
- Staff recognised this was a period of change and adjustment. Surgical activity was changing at North Tyneside General Hospital and they were prepared for an increase in activity in 2016 with plans for some services being delivered at the site, for instance bariatric (weight loss) surgery and some breast reconstruction with microsurgery.
- Some nursing staff reported concerns about frequent moves at short notice to cover staff shortfalls on other sites but recognised the need to keep patients safe where there was greater need for staff across sites. Managers made daily decisions to cover site issues with nursing staff.
- Trust policy was that the use of agency staff had to be approved by a senior manager. The policy identified

how to source staff and required agency staff to complete an induction and submit to relevant staff checks. Wards 7, 8 and the day unit had minimal or nil use of agency staff.

- Advanced Nurse Practitioners (ANP's) had an established role in surgery and added value to the service, patient care and decision making.
- Nursing staff had been given choice in re-deployment and some had taken the opportunity to move to areas where they could further develop their knowledge and skills. The changes were not seen as a problem to the staff we spoke with and staff were motivated and enthusiastic about their development.
- Nursing staff were observed performing organised and structured patient handovers with their colleagues and the multidisciplinary team. Staff on Wards 7 and 8 reported good teamwork and relationships with doctors.

Surgical staffing

- Consultants and junior doctors and nurse practitioners were available for handovers, ward rounds and MDTs. Staff told us that they had good relationships with senior surgical doctors and Consultants.
- Consultant anaesthetist and medical staff had agreed to stay on-site until the last patient of the day had been recovered following surgery and was transferred back to the ward. A foundation level medical officer was on-site at all times.
- Out of hours cover from senior medical staff was provided from NSECH. A clear deteriorating patient pathway was in place that allowed for transfer to NSECH for 24 hour access to Consultant care when needed.
- Consultants operated surgical lists from the general hospitals at Hexham, Wansbeck and North Tyneside, for elective surgery. They also had some lists at NSECH and operated a one week in seven on-call rota for NSECH. Consultant Job Plans were altered to reduce travel so that most only work on a single site on any given day.
- Advanced Surgical Nurse Practitioners were developed for 24/7 cover of the surgical wards at North Tyneside General Hospital. This workforce planning was embedded and roles in other surgical specialties have been in place for some time.

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- We spoke with doctors who were enthusiastic and had a vision for the future of surgical services at North Tyneside General Hospital. They told us they were proud to work for the trust and had excellent working relationships.

Major incident awareness and training

- Staff were aware and understood the appropriate major incident policy and business continuity planning. Staff explained they would be able to access this through the intranet and were able to explain where the policy was kept on the ward; we observed this folder in the ward managers office on Wards 7 and 8.
- Staff we spoke with were confident in their use of the policy and that this would provide appropriate direction if a major incident was to occur.

Are surgery services effective?

Good



We rated effective as good because:

Staff used evidence based guidance to inform their practice and were encouraged to seek out new evidence-based techniques and technologies to support the delivery of high quality care. The surgical business unit had a programme of local clinical audit and took part in any national audit for which they were eligible.

Appraisals were in place with rates above the trust target levels. Staff told us appraisals were helpful and aided their professional development.

Patients pain and nutritional needs were appropriately monitored and met by staff. National Early Warning Scores (NEWS) were also completed consistently by staff.

Staff can access information in a timely way at North Tyneside General Hospital. Consent to treatment was in line with the trust policy and Department of Health guidelines. Policies and procedures, which staff we spoke with understood, were in place in relation to the Mental Capacity Act (MCA) and Deprivation of Liberty Safeguards (DoLS). Staff had up to date training and sound knowledge of consent and mental capacity issues. Consent practices and records were monitored and reviewed to improve how people were involved in making decisions about their care and treatment.

Evidence-based care and treatment

- Staff were aware of relevant professional guidance. Policies and procedures were based on guidance from appropriate professional bodies, including National Institute of Health and Clinical Excellence (NICE), Royal College of Surgeons guidance, the Association of Anaesthetics, and guidance from the British Association of Day Surgery.
- The surgical division took part in all the national clinical audits that they were eligible for. The division had its own formal clinical audit programme where national guidance was audited and local priorities set.
- North Tyneside hospital performed better than the England average in eight of the ten audited areas of the national hip fracture audit. It performed worse than the England average related to pre-operative assessment by a geriatrician (19% compared to 51%) and the mean length of stay (23 days compared to 19 days).
- The trust performed better than the England average for cases being discussed at multidisciplinary team meetings, patients being seen by a clinical nurse specialist and the timeliness of CT scan reporting in the national bowel cancer audit.
- The trust performed better than the England average for the percentage of patients discussed at a multidisciplinary team meeting in the national lung cancer audit. The percentage of patients receiving CT scans before bronchoscopy (84% compared to 94.2%) and the percentage of patients receiving surgery (12.3% compared to 15.1%) were below the England averages.

Pain relief

- Patients were asked regularly about their pain levels and scores were recorded regularly on pain tools and charts available at the bedside as part of the National Early Warning Score (NEWS) chart used throughout the trust for recording observations.
- Patients we spoke with (eleven) all shared good experiences of pain being well controlled by staff, and regular pain assessments were noted.
- We saw that appropriate pain assessments had been completed in eight of the nine records reviewed. In one record, one of five pain assessment questions had been completed.
- There was a pain assessment scale within the National (Northumbria) Early Warning Score (NEWS) chart used throughout the hospital. NEWS audits were in place and

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supported through feedback from the Friends and Family Test and directly from patients. These showed 100% of NEWS charts had been correctly recorded and responded to within surgery (August 2015).

- The trust had a dedicated pain team and link nurses were identified in the ward areas.
- Pain control was prioritised in pre assessment for surgery and this approach continued after discharge as staff assessed the patients pain control in follow up phone calls after treatment and surgery.

Nutrition and hydration

- Patients were screened on admission using the Malnutrition Universal Screening Tool (MUST). If patient assessment triggered risk or concern a referral was made to the dietician.
- The trust carried out a trust wide nutrition audit. For the first quarter of this year, this showed that an average of 65% of patients had received a nutritional assessment within 24 hours of admission. The available data from the second quarter (July and August 2015) showed that this had increased to an average of 96%.
- The nine records we observed contained appropriate MUST assessments and details of the patients nutrition and fluid intake on food and fluid balance charts. We saw patients who had been given dietary supplements.
- Nutritional nurses were implemented across the surgical division to support patients in the post-operative recovery phase. This was an evidence based approach to enhanced recovery after surgery and this new initiative was being rolled out across sites.

Patient outcomes

- Surgical teams had transferred surgical work to NSECH and trust outcome data regarding this activity (for example, National Mastectomy and Breast Reconstruction Audit, National Hip Fracture Audit) is reflected in the report on NSECH.
- The hospital's standardised relative risk of readmission following surgery was lower than the England average ratio in regard to upper gastrointestinal surgery (87 compared to 100) and colorectal surgery (85 compared to 100).
- The standardised relative risk of readmission was higher for trauma and orthopaedic surgery (145 compared to 100). These figures were consistent with trust wide data and North Tyneside Hospital achieved the average score for elective surgery.

- In the most recent Patient Reported Outcome Measures (PROMS), the proportion reporting improvements and worsening were comparable to England averages.
- Day case rates for bariatric surgery, gastric bypass and banding was significantly better than the national averages. Data showed the percentage of excess weight loss at one and 2 years post-surgery for gastric bands achieved 47% and 56% respectively (against a national figure of 43% and 50%).
- For gastric bypass the trust achieved 73% at year one and year two (against a national figure of 68% and 60-80%), and for gastric sleeves the trust achieved 56% and 58% respectively (against a national figure of 54% and 50-60%).
- North Tyneside Hospital was ranked fifth in England for achievement of the best practice tariff.

Competent staff

- We were told that nursing staff received clinical supervision through one to one meetings, team meetings and informal discussions with their peers. We asked for evidence of formally recorded clinical supervision. Staff told us that this did not yet occur, but plans were in place for formal supervision logs to be introduced in 2016.
- New nursing staff underwent an induction and structured preceptorship programme and completed learning objectives with a designated supervisor.
- Nursing staff told us that they received support and information from the trust to help them with the revalidation process. We saw a screensaver used across the trust to raise awareness of this and to advise nurses of the support available.
- Staff we spoke with at North Tyneside General Hospital told us they had annual appraisals and professional development plans. All staff groups had achieved the target of 85% for staff appraisal. The majority of staff groups had achieved 100% in previous years.
- At part way through the current year North Tyneside General Hospital had to perform 392 staff appraisals to achieve their 85% performance target by April 2016. At the time of inspection 221 staff (31%) had completed appraisal.
- Junior doctors were involved in support processes, ward based teaching, meetings and clinical audit. They told us they could approach their seniors with concerns.

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- All measures in the General Medical Council (GMC) national training scheme survey 2015 were within expected levels and did not identify any risks. Revalidation and clinical outcomes were assessed and monitored by the Deanery.
- Advanced nurse practitioners had a designated consultant who provided clinical supervision and guidance.

Multidisciplinary working

- All staff we spoke with told us that they worked well with the wider multidisciplinary team. There were no concerns expressed about any aspects of team working during our inspection visit, through the forums or staff satisfaction surveys.
- Staff on the day surgery unit explained they had previously had physiotherapy support in discharging patients. This service had been removed and staff were now asked to provide guidance and information leaflets themselves. Staff told us this made them anxious as they did not feel fully equipped to provide this advice and did not believe that the service was delivered to patients to the same standard without a physiotherapist.
- Protocols had been developed for the effective handover of patients to the newly opened NSECH. These involved staff identifying bed availability, NEWS assessment and both verbal and written transfer of information using the Emergency Care Transfer Checklist.
- We spoke with Occupational Therapy staff and they reported good working relationships with nursing staff on the wards. They delivered a full 7 day service and were available at weekends on a rota.
- The multidisciplinary team (MDT) meetings were led by nursing staff every day on ward areas to direct care and treatment for patients and assist in discharge planning.
- Daily handovers were carried out with members of the MDT. When required referrals were made to the wide range of support services and specialist health professionals in the trust. There was good access to the dietician, diabetes or respiratory nurse, speech and language team and clinical nurse specialists when needed. We saw evidence of access and prompt response from referrals to the multidisciplinary team.

Seven-day services

- North Tyneside Hospital operated an elective programme for surgery over 5 theatre days. There was weekend theatre utilisation when required. Wards 7 and 8 were established to deliver services 24/7 and staff escalated emergency concerns.
- Consultants were available on-call out of hours on a rota and attended to see patients at weekends when required. A foundation level doctor and advanced nurse practitioners were on site at the hospital at all times.
- Middle grade doctors and Consultants were available on site Monday to Friday. Cover for emergencies and advice was provided from NSECH.
- Daily ward rounds are performed seven days a week for review of patient treatment plans and to facilitate appropriate discharge.
- Access to diagnostics, such as X-ray, was available at weekends and overnight.
- Physiotherapy and Occupational Therapy was available at weekends.
- The trust met all 10 national standards for 7 day working. A comprehensive escalation and transfer plan was in place for deteriorating patients to access emergency care 24/7.

Access to information

- Staff explained that information could be easily accessed using the trust intranet and they were confident in doing so.
- The wards and day surgery unit also had paper files containing relevant policies, procedures and records (such as team meeting minutes) to allow staff access.
- Notice boards displayed staff uniforms to assist visitors and patients in understanding nursing roles. Patient and visitor information displayed leaflets on PALS, infection control, protected mealtimes and chaplaincy services.
- Patient information was accessible and easy to understand. Notes were well organised for different steps in the patient journey in the surgical pathway.
- Discharge planning commenced as soon as possible after admission assessment. Systems were in place to provide GP's and support services with information after discharge or treatment.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards (DoLS)

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- The trust had policies in place to cover DoLS and the Mental Capacity Act. Information and guidance was provided to staff on terminology, issues surrounding capacity when taking patient consent and identifying trust leads for the escalation of issues.
- The trust provided data on an audit on surgical consent that it had carried out in June 2014. A repeat audit was planned for autumn 2015 but the data was not available at the time of our inspection. Of 22 records audited, this showed 100% compliance with the person taking consent being capable of performing the procedure in question, the procedure being explained to the patient, and any relevant risks and side effects being explained.
- We saw the audit was discussed at the Surgical Integrated Governance Group. Staff were reminded about the importance of good recording and documentation, including practice around gaining and recording consent.
- The percentage of cases submitted to the National Joint Registry from North Tyneside, where patient consent was confirmed, was 99%. The benchmark figure is 95%, with the wider trust achieving 99%.
- Staff we spoke with in Wards 7 and 8 had awareness of consent issues, DoLS and the Mental Capacity Act and assessment process. They had received training with the trust.
- We looked at nine records and observed 100% consent completed in line with trust policy and Department of Health guidelines. Patients we spoke with expressed no concerns about the consent process they described to us.

Are surgery services caring?

Outstanding



We rated caring as outstanding because:

The surgical services in this North Tyneside General Hospital received consistently positive feedback scores and comments through the NHS Friends and Family test. There were a number of approaches taken at the trust to gather feedback from people, the local '2 minutes of your time' survey, a real-time feedback process and a social media feedback approach managed by the Trust Communications and PALS team.

All patients we spoke with in wards 7 and 8 and reported staff were friendly, professional and caring. Staff offered patients positive encouragement and challenge when mobilising following surgery. Patients told us this support and encouragement struck the right balance between encouraging them while respecting their limitations. We observed examples of staff compassion with patients and caring communication amongst staff and patients. Comments were consistently positive without exception during our discussions with patient in both surgical wards.

In wards and departments we observed patients cared for with dignity, compassion and respect. We saw patients spoken to in a professional and polite manner. All patients spoken to gave positive feedback about relationships with staff.

Meeting people's emotional needs was embedded in the assessment, planning and delivery of care, and we were told of the range and experience of support given to patients after discharge home.

Compassionate care

- Hospital data between July 2014 and July 2015 on the NHS Friends and Family test showed a response rate of 18% (1,495 responses) compared to a trust average of 23% and an England average of 36%. The lowest satisfaction rating received was 80%, with the hospital regularly achieving 100% satisfaction scores.
- The trust's national inpatient survey results are within the top 20% of trusts for the most recent three months. The average satisfaction score for the Trust is 85%.
- Within the surgical division, the lowest score recorded was from general surgery (81%) with the highest being in orthopaedics and upper gastrointestinal surgery (90%).
- In addition to the NHS Friends and Family test data, the trust performed its own 'two minutes of your time' survey. The patient experience was captured approximately every two weeks. Information was displayed prominently on entrances to the wards and the day surgery unit.
- We saw staff offered patients positive encouragement and challenge when mobilising following surgery. Patients told us this support and encouragement was helpful and struck the right balance between encouraging them while respecting their limitations.
- Of the 11 patients we spoke with, all explained that staff helped them to maintain their privacy and dignity by

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using curtains to protect privacy during delivery of care, and by answering call bells promptly. Without exception staff attitudes were stated to be friendly, professional and caring.

- We observed an episode of compassionate care where a team of 4 healthcare staff on Ward 8 assisted and encouraged a young man to walk with the use of a walking frame. The patient had rapport with staff and was encouraged gently and with good humour to make progressive steps along the corridor. His dignity and self-esteem was maintained and encouraged throughout. Time was taken and it was clear from how the patient communicated with the team that a therapeutic relationship had been built with the staff. He appeared proud of his progress and shared that achievement with the Ward Sister.

Understanding and involvement of patients and those close to them

- Patients and relatives felt involved in their care. Regular ward rounds with consultants and nurse practitioners gave patients the opportunity to ask questions and have their surgery and treatment explained to them.
- Patients received information in a way they understood and they were knowledgeable about their treatment, progress and discharge plan. Patients told us staff routinely informed relatives of updates on treatments, and transfer or discharge arrangements.
- The system for pre-assessment worked well for patients and we were told that information was received about treatment, surgery and post-operative exercises.
- All patients we spoke with lived locally, close to the hospital and felt that their families were involved and given information.

Emotional support

- Patients at North Tyneside General Hospital did not raise any concerns. During our inspection we observed staff talk with patients at the bedside and during delivery of treatment. Patients told us staff took time with them, giving them an opportunity to listen and offer support.
- Care plans we reviewed were complete and highlighted the assessment of patients emotional, spiritual and mental health needs.
- Clinical Nurse Specialists provided support services that patients accessed after discharge. A patient-led stoma

support group had been established by specialist nurses at North Tyneside General Hospital. There was also a helpline for patients who had undergone upper and lower gastrointestinal and stoma surgery.

- The surgical division had developed a post-discharge follow-up call system for all inpatients and included patients who had treatment during a short stay as well as those who have experienced surgery.
- Responses to patients are proactive and aimed to rectify concerns raised at the time of the call. Calls were managed by experienced surgical nurses, some of whom had been recruited for this specific role, through the nurse bank, following retirement. We were told patients benefitted from speaking to an experienced clinical member of the team for support and advice.

Are surgery services responsive?

Outstanding



We rated responsive as outstanding because:

Surgery services at NTGH were planned and delivered to meet the needs of local people in a timely way. The service was part of the wider hospital network and incorporated the NSECH emergency care model. This allowed patients access to elective care at North Tyneside Hospital and emergency support when needed.

All staff were aware of the need for flexibility towards surgical services provided at the hospital. Emergency and high-risk surgery was provided at NSECH but was subject to constant review by senior managers within the division. Some high-risk surgery (for example, bariatric surgery) was planned to be returned to base sites following review and assessment of risk and safety issues. Patients told us they understood and accepted the need for the centralisation of emergency services.

The service reported waiting times better than NHS averages and had been responsive in analysing, assessing and considering patient risk when identifying where best to care for high risk patients.

There is a proactive approach to understanding the individual needs of patients attending the hospital and pathways of care for patients requiring complex and multi-disciplinary involvement are innovative and embedded in practice in surgery across the trust. The trust

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had developed dementia pain training for staff to access; there was good provision of specialist bariatric equipment and an understanding of the support needed for some patients with learning disabilities. This included supporting individual needs of patients with learning disabilities to ensure a positive patient experience. Dementia friendly patient rooms had been developed and link staff in dementia and learning disabilities identified in ward 7 and 8.

Numbers of complaints were low in surgical departments at North Tyneside General Hospital. They were proactively reviewed and it was identified that there were no identified trends or themes within these complaints. We saw evidence that learning was shared with the necessary staff and improvement to services were made when needed..

Service planning and delivery to meet the needs of local people

- The hospital was part of a wider network that provided co-ordinated care since the opening of NSECH in June 2015. Care was planned to allow emergency and high risk patients to attend NSECH, while elective surgery for patients at lower risk was carried out at North Tyneside Hospital.
- This allowed patients 24 hour access to consultant level emergency care using NSECH while also ensuring that elective work was available at a base hospital of the patients choice for most specialities.
- This model of care was five months old at the time our inspection. The model had begun to embed within the service and there was a clear understanding amongst staff and patients of how the new system of care operated within the trust.
- The number of operations cancelled by the trust was consistently below the England average over the past nine quarters. Between April and June 2015 the trust had cancelled 44 operations.
- Of those cancelled between April 2014 and June 2015 (296), six people were not treated within 28 days. This is better than the England average.
- A transport service had been provided for patients and relatives to get easy access across hospital sites.
- Fast track joint replacement relied on an anaesthetic spinal block before surgery. Patient feedback was collected on their experience with the spinal block

procedure to determine if this was what patients would prefer. This had shown that 97% of patients surveyed preferred the spinal block to a general anaesthetic for surgery and a longer hospital stay.

Access and flow

- The trust had 33,909 surgical spells between January 2014 and December 2014. This was around the average for NHS trusts. Of these North Tyneside General Hospital had around 12,500 surgical spells during this period. The main specialty seen at North Tyneside (37%) was trauma and orthopaedic surgery, with 20% upper gastrointestinal, 17% colorectal and 26% other surgery. 62% of patients had day case surgery.
- Trust data showed it was meeting (93%) the NHS operational referral to treatment target (RTT) of 92% of patients waiting less than 18 weeks for treatment, and had done so since April 2015.
- RTTs had steadily improved since the opening of NSECH and were met within general surgery (94%), urology (96%), plastic surgery (93%) and oral surgery (96%).
- Trauma and orthopaedics was the only area where this target was not met although there had also been improvement from 86% (September 2015) to 87% (November 2015) and 92% of patients were waiting less than 21 weeks.
- The trust's performance against the NHS 18 week referral to treatment target had been above the England average since January 2014.
- Trust data identified the reasons given for delayed transfers of care and this showed the primary reason for delayed transfer of care was patient or family choice. This was the reason for delay given in 32.5% of cases, against an England average of 13.5%.
- Data gathered by NHS England showed that bed occupancy rates were consistently lower than the England average, although they have been trending upwards since quarter four of 2013/14.
- Trust data on the average length of stay at North Tyneside General Hospital showed that length of stay was in line with the England average for elective patients (3.3 days compared to 3.1 days). Upper gastrointestinal surgery was better than the England average (2.1 days compared to 4.3 days).
- Surgical lists in theatres had been amended to run for the whole day at the base site hospitals. This was to

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avoid surgical staff travelling between hospital sites and reducing available operating time. Theatre management staff told us that this had allowed extra patients to be seen on each list.

- The day surgery unit was open from 07:15 to 17:00, Monday to Friday. Staff told us that they routinely stayed behind to ensure patients were not rushed in being discharged. This was not reported as a complaint but it is recognised that it would not be sustainable working practice.
- Eight theatres were available at North Tyneside, with six theatres operational at the time of our inspection. They were open 08:00 to 20:00 five days each week and mostly provided general surgery and elective orthopaedic work.
- Hospital data showed theatre utilisation rates had declined from an average of 84% (February 2015) to 45% (August 2015). The impact of the new emergency care model was not represented fully by this data and significant changes in activity and utilisation were anticipated.
- Two staff in the surgical colorectal service raised concerns with us that the new emergency model of care, incorporating NSECH, had led to a lack of continuity in patient care. They reported that patient care was now delivered across sites and this new pathway meant the patient could be seen by many consultants and also staff have increased travel from home. Staff did not feel this process was unsafe, but felt that patients they spoke with had found this less satisfactory. This was not reflected in patient experience reports at the time of inspection.
- Members of the healthcare team told us that bariatric (weight loss) surgery at North Tyneside had been deferred to the new hospital site as patients were assessed as high risk and the preference was to operate where critical care and 24/7 consultant care was available. This had created some short term waiting delay for patients due to a lack of capacity.
- More recently the surgical team presented a case study of a bariatric patient who had needed to be transferred to NSECH for management of complications. The care of the patient, early recognition of the complication and subsequent transfer had been well managed and escalation processes were working well at the base site. As a result of this and an audit review, a full programme of bariatric surgery was planned to recommence in early 2016 at North Tyneside Hospital.

- The trust had developed a day case mastectomy service. Length of stay had reduced to between 2.7 and 4.2 days (depending on patient risk at the time of surgery). This compared to a national average of 4.8 days.
- The hospital had an escalation and surge policy and procedure to deal with busy times. Capacity bed meetings were held to monitor bed availability, review planned discharges and assess bed capacity throughout the hospital and trust on a daily basis. Staff we spoke with were aware of, and involved in processes and decision making.

Meeting people's individual needs

- Bariatric services had developed a drop in support service for patients at a local medical centre in Monkseaton. There was opportunity for weight loss surgery patients to share their successes and shared learning, with support of the MDT, took place.
- Interpreter services were available to staff, both in person and on the telephone. Staff told us that individual needs were routinely identified at pre-assessment and a face to face service was booked for when a patient attended. When this was not possible, staff contacted a telephone interpreter service and they described how they would do this. Staff also had access to foreign language patient information using the trust intranet.
- Staff described how patients with learning disabilities were supported by their carer during a visit. Staff arranged for patients with learning disabilities to visit the hospital prior to their procedure, so that they could see the surroundings and become comfortable with the environment.
- There was a nominated link nurse within the trust for learning disability patients. Staff we spoke with were aware of how to contact the nurse and access for support and advice was good.
- The day surgery unit hosted a bi-monthly dental clinic for patients with learning disabilities. Staff told us they worked closely with the link nurse to make the experience as enjoyable as possible for patients. Examples of this included staff decorating a patient room with photographs of Elvis for a patient and staff invited to patient birthday parties as a result of the rapport they had built with patients.

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- We saw a patient attending for day surgery that had specific bariatric needs. Staff had removed a standard day unit chair and had replaced this with a specialist bariatric chair that was appropriate for the patient. Staff were also able to access larger size gowns and could use the correct scales from other areas of the hospital.
- There was evidence of link nurses for patients living with dementia in wards, but not in the day surgery service. Staff were able to explain they accessed information about providing support and advice for patients and families.

Learning from complaints and concerns

- Surgical services in North Tyneside had received 18 complaints since November 2014, with nine of these complaints related to wards that had closed since services had been realigned with NSECH. Complaints were proactively reviewed and it was identified that there were no identified trends or themes within these complaints. We saw evidence that learning from complaints was shared with the necessary staff.
- The trust had an up to date complaints policy in place. This provided guidance on the complaint process, including the nominated investigative lead and timescales for responses.
- Conflict resolution training was part of mandatory training for some staff groups. Training had been identified as a means to deal with complaints at a local level.
- Staff on the day surgery unit recalled only one recent concern raised by a patient who had lost valuables. An investigation was commenced to locate the item. This complaint was on-going with the trust patient advice and liaison service (PALS) team and feedback was expected.
- We saw leaflets available throughout the hospital informing patients and relatives about this process and patients we spoke with felt confident that they knew what to do if they had wanted to complain.
- Patients we spoke with were aware of the complaints process and told us that they would speak to staff in the event of having any problems.

We rated well-led as outstanding because:

There were consistently high levels of staff satisfaction and staff spoke strongly about the supportive and open culture at the trust; staff were proud to work for the trust.

Senior managers had a clear vision and strategy for the division and identified actions for addressing issues within the division. The strategy clearly identified the new model of emergency and high-risk surgery provided at NSECH and the relationship between NSECH and the base hospitals. The new model was under constant review to determine the most effective site to undertake different procedures depending upon risk and safety. The trust had engaged on a major change to services in the months before inspection and local communities had been engaged in the consultation and development of the strategy for the new model of care.

Senior leaders welcomed challenge and there was a continuing history of innovation being embraced and promoted amongst staff. There is an approach to innovation that is celebrated and encouraged and the new model of care has been embedded through a planned change in services, while supporting and motivating staff.

Strong governance structures were in place across the directorate and there was a systematic approach to considering risk and quality management. Senior and site level leadership was visible and accessible to staff. We saw constructive engagement with staff and managers at all levels, communicated in person to staff in one to one and team meetings and through the weekly e-bulletin, team briefs, the staff magazine and internal campaigns.

Staff spoke very positively about their immediate line managers and senior leaders. Comprehensive leadership strategies were in place to promote and ensure delivery of the desired culture. This included pilot initiatives such as the 'shared purpose' wards and value based recruitment.

The surgical team at North Tyneside General Hospital and across the trust used a range of methods to gather meaningful feedback from patients and staff. Information was used to make improvements in quality of care and peoples experiences. There was evidence of innovative practice to improve patient outcomes.

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

Are surgery services well-led?

Outstanding



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addressing issues within the division. The strategy for surgical services clearly identified the new model of emergency and high-risk surgery provided at NSECH and the relationship between NSECH and the base hospitals.

- The new model was under constant review to determine the most effective site to undertake different procedures depending upon risk and safety. We saw examples of the flexibility and ongoing adjustment within the strategy through the provision of high-risk bariatric surgery planned for return to the base hospitals following assurance that it was safe to do so.
- The vision and strategy had been communicated throughout the trust and staff were encouraged to contribute to its development. During individual interviews staff were able to repeat this vision and discuss its meaning with us.
- The trust vision and strategy was clearly displayed in ward areas and staff were able to articulate these to us. We noted that the trust's values and objectives were embedded across the surgical division.
- 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. We saw agendas and minutes with evidence of good audit activity, learning from complaints and clinical risk management issues. We observed peer review data, and patient and public involvement was evident.
- A rolling agenda was discussed in these meetings that included: infection control, alert notices, examples of good practice, compliance with national service frameworks, and research projects. Evidence of action plans and staff responsibility was evident in minutes.
- The trust had monthly mortality and morbidity case review meetings that were well attended. Due to changes in job plans and team locations the meeting had been recently reorganised and rescheduled. During this period of change across the trust, interim measures had been in place to review mortality and concerns in the absence of formal meetings. We were told that the new meeting structure was now in place in surgery.

- The division's 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. The register included risk ratings, action plans, and information on timescales in which issues were to be resolved. These were actively reviewed.
- We saw communication and engagement with these issues at all levels and it was clear that a 'board to ward' approach was a part of the culture at the trust.

Leadership of service

- The trust had engaged on a major change to services in the months before inspection. Staff at all levels told us they had been fully engaged in this process and felt their views had been taken in to account. While the change to the delivery of surgical services was managed flexibly at the time of inspection, staff told us they were fully engaged in this process.
- All staff we spoke with felt that they received appropriate support from management to allow them to perform their roles effectively.
- All staff explained that they would be happy to approach senior staff to raise concerns and that they would manage issues in a timely and responsive manner.
- Management staff told us that they had appropriate access to senior staff members. This included being able to access support and leadership courses to help them in delivering services.
- Staff reflected on the strong leadership and visibility of senior members of the trust board and executive team. This motivated staff and staff felt that senior leadership reflected the vision and values that they shared with the organisation. Staff on wards knew the Chief Executive and senior members of the trust team. A positive relationship was evident.
- Ward managers had dedicated management time when they were not providing clinical care. This allowed them to focus on management and administrative issues.
- Monthly speciality meetings were held to discuss financial and clinical performance, patient safety and operational issues.

Culture within the service

- All staff we spoke with described a friendly and supportive culture within the service.

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- Many staff described the best thing about work as being the teamwork and the colleagues they were able to work with on a day to day basis.
- Staff spoke of a caring culture and reflected on how this was now reflected in recruitment to the trust. Recruitment was now 'value based' to align with the trust values and management and staff were confident that this would further enhance the culture at the trust.
- Staff spoke of the 'Northumbria' way with regard to innovation in care and ensuring that they provided a high quality experience to patients.
- Staff felt supported to develop their skills and progress their careers. Many staff we spoke with had been with the trust for many years, and had achieved career progression in clinical, nursing or management roles through education and support available from the trust.
- Staff reported, following the opening of NSECH, that activity had increased and there were now more patients using the hospital services. Activity was now approaching previous levels and they found this had improved morale after a recognised period of adjustment to the new model of care.
- Staff spoke positively about surgical services and the service they provided for patients at North Tyneside General Hospital. They valued high quality and compassionate care and it was evident that they valued and respected each other.
- Fifteen step challenge data from theatres in March 2015 demonstrated detailed assessments were carried out against the Care Quality Commission (CQC) key lines of enquiry. Where issues were identified a detailed action plan was developed to resolve any issues. We saw that many issues identified had been resolved at the time of our visit.
- The hospital also received feedback through the in-patient survey (October 2015). Results showed 100% of patients were treated with respect and dignity, 98% of patients were involved in their care and 100% of patients rated staff as 'good'.
- The trust holds quarterly stakeholder engagement forums with voluntary and community groups and issues regular bulletins to stakeholders including GPs.
- Programmes had been developed across the county to focus on issues such as: older people's health; gardening for people with dementia; supported walks; loneliness; warmer health promotion; living with dementia training; and 'get in to golf'.

Staff engagement

Public engagement

- Local communities had been engaged in the consultation and development of the strategy for the new model of care. This had a positive effect upon the feedback received from patients and relatives received during the inspection at NSECH and also at the base hospitals.
- The surgical services at this hospital used various innovative ways to gather feedback from patients. This included the NHS Friends and Family test, the local '2 minutes of your time' survey, a real-time feedback process and a social media feedback approach managed by the trust Communications and PALS team.
- The trust used a '15 step challenge' approach to engage the public in assessing the hospital environment. This helped the trust to gain an understanding of how patients and service users felt about the care and services provided. An audit (April 2015) showed: staff were clear regarding their role; emphasised patient care; and ensured safety and wellbeing was paramount.
- All 13 measures surveyed in the General Medical Council (GMC) national training scheme survey 2015 were within expected levels. The survey asks questions about the quality of education, supervision and support.
- Data collected by the Health and Social Care Information Centre (HSCIC) showed that the sickness absence rates for the trust have been very similar to the England average during the period from January 2011 to January 2015.
- Results from the 2014 NHS Staff Survey showed that the trust performed well, with 26 positive findings, six findings within expected levels, and no negative findings. Based on staff survey results the trust was within the top 20% of trusts in England.
- Senior staff at North Tyneside Hospital told us they were involved in supporting development of an e-prescribing system in the trust that was due to launch after our inspection. This involvement had included being shadowed by the team building the system to ensure they understood the needs of staff around prescribing medications for patients.
- We saw senior managers communicated to staff through the weekly e-bulletin, team briefs, the staff magazine

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and internal campaigns. Staff had been engaged in: deciding on annual priorities; the appointment of staff governors, health and wellbeing advocates, sustainability champions; and staff road shows.




- Staff reported they were in a period of adjustment with the introduction of the new model of working but did not report any negative impact on performance or patient safety. Staff had been involved and engaged with the development of the new model of emergency care and told us they had been supported. Some changes were reported to have had a negative impact, such as short notice cross site working to cover staff shortages and a reduction in activity initially. Overall staff were very positive and told us about the opportunities that the changes will bring.

Innovation, improvement and sustainability

- The trust was recognised nationally for the treatment of emergency hip fractures. North Tyneside General Hospital is rated in the top five hospitals in the country.
- North Tyneside General Hospital was recently recognised by the General Medical Council as the best in the country for the quality of training for orthopaedic surgeons of the future.

- The trust has developed a dedicated bone health clinic managed and co-located with a breast cancer service. Patients undergo a DXA scan and then are given an assessment of non-cancer fracture risk. Management plans, including lifestyle advice, patient education, anti-fracture therapy, nutritional supplements and falls risk assessment are instigated. Plans for review of medication compliance and monitoring treatment response are established.
- The trust had developed a day case mastectomy service at North Tyneside General Hospital. This was proposed to save 201 bed days each year. Average length of stay had also reduced to between 2.7 and 4.2 days (depending on patient risk at the time of surgery). This compared to a national average of around 4.8 days.
- The trust hosted one of four national Royal College of Surgeons bariatric fellowships which was a reflection on the standard of service delivered to patients requiring bariatric surgery at the trust. North Tyneside would provide the main bariatric surgery from 2016.

Maternity and gynaecology

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

Information about the service

Prior to June 2015 the maternity unit in North Tyneside General Hospital was midwifery led with no obstetric intervention. In June 2015 all intrapartum services was relocated to the Northumbria, Specialist Emergency Care Hospital (NSECH).

At the time of our inspection the service offered a limited number of maternity and obstetric services at North Tyneside, these included a pregnancy assessment unit, antenatal clinic, scan facilities, early pregnancy assessment and a pregnancy control service and elective gynaecology services. Between April 2014 and March 2015 there were 151 births at the unit, at the time of inspection this had reduced to none.

The service offered both medical and surgical termination of pregnancy and carried out 608 medical and 21 surgical terminations between April 2014 and March 2015. There were processes in place to ensure the sensitive disposal of pregnancy remains. All planned and routine gynaecology was undertaken on other sites within the trust. Gynaecological oncology services were provided by neighbouring trusts.

There was no neonatal care service based at this location.

We visited the Pregnancy assessment unit, Early pregnancy assessment unit, Antenatal clinic and also surgical wards. We spoke with three women, nine staff including midwives, health care support workers and doctors. We observed care and treatment and looked at four care records. We also reviewed the trust's performance data.

Summary of findings

We rated obstetrics and gynaecology services as good overall with the well-led domain rated as requires improvement because:

There were systems for reporting, investigating and acting on adverse events. The service routinely collected and reviewed standards and safety and shared it with staff. Medicines were stored correctly and checks on emergency equipment were in line with trust policy and were complete. Staff followed safety guidance for infection prevention and control. We found clear safeguarding processes in place; staff knew their responsibilities in reporting and monitoring safeguarding concerns. There were plans in place to ensure staff attended mandatory training. There was no medical staff present on the pregnancy assessment unit, however, support was provided from the antenatal clinic and staff had open access to the medical team based at NSECH.

We found the service used evidence-based guidelines to determine the care and treatment they provided. We reviewed the annual audit plan staff were involved in regular local audit. We found staff had the correct skills, knowledge and experience to do their roles, however, we found that training had not been provided to support staff on ward 7 when gynaecology was relocated. Training ensured medical and midwifery staff could carry out their roles effectively. Competencies and professional development were maintained through supervision.

Maternity and gynaecology

We found patients were respected and valued. Feedback from patients was positive about the care they experienced and were fully informed about what to expect. We observed patient care in the pregnancy assessment unit and antenatal clinic staff were supportive and compassionate.

The service had gone through a significant reconfiguration to a new model of care. Services were maintained at North Tyneside to support the local population. We found there were robust policies in place to ensure that patients were seen at the right place at the right time. We were informed of occasions where women experiencing miscarriage and termination of pregnancy were next to each other. The fertility control pathway provided an efficient and effective service to women in response to their respective needs, and was provided with choice in how they would like to dispose of pregnancy remains. Women using the service could raise a concern and be confident that concerns and complaints would be investigated and responded to.

Although the senior management team were aware of the challenges to the service and had a vision for the future, the formal clinical strategy for maternity or gynaecology services which was contained within the surgical business unit annual plan was very generic in terms of outcomes and references to maternity and gynaecological services were minimal. This did not support identification of how the service was to achieve its priorities or support staff in understanding their role in achieving the services priorities. The risk register did not reflect the current concerns of the senior management team. We found there were risk and governance processes in place; however, we were concerned with the levels of scrutiny provided by the directorate with regard to the clinical dashboard. Risks were reported and monitored and action taken to improve quality. We were concerned with the culture of the service, as staff have to overstep their personal objections to care for patients.

Are maternity and gynaecology services safe?

Good



We rated the safe domain as good because:

There were systems for reporting, investigating and acting on adverse events. The service routinely collected and reviewed standards and safety and shared it with staff.

We found medicines were stored correctly and checks on emergency equipment were in line with trust policy and were complete.

Staff planned and provided care and treatment in a way that ensured women's safety and welfare. Staff followed safety guidance for infection prevention and control. There were clear safeguarding processes in place; staff knew their responsibilities in reporting and monitoring safeguarding concerns.

There were plans in place to ensure staff attended mandatory training.

There was no medical staff present on the pregnancy assessment unit, however, support was provided from the antenatal clinic and staff had open access to the medical team based at NSECH.

Incidents

- The trust had policies for reporting incidents, near misses and adverse events. All staff we spoke with said they were aware of the process to report incidents. We saw printed information in all clinical areas which details what incidents should be reported. Staff reported incidents on the trust's electronic incident-reporting system. Staff told us they received feedback about incidents they had reported, with details of the outcomes of any investigations.
- Between August 2014 and July 2015, 62 incidents reported for maternity and gynaecology. Three were classified as moderate harm for example, post-operative complications and an extensive vaginal repair which required transfer to a consultant led unit. 13 incidents were reported as minor harm and these included availability of sonographers and 46 were classified as no harm.

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- The service used a weekly safety bulletin to inform staff of learning and changes to practice and keep staff informed of the risks which faced the directorate. We observed the bulletin was displayed in clinical areas; staff we spoke with informed us that the bulletin was discussed at team meetings.
- There were no Never Events reported for maternity and gynaecology in 2014/15.
- Perinatal mortality and morbidity were monitored through monthly perinatal meetings, which were attended by staff and reported quarterly to the trust mortality and morbidity steering group chaired by the medical director. Minutes of meetings from March 2015 to May 2015 included examples of the steering group reviewing cases and recommending changes to clinical guidelines and practice as a result.
- Staff were aware of the principles of duty of candour, and were able to provide us with verbal examples of where it had been applied.

Safety thermometer

- There was no maternity thermometer data specific for this location, however, trust wide, the service had started using the national maternity safety thermometer. This allowed the maternity team to check on harm and record the proportion of mothers who had experienced harm-free care. The maternity safety thermometer measures harm from perineal and abdominal trauma, post-partum haemorrhage, infection, separation from baby and psychological safety. In addition, it identified those babies with an Apgar score (a method to quickly summarise the health of the new-born) of less than seven at five minutes and those babies who were admitted to a neonatal unit.
- The service participated in the pilot for the national maternity safety thermometer. Results showed for combined harm free care between November 2014 and October 2015 between 52% and 87% of women received harm free care, however this was not benchmarked against other trusts.

Cleanliness, infection control and hygiene

- The service undertook patient-led assessments of the care environment (PLACE) across obstetrics and gynaecology services. We found all areas passed the assessments when they were conducted in May 2015.

- There were no cases of hospital-acquired Methicillin-Resistant Staphylococcus Aureus (MRSA) or Clostridium difficile (C. difficile) in 2014/15.
- Patients and visitors were encouraged to cleanse their hands with antibacterial foam. Areas we visited had antibacterial gel dispensers at the entrances. Appropriate signage was on display regarding hand washing for staff and visitors.
- Observations during the inspection confirmed that all staff wore appropriate personal protective equipment when required, and they adhered to 'bare below the elbow' guidance, in line with national good hygiene practice.

Environment and equipment

- All equipment safety tests were completed. Staff also completed a self-assessment to identify their competence, which identified any medical devices training needs.
- There was adequate equipment on the wards to ensure safe care – specifically, cardiotocography (CTG) and resuscitation equipment. Staff confirmed they had sufficient equipment to meet patients needs.
- All checks on emergency resuscitation trolleys were up to date.

Medicines

- We saw that fridge temperatures were checked in the pregnancy assessment unit.
- We saw that medicine cupboards were locked and in a locked room. There were no controlled drugs stored in the cupboard at the time of our visit.

Records

- The service was in the process of transition between paper records and electronic records. At the time of inspection antenatal records were completed electronically, and women kept their hand held paper record. Women were advised to take them to every midwife and doctor appointment. These notes contained details of their antenatal checks, scans and screening tests.
- The trust also retained a separate set of records which were held in the women's local base hospital.
- We reviewed 6 sets of care records and found good compliance with venous thromboembolism (VTE) risk assessments and good levels of documentation.

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- The service kept medical records securely in line with the data protection policy.
- The service used approved documentation for the process of ensuring that all appropriate maternal screening tests were offered, undertaken and reported on during the antenatal period.
- We reviewed an annual supervisor of midwives (SOM) audit of record keeping dated October 2014. A review of 25 patient records identified improvements were required in four areas, these were:
 - Basic record keeping.
 - Antenatal records.
 - Labour records.
 - Postnatal care.
- We reviewed the November 2015 SOM record-keeping audit which reviewed 27 health records and found improvements had been made; however, some areas had reduced in performance for example clients details on all pages had reduced from 100% compliance in 2014 to 85% compliance in 2015. Evidence of birth plan discussion had reduced from 100% to 73%. If CTG was used in labour hourly fresh eyes documentation had reduced from 70% to 50%. The postnatal checklist completed by midwife and evidence of health visitor handover had both reduced from 100% to 67%. The audit showed actions taken immediately by the SOM during review, however there was no detailed action plan, although there were recommendations around discussion documentation compliance in the annual SOM review and also the SOM mandatory training sessions.

Safeguarding

- There were effective processes for safeguarding mothers and babies. The service had a dedicated midwife responsible for safeguarding children, following a serious case review in June 2014.
- The safeguarding plan sits in the back up medical notes and the care plan was based in the electronic notes.
- Staff demonstrated a good understanding of the need to safeguard vulnerable people. Staff understood their responsibilities in identifying and reporting any concerns.
- The safeguarding lead told us all midwives received annual safeguarding training and community midwives also had face to face supervision at least every six months, and hospital based staff attended group supervision.

- Records showed 98% of nursing and midwifery registered staff based in the hospital and community had completed level three childrens safeguarding training; this was against a trust target of 85%.
- Records showed 81% of staff had completed safeguarding adults level one training against a trust target of 85%.
- We asked staff how they assessed and reported concerns around female genital mutilation (FGM). The World Health Organisation (WHO) defines FGM as procedures that include the partial or total removal of the external female genital organs for cultural or other non-therapeutic reasons. Senior clinical staff told us there had been training about FGM the previous year, which raised awareness. A guideline was in place to support staff in the identification of those at risk of FGM and management. Since September 2014, it has been mandatory for all acute trusts to provide a monthly report to the Department of Health on the number of patients who have had FGM or who have a family history of FGM. In addition, where FGM was identified in NHS patients, it is now mandatory to record this in the patients health record; there was a clear process in place to facilitate this reporting requirement.

Mandatory training

- Midwifery staff attended a two-day obstetric PROMPT mandatory programme, which included emergency drills, adult and neonatal resuscitation, infant feeding, record keeping and risk management awareness. Staff we spoke with informed us that mandatory training was monitored by SOM and team leaders.
- We reviewed data, which showed mixed mandatory training rates. We found that 74% had a mentorship qualification (53% on ward 7), 76% had completed basic life support training (47% of staff on ward 7), 86% of staff had completed aspects of the essence of care training, 72% of staff had completed infection prevention and control training (59% on ward 7), against a trust target of 85%. There were plans in place to ensure the service met the trust target by end of March 2016.

Assessing and responding to patient risk

- We observed staff on the pregnancy assessment unit under taking a detailed risk assessment and triage, on the telephone with mothers wishing to attend the unit. Staff used a situation, background, assessment and recommendation (SBAR) tool to assess the suitability of

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the unit in relation to the needs of the mother. We spoke with senior staff who explained that this was to ensure that women could be referred directly to the correct unit for treatment without delay.

Midwifery staffing

- The service met the national benchmark for midwifery staffing set out in the Royal College of Obstetricians and Gynaecologists (ROCG) guidance (Safer Childbirth: Minimum Standards for the Organisation and Delivery of Care in Labour) with a ratio of 1:19 across both community and hospital staff which was better than the national recommended 1:28. However, the service was unable to provide this data for this location.
- We found staffing levels were displayed on wards. We reviewed staff “off duty” and found a correlation between planned versus actual staffing numbers.
- We were advised that community midwifery caseloads were between 1:98 and 1:160 (documented on the directorate risk register, however, staff we spoke with gave examples of community midwife caseloads between 132 and 164. This was on the directorate risk register and we found that the service was looking to recruit an additional four community midwives.

Medical staffing

- There was no dedicated consultant presence for the pregnancy assessment unit or for gynaecology. There were consultant-led clinics however, no resident consultant or gynaecologist at any level. If a woman required a medical review a doctor would attend if a clinic was on session in the antenatal clinic, however, if there was no medical presence on site we were informed staff would contact NSECH and speak to a senior member of the on call team.

Major incident awareness and training

- Business continuity plans for maternity services were in place. These included the risks specific to each clinical area and the actions and resources required to support recovery.
- There were clear escalation processes to activate plans during a major incident or internal critical incident such as shortfalls in staffing levels or bed shortages.
- Midwives and medical staff undertook training in obstetric and neonatal emergencies at least annually.

- The trust had major incident action cards to support the emergency planning and preparedness policy. Staff understood their roles and responsibilities.

Are maternity and gynaecology services effective?

Good



We rated the effective domain as good because:

The service used national evidence-based guidelines to determine the care and treatment they provided and participated in national and local clinical audits.

Staff had the correct skills, knowledge and experience to do their job. Training ensured medical and midwifery staff could carry out their roles effectively. Competencies and professional development were maintained through supervision.

We saw patient information leaflets did not reflect current contact information. The trust informed us that it was unable to order new leaflets until the contact details for NSECH were known and as soon as this information was received new leaflets were ordered. In the meantime labels containing the new information were applied to the out of date leaflets, however, we did not see these in use.

Evidence-based care and treatment

- Medical and clinical staff reported having access to guidance, policies and procedures on the hospital intranet.
- From our observations and through discussion with staff care was in line with the National Institute for Health and Care Excellence (NICE) Quality Standard 22. This quality standard covers the antenatal care of all pregnant women up to 42 weeks of pregnancy, in all settings that provide routine antenatal care, including primary, community and hospital-based care.
- The care of women who planned for or needed a caesarean section was seen to be managed in line with NICE Quality Standard 32.
- We saw clinical guidance for the management of induced abortion up to 17 weeks and 6 days of pregnancy. This was based on the Abortion Act 1967 and the Human Tissue Authority’s ‘Code of Practice 5 on the disposal of human tissue’ and Royal College of

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Obstetricians and Gynaecologists 'national evidence based clinical guideline number 7'. We found staff in the fertility control service adhered with The Abortion Act 1967 and Abortion Regulations 1991. This included the completion of the necessary forms (HSA1 and HSA4).

- There was evidence to indicate NICE Quality Standard 37 guidance was being met. This included the care and support that every woman, their baby and as appropriate, their partner and family should expect to receive during the postnatal period. There were arrangements in place that recognised women and babies with additional care needs and referred them to specialist services. For example, there was an on-site special care baby unit (SCBU).
- Staff were consulted on guidelines and procedures, which were regularly reviewed and amended to reflect changes in practice. Policies and procedures were available on the trust's intranet and were approved by the clinical governance group. The policies we reviewed (post-partum haemorrhage, multiple births, pre-eclampsia and raised blood pressure) were all in-date and in line with best practice.
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Pain relief

- Although no births took place at North Tyneside, we saw a leaflet available for women on pain relief in labour. The leaflet was written by the Obstetric Anaesthetists' Association.

Nutrition and hydration

- The trust was implementing United Nations Children's Fund (UNICEF) Baby Friendly Initiative standards. The unit had achieved stage two of the accreditation process, however, were unsuccessful when the service was assessed for stage three of the accreditation process.

Patient outcomes

- There were no risks identified in maternal readmissions, emergency caesarean section rates, elective caesarean sections, neonatal readmissions or puerperal sepsis and other puerperal infections (Source: HES 2014/15; Intelligence Monitoring Report May 2015).
- The service offered both medical and surgical termination of pregnancy and carried out 608 medical and 21 surgical terminations between April 2014 and March 2015.

Competent staff

- The head of midwifery, matron and team leaders, allocated staff to training and identified through appraisals the need for additional training over and above mandatory training, monitored staff training monthly. The appraisal rate was 93% for 2014/2015. All staff we spoke with informed us their appraisal was up to date.
- We were told the PROMPT training programme for obstetrics ran over a two-year cycle, which ensured a comprehensive training programme. Subjects included, antenatal and new born screening, and public health initiatives. The training programme also included skills drills in subjects such as cord prolapse (including at home) and breech delivery, shoulder dystocia, eclampsia and obstetric haemorrhage.
- Newly qualified band 5 midwifery staff had a period of 'preceptorship', where they received additional support and went through a programme of competencies. Staff reported the level of support and training was "good."
- Healthcare support workers attend PROMPT training to support the delivery of services and examples of subjects included the care of deteriorating patients and MEOWS, maternal observations, skills drills, breech births, eclampsia and neonatal life support.
- All midwives had a named supervisor of midwives (SOM). Staff we spoke with told us they had access to and support from an on call SOM 24 hours a day. The ratio of SOM to midwives was one to 11 which was in line with recommendations. The 2014/15 local supervisory authority (LSA) report identified that SOMs needed to negotiate enough protected time to undertake statutory work, and also consider new models for supervision.
- Staff we spoke with on ward 7 informed us they had not received any additional knowledge or training in how to look after gynaecological women. We were informed this was due to happen however had not taken place as yet.

Multidisciplinary working

- We saw and were informed of the effective working relationships involving doctors, therapists, midwives and nurses from the pregnancy assessment unit, antenatal clinics and gynaecology. We were also told that community midwives would visit the unit to attend meetings or discuss issues with colleagues.

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Seven-day services

- The pregnancy assessment was open five days a week 08.30 to 17.30 and at all other times women were advised to attend NSECH.
- The early pregnancy assessment unit was open five days a week 08.30 to 17.30.
- Elective gynaecology procedures took place Monday to Friday; however, no elective work was undertaken at the weekend.

Access to information

- We found that there were a good range of helpful leaflets available. However, we noticed that leaflets on anti-D prophylaxis and caesarean section had been updated but that both the old and new versions were in circulation.
- Some leaflets were significantly out of date but were still being used. These included a leaflet on ectopic pregnancy which was due for review January 2010. We also found a leaflet on external cephalic version (a process by which a breech baby can be turned to head down) which expired in October 2009. We spoke with staff who confirmed these leaflets were still being given to women.
- For some of the leaflets that were in-date or had been updated recently, the telephone numbers did not reflect the new service at NSECH and still referred to services that were no longer available at North Tyneside.
- Staff we spoke with said that there was a reluctance to print new leaflets until the future of the maternity services were more certain. In the meantime, they had been given address labels to stick on the old leaflets before being handed to women.
- However, the trust informed us that it was unable to order new leaflets until the contact details for NSECH were known and as soon as this information was received new leaflets were ordered. In the meantime labels containing the new information were applied to the out of date leaflets.
- We found that HSA4 forms were completed electronically and in a timely manner.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- There was a system to ensure consent for the termination of pregnancy was carried out within the

legal requirements of the Abortion Act 1967. We advised compliance with the completion was not undertaken, however, was monitored by senior medical secretaries who ensure legal requirements are complied with.

- The fertility control service followed trust policy to gain consent prior to termination of pregnancy, however, Gillick and Fraser guidelines are not referred to in this guideline or the safeguarding children guidelines.

Are maternity and gynaecology services caring?

Good



We rated the caring domain as good because:

We found patients were respected and valued.

Feedback from patients was positive about the care they experienced and were fully informed about what to expect.

We observed patient care in the pregnancy assessment unit and antenatal clinic staff were supportive and compassionate.

Compassionate care

- Results of the NHS Friends and Family Test showed that between July and September 2015 an average 98% of women would recommend their birth experience; this was better than the England average at 97%. Staff proactively promoted patient experience projects, including the NHS Friends and Family Test, which included a feedback card and envelope system to improve the response rate.
- Following a number of complaints received in 2014 at Wansbeck hospital, the service introduced a programme of compassion training which was offered to all staff. Staff informed us that originally they felt it was unnecessary, however, following the training all staff said they found it extremely valuable.
- Results from the Maternity Service Survey 2015, showed the service scored the same as other trusts for antenatal care.
- We observed positive interactions of staff with women and their partners. Staff were calm and compassionate and knocked and waited at the patient door before being invited in.

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Understanding and involvement of patients and those close to them

- Women were involved in their choice of birth, at booking and throughout the antenatal period. Women we spoke with said they had felt involved in their care; they understood the choices open to them and were given options of where to have their baby. All women we spoke with were aware of which pathway they were following (High or Low risk).
- We noted the rate of home births was low (below 1%), Records showed staff discussed birth options at booking and during the antenatal period. Supervisors of midwives, and the consultant team were also involved in agreeing plans of care for women making choices outside of trust guidance, focusing on supporting women's choices of birth while ensuring they were making fully informed decisions.

Emotional support

- Standard operating procedures were in place for the sensitive disposal of fetal/placental tissue, following early pregnancy loss.
- There was also a local charitable group called 'Teardrop' which worked with the bereavement midwives to provide support for women and their families following pregnancy loss.
- Women who had experienced a previous traumatic birth or struggled to adjust following termination of pregnancy or early pregnancy loss were supported by the Health Psychology Service; the outcomes of this service were reported as good. This was a well-established service and patients self-referred or were assessed and referred by staff. Patients were contacted promptly, appropriately assessed and redirected offering early engagement and reassurance to this patient group.

Are maternity and gynaecology services responsive?

Good



We rated the responsive domain as good because:

The service had gone through a significant reconfiguration to a new model of care. Services were maintained at North Tyneside to support the local population.

There were robust policies in place to ensure that patients were seen at the right place at the right time.

We were provided with an example where women experiencing miscarriage and termination of pregnancy were next to each other, however, staff identified this was not ideal but was unavoidable at the time.

The fertility control pathway provided an efficient and effective service to women in response to their respective needs, and was provided with choice in how they would like to dispose of pregnancy remains.

Women using the service could raise a concern and be confident that concerns and complaints would be investigated and responded to.

Service planning and delivery to meet the needs of local people

- The service had undergone a significant restructure following the commencing of the new model of care in June 2015, and the discontinuation of the midwifery led service at North Tyneside.
- Antenatal and early pregnancy care continued at this location in order to support the local community.
- The service had begun to engage with service users and had held one meeting of the Maternity Service User Forum in September 2015. It was planned that this group would meet quarterly and the next meeting was set for January 2016.

Access and flow

- All antenatal clinics had a scanning service running in parallel, however we were informed women may not be able to get scan appointments on the same day at their consultant appointment. This meant that some women would need to attend the clinic twice and wait for follow up.
- The pregnancy assessment unit was open from 08.30 to 17.30 Monday to Friday with the last booking at 16.30.
- Women were referred to the pregnancy assessment unit by either the community midwives or general practitioner, women could also self-refer if they were concerned.
- Women could contact the pregnancy unit and there was a telephone triage service. There was clear acceptance criteria, and those who did not meet this were referred to the Northumbria Specialist Emergency Care Hospital for review.

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- We saw that between July and September 2015, 564 women had been seen on the PAU since the reconfiguration of services, and 17 women were transferred to NSECH during this time.
- There was no onsite medical gynaecology cover; however, patients were reviewed by a gynaecology nurse specialist. Staff we spoke with could not recall any incidents where this had not been sufficient.
- Ward 7 admitted elective gynaecology inpatients, miscarriages and terminations.

Meeting people's individual needs

- Staff we spoke with informed us of occasions where women experiencing miscarriage and those undergoing a termination of pregnancy were required to be in adjacent beds on ward 7. Staff highlighted this was not ideal; however, they were the only beds available at that time. We have not seen any reported data for this.
- There were arrangements to support individuals with complex needs, with access to clinical specialists and medical expertise, for example, arrangements were put in place to support a woman with complex health and social care needs. There was a network of midwives and consultants with special interests in teenage pregnancy, high risk pregnancy, diabetes and bereavement.
- Staff could explain how the translation service was accessed and used; however, we reviewed an incident which was reported when the translation service cancelled an interpreter at short notice for a sensitive discussion with a patient. This had already been delayed. Staff we spoke with informed us this was not a one off event.
- There were processes in place to ensure the process of disposal of pregnancy remains was handled sensitively. Women were provided with a choice of how they would like to dispose of pregnancy remains. This included cremation or being enabled to take them home.

Learning from complaints and concerns

- Complaints and concerns were included on a performance dashboard and monitored monthly at the obstetrics and gynaecology governance group.
- Both formal and informal complaints were treated with the same seriousness by the service. Staff offered to meet the complainant when complaints were received; the PALS team supported this.
- Between August 2014 and September 2015, the service received five complaints. We reviewed a selection of

cases and the outcomes of which were appropriate, with duty of candour appropriately applied in all cases. Themes of these complaints included staff attitude and aspects of clinical treatment.

Are maternity and gynaecology services well-led?

Requires improvement

Leadership in maternity and gynaecology services required improvement because:

Although the senior management team were aware of the challenges to the service and had a vision for the future, the formal clinical strategy for maternity or gynaecology services which was contained within the surgical business unit annual plan was very generic in terms of outcomes and references to maternity and gynaecological services were minimal. This did not support identification of how the service was to achieve its priorities or support staff in understanding their role in achieving the services priorities. The risk register did not reflect the current concerns of the senior management team.

Staff were not appropriately trained to care gynaecology patients and were required to go against their own objections when gynaecology staff were unable to attend the ward.

The service had not benchmarked themselves effectively against the recommendations of the Kirkup Report (2015).

There were risk and governance processes in place; however, we were concerned with the levels of scrutiny provided by the directorate with regard to the maternity dashboard. Risks were reported and monitored and action taken to improve quality.

The views of the public and stakeholders through participative engagement were actively sought, recognising the value and contributions they brought to the service. There was some evidence of innovative practice.

Vision and strategy for this service

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- The senior management, midwives and consultants were all committed to their patients, staff and unit. The vision of the unit was to provide the best outcome for women through promoting normality and high quality care and to become the “provider of choice”.
- Although the senior management team were aware of the challenges to the service and had a vision for the future, the formal clinical strategy for maternity or gynaecology services which was contained within the surgical business unit annual plan was very generic in terms of outcomes and references to maternity and gynaecological services were minimal. This did not support identification of how the service was to achieve its priorities or support staff in understanding their role in achieving the services priorities. A business case had been put forward to progress the development of a PAU at NSECH, and we were informed this needed to happen as soon as possible. In the long term there were plans in place to locate the early pregnancy assessment service at NSECH and provide this seven days a week, however, there was no specific time scale for this. Staff were aware of this, however, and were concerned as there was no timescale and they were concerned for their roles.
- Most staff were aware of the trust’s vision and were committed to embedding the improvements both in maternity and gynaecology services and as part of the trust as a whole.

Governance, risk management and quality measurement

- The maternity risk management strategy set out guidance for the reporting and monitoring of risk. It detailed the roles and responsibilities of staff at all levels to ensure poor quality care was reported and improved. The risk management strategy had not been reviewed to reflect the current service provision as it did not highlight the care provided at NSECH.
- The maternity incident review group was chaired by the consultant on call or by the obstetric delivery suite lead and reviewed clinical incidents. This group collated a summary of incidents which then escalated concerns to the obstetrics and gynaecology governance group (OandGGG) chaired by the head of midwifery (HOM). The aim of the group was to look at any areas for concern in practice and to identify trends and determine what actions should be taken to avoid a similar incident in the future.
- A clinical governance coordinator reviewed and responded to risks on a daily basis. A quarterly report was produced from incidents, data from the birth register and key performance measures (that were monitored on the maternity services dashboard each month).
- Learning was encouraged through further discussion at local meetings and memorandums and also one-to-one meetings where required.
- The service used the maternity and also the gynaecology dashboards recommended by the RCOG. The dashboards showed clinical performance and governance scorecard and helped to identify patient safety issues in advance. There were no issues RAG rated red in the Gynaecology dashboard since June 2015.
- A maternity and gynaecology risk register contained 27 risks in total. It was updated on a monthly basis at the obstetrics and gynaecology operational management board meeting (OandGOMB). Risks included cost pressure, maternity IT systems, and latex sensitivity. We saw that the top three risks were shared with staff weekly in the safety bulletin. All staff we spoke with were able to inform us of these risks. We found the dashboard contained inaccuracies, for example the number of instrumental, operative and vaginal births did not equate to 100%. This meant we were concerned with the accuracy and monitoring of the dashboard at all levels within the service.
- There was no alignment between the risk register and the senior team worry list, and through discussion with the senior team there was concerns about staffing levels at NSECH, as the demand had exceeded expectations. The senior team also stated high on their list of priorities was the relocation of pregnancy assessment services at NSECH. Neither of these concerns were documented on the directorate risk register.
- Governance documents identified the roles of the SoMs and the Local Supervising Authority. SoMs told us they attended in this capacity and not in a dual role. This was in line with recommendations by the Nursing and Midwifery Council.
- Most staff we spoke with had an awareness of the new regulations relating to ‘duty of candour’ and were able to inform us of information that was posted on wards and departments.
- We received two Kirkup (2015) gap analyses from the service. The first was data prior to the publication of the report and the second was data following. However, the

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service only assessed itself against the recommendation applicable to the wider NHS and not against the recommendations made for the individual service named in the report.

- Completion of HSA1 (grounds for carrying out an abortion) and HSA4 (abortion notification) forms were completed by two doctors who followed guidance and submitted the forms to the Department of Health as required.

Leadership of service

- The maternity and gynaecology service was part of the Surgical Business Unit.
- Senior staff in the pregnancy assessment unit, clinics and gynaecology were knowledgeable about their service and they were able to describe the patient pathway.
- Staff we spoke with were positive about the local leadership of the service.
- The structure that leads the maternity and gynaecology service is as follows: business unit director; deputy executive director; clinical director; general manager; head of midwifery; operational service manager (OSM); clinical Lead Midwife/matron; Acting Clinical lead midwife/matron and a matron for gynaecology. The day to day management of the unit is provided by the clinical lead midwife/matron who links in with the team leaders, HOM, OSM and general manager.
- Across the service, there was a matron for gynaecology and one for maternity and an interim matron for community; however, due the geographical spread the service required additional matron posts. We were informed two substantive matron posts had been advertised, one for the midwifery led units and one for community. It was expected that interviews would take place in December 2015.

Culture within the service

- Staff we spoke with informed us that elective gynaecology has relocated to Ward 7, and staff were uncomfortable with caring for women undergoing a termination of pregnancy, and most staff had chosen to conscientiously object to being involved with termination of pregnancy. We were informed that staff from the gynaecology clinic would attend the ward to

administer medication as required. We were informed of one occasion where no staff were available to support and a senior nurse had to give the medication against her own objection.

- Managers operated an 'open door policy' for staff to raise any issues or concerns which staff felt confident would be acted on.
- Staff sickness levels in maternity between June 2015 and August 2015 was 1.49%, this equated to 1.75% for community midwifery, 1.13% for obstetrics and gynaecology and 1.38% for ward 1. The overall sickness absence rate for Obstetrics and Gynaecology was 2.25%, against a trust target of 3.5%. Some of these related to long-term sickness.

Public engagement

- The service was beginning to take account of the views of women and their families through the maternity services user forum, a multidisciplinary forum where comments and experiences from women could be used to improve standards of maternity care. Due to the infancy of this group we were unable to identify any actions which had occurred from the first meeting

Staff engagement

- There were no directorate specific results 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 3.93. This score placed the trust in the highest 20% of trusts compared to similar trusts.
- We spoke with staff and in all areas staff were very engaged and felt involved in service development especially during the consultation periods prior to the relocation of maternity services from the Wansbeck General and North Tyneside General Hospitals to NSECH.

Innovation, improvement and sustainability







- The service had the support of a small health psychology team. This team supported women who had experienced a previous traumatic birth or struggled to adjust following termination of pregnancy or early pregnancy loss. The outcomes of the service were reported as good. The service implemented a series of workshops to equip staff with the necessary skills to enable them to deliver compassionate care by utilising appropriate communication skills and strategies with

Maternity and gynaecology

patients and families. The health psychology team delivered this, following a review of the 2015 CQC

patient experience survey the trust has ranked within the top 10% for patient experience. This meant that the compassion training was improving patients experience of care and interactions with staff.

End of life care

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

Information about the service

Northumbria Healthcare NHS Foundation Trust provides an integrated trust wide end of life care service. The service consists of three integrated acute hospital specialist palliative care liaison teams based at Northumbria Specialist Emergency Care Hospital (NSECH), North Tyneside General Hospital (NTGH) and Wansbeck General Hospital (WGH). The hospital liaison teams consist of a band seven specialist palliative care nurse and two palliative care nurses (Band 5 and Band 6). Their role is to provide specialist support to each hospital site and to provide a rapid discharge service for patients wishing to be discharged to die in their preferred place of care. The rapid discharge service involves a member of the liaison team accompanying the patient home and handing over their care to colleagues in the community services. Also as part of the integrated end of life care service are two specialist palliative care community teams and two specialist palliative care units based at NTGH and WGH. Between January and December 2014 the trust had a total of 2,364 in-hospital deaths.

NTGH had a dedicated palliative care unit for patients with end of life and palliative care needs. Patients requiring end of life care would also be cared for in ward areas throughout the hospital with support from the hospital liaison palliative care team. Specialist palliative care was provided as part of an integrated service across the hospital and community teams and the palliative care service sat within the trust's community and social care business unit. The hospital liaison palliative care team at NTGH consisted of two nurses, one band 7 specialist

palliative care (SPC) clinical nurse specialist (CNS) and one band 6 palliative care nurse. There was a band 5 vacant palliative care nursing post that the trust was recruiting to and an additional band 7 CNS post had been identified as necessary following a review of palliative care activity within the hospital since opening.

We saw that referrals to the integrated trust wide palliative care service totalled 2142 between April 2014 and March 2015 (this increase included the hospital liaison team) and that 70% of patients referred had a cancer diagnosis of which 30% had non-malignant disease. During our inspection we spoke with staff based on the palliative care unit, members of the hospital liaison palliative care team, the wider integrated palliative care team, mortuary staff, chaplaincy staff and ministers, medical staff, ward managers, nursing staff, health care assistants, allied healthcare professionals and student nurses. In total we spoke with 22 staff. We visited a number of wards and clinical areas across the hospital including palliative care, surgery, respiratory, acute medicine, elderly care, stroke care, and cardiology. We reviewed the records of 15 patients at the end of life and reviewed Do Not Attempt Cardio Pulmonary Resuscitation (DNACPR) orders. We spoke with two patients and three relatives and we reviewed audits, surveys and feedback reports specific to end of life care.

End of life care

Summary of findings

We rated end of life care as outstanding because:

We found that the trust was providing high quality end of life care services using an innovative model of working and effective partnership working. There had been significant investment in palliative and end of life care services and the trust was responsive to addressing issues as they arose with flexibility in relation to staffing and resources. There was a clear vision, strategy and leadership at all levels of the organisation with a focus on good quality end of life care. The structure of the hospital liaison service that had been developed in partnership with Marie Curie provided additional flexibility to enable specialist palliative care staff to provide support to patients at the end of life irrespective of the complexities of their condition. This was sometimes in the form of supporting a rapid discharge to the patients preferred place of care in the community and as such involved a very hands on approach to ensuring as straightforward a transition as possible with hospital staff accompanying the patient in order to handover to community staff.

We saw evidence of the use of national guidance and appropriate anticipatory prescribing of medicines at the end of life. Multidisciplinary working was apparent across services within the hospital and the community. The use of a dedicated palliative care unit and hospital liaison meant that there was a culture of understanding of palliative and end of life care that was integrated across disciplines and with other services. Patients and their families were involved in that care and we saw a number of initiatives in use to record patient wishes including advance care plans, emergency healthcare plans and treatment escalation plans.

Feedback from patients and their relatives was positive about the way staff treated them with one person telling us that staff really care and go above and beyond what they would expect. There was a strong person-centred culture within the hospital and staff consistently appeared to be committed to providing compassionate care and promoting people's dignity. The trust performed in the top ten NHS trusts in England in the 2014 National Cancer Patient Experience Programme national survey, with 95% of respondents rating the care

as being excellent or very good. Spiritual care was seen to be important with initiatives having been developed in supporting staff in the assessment of spiritual needs through training and the use of an internally designed assessment tool. Chaplaincy support saw multi-denominational ministers and faith leaders available for patients, relatives and staff.

The leadership, governance and culture were used to drive and improve the delivery of high quality person-centred care through collaboration and partnership working. The trust had clear leadership for end of life care services that was supported at the top of the organisation. There was a clear proactive approach to seeking out and embedding new and more sustainable models of care. Staff we spoke with consistently told us they felt that end of life care was a priority for the trust.

End of life care

Are end of life care services safe?

Good



We rated safe in end of life care services as good because:

There was a good track record and evidence of improvements in safety. Staff understood and fulfilled their responsibilities to raise concerns and report incidents. When something went wrong there was a thorough review and investigation that involved relevant staff with learning suitably cascaded and shared. Actions were identified to improve processes to prevent the same thing from happening again and staff had an understanding of the need for openness and candour with patients as well as relatives when something went wrong.

Staffing levels and skill mix were planned, implemented and reviewed to keep people safe. Risks to people who used the services were assessed, monitored and managed. Staff had attended mandatory training specific to their role. Where staff were not up to date with mandatory training there was a plan in place ensuring they would be up to date within a short timescales.

Incidents

- There had been no end of life care related never events reported in the last 12 months (a never event is a serious incident that is 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).
- Staff delivering end of life and specialist palliative care understood their responsibilities with regard to reporting incidents. Staff we spoke with told us that when an incident occurred it would be recorded on an electronic system for reporting incidents.
- Staff on the PCU (palliative care unit) told us that the ward manager and matron would investigate any incidents that occurred. The ward manager or a representative from the ward attended weekly incident review meetings that were attended by staff from across the hospital and facilitated by clinical matrons. This enabled staff to discuss incidents outside of individual units and share learning across wards and clinical areas.

- We viewed minutes of bi-monthly clinical governance meetings where incidents were discussed. Specific learning included working with the ambulance service regarding a delayed patient transfer and working with the tissue viability nurse regarding a deteriorating pressure ulcer.
- We observed learning leading to changes to practice in the mortuary following an incident relating to two patients with the same name. Changes included additional checks to verify the patients identify. We saw evidence that the learning from this incident had been cascaded across all mortuary sites within the trust.
- We saw evidence that incidents were discussed by the palliative care steering group and at relevant ward based and team based meetings to share information and identify opportunities for learning.
- Staff we spoke with had an awareness of their responsibilities in relation to Duty of Candour.

Safety thermometer

- Safety thermometer information was visible on the wall in the Palliative Care Unit (PCU). The NHS Safety Thermometer has been designed to be used by frontline healthcare professionals to measure a snapshot of harm once a month from pressure ulcers, falls, urinary infection in patients with catheters and treatment for VTE (venous thromboembolism).
- The safety thermometer dashboard between October 2014 and September 2015 showed that on average 94% of patients received harm free care. Harm free care is defined by the absence of pressure ulcers, harm from a fall, urine infection (in patients with a catheter) and new VTE.

Cleanliness, infection control and hygiene

- Clear guidance was available for staff to follow to reduce the risk of infection when providing end of life care. We observed staff using appropriate techniques to reduce the risk of infection including handwashing and the use of personal protective equipment (PPE) such as gloves and aprons.
- We observed staff on the PCU using appropriate barrier nursing techniques and seeking advice from the trust's infection control team as necessary.
- Mortuary procedures and protocols incorporated infection control mechanisms including daily monitoring and recording of the temperature of the mortuary fridges.

End of life care

- The trust monitored compliance with infection control procedures through the use of the 15 steps Safety and Quality assessment. Specific observations included the general cleanliness of the ward, the use of PPE and the effective management of clinical waste.

Environment and Equipment

- The PCU was situated away from the main hospital site in a building that was co-located and managed by a nursing home. The environment was clean, comfortable and appropriate for the needs of patients at the end of life.
- Staff told us they were able to request changes to the environment as needed and worked closely with the management of the nursing home to ensure this. One example was that patients had commented that staff closing doors at night had disturbed them so silencers had been fitted to the doors to stop this from happening.
- There was a mortuary at NTGH. We viewed mortuary protocols and spoke with mortuary and portering staff about the transfer of the deceased. Staff told us that the equipment available for the transfer of the deceased was adequate and we saw that this included bariatric equipment.
- The mortuary fridges were temperature monitored and alarmed.
- We observed the use of McKinley syringe drivers on the wards and saw that regular administration safety checks were being recorded.
- Staff on the PCU and the specialist palliative care team told us that equipment was available when they needed it from the equipment library. None of the staff we spoke with had experienced any difficulty in accessing equipment when they needed it.

Medicines

- Medicines were prescribed using guidance from the Northern England Strategic Clinical Networks. The guidance was available on the intranet and as part of the trusts Care of the Dying Patient (CDP) document. The guidance included different scenarios for a range of symptoms that could be experienced at the end of life.
- Medicines for use at the end of life, including those for use in a syringe driver were readily available on the wards. Controlled drugs were stored safely and correctly.

- We spoke to a pharmacist on the PCU and saw that they visited daily to reconcile medicines and carry out activity such as medicines audits.
- We viewed an August 2015 audit of omitted medication doses to ensure that critical medicines were administered as prescribed and saw that performance had improved on the PCU in this area.

Records

- We saw that an inpatient admission record was used to record patient details, medical and nursing assessments and risk assessments, and care plans.
- Patients identified as being ill enough to die were cared for using the CDP guidance that had been developed by the Northern England Strategic Clinical Networks.
- We viewed the records of 15 patients who were considered to be ill enough to die. In all cases we saw that assessment and care records were completed appropriately and accurately.
- We reviewed 10 Do Not Attempt Cardiopulmonary Resuscitation (DNACPR) forms. In all cases we saw that there was a clearly documented reason for the decision recorded with clinical information included. All decisions were dated and approved by a consultant. Discussions about DNACPR with patients and relatives were recorded in sufficient detail within the patients notes.
- Palliative care staff had access to the same electronic patient record system as community palliative and nursing staff although this was a new development that was not yet fully embedded. We saw that the system was being implemented in a phased way and included plans for specialist palliative care staff to have access to GP palliative care registers.

Safeguarding

- The trust had appropriate safeguarding systems in place with policies and procedures in place in relation to safeguarding adults and children.
- We viewed mandatory training records and saw that members of the palliative care team had attended training in Safeguarding children at level 1 or 2 and safeguarding adults although this was below target for staff on the palliative care unit. 64% of nursing staff had attended safeguarding level one training against a target

End of life care

of 85% and 71% had attended safeguarding children training against a target of 85%. There was a plan in place for all staff to complete their safeguarding training by the end of March 2015.

- Staff we spoke with demonstrated a good understanding of their responsibilities in reporting safeguarding concerns. They were able to explain what constituted a safeguarding concern and the steps they were required to take.

Mandatory training

- We viewed training records and saw that members of the palliative care team had attended training in a number of mandatory areas. Examples included fire safety, safeguarding, mental capacity act, infection control, moving and handling and basic life support.
- Records for the nurses on the palliative care unit showed that 86% had attended clinical falls training against a target of 85%, 100% had attended health and safety training and information governance training. Some areas of mandatory training were below target such as basic life support (79%) and conflict resolution (43%). There was a plan in place for all staff to complete their mandatory training by the end of March 2015.

Assessing and responding to patient risk

- We observed the use of general risk assessments on the wards, including those relating to the risk of falls, malnutrition and dehydration, the use of bed rails and the risk of pressure damage.
- The patients whose records we reviewed all had treatment escalation plans (TEPs) in place. A TEP provides the opportunity for patients, doctors and nurses to outline an overall plan of care. It gives guidelines on what treatments patients may receive should their condition get worse and enables quick escalation of care for those patients who need it, while avoiding unnecessary treatments for those who do not.
- The trust had in place the Northern England Strategic Clinical Networks guidance on caring for the dying patient. The guidance was in place for the care of patients whose condition had deteriorated and the clinical team believed that the patient was ill enough that they may die within hours or days. The guidance included the requirement for the senior clinician in

charge of the patients care to review the patient and to make a plan for symptom management. Additional guidance included the need for a daily medical assessment and two hourly nursing assessments.

Nursing staffing

- The staffing establishment for the PCU had been identified using a safer nursing acuity tool. We viewed rotas and saw that the establishment was generally met using permanent and regular bank staff, with a minimal use of agency staff.
- Staff we spoke with on the PCU told us there was some flexibility with staff and that they were able to request additional staff if they had higher patient dependency levels. The ward manager and matron told us that the director of nursing had recently agreed to increase the establishment of staff at night.
- The trust had worked in partnership with Marie Curie to develop an integrated model of palliative care nursing that included the use of hospital liaison teams. The liaison team at NTGH operated an establishment of 3WTE (whole time equivalent) palliative care nurses. Of these, one was a band 7 specialist palliative care nurse and the other two were palliative care nursing posts at band 6 and band 5.
- Specialist palliative care nurses were available from 9am – 5pm Monday to Friday. There was no on call specialist palliative nursing cover out of hours although staff had access to an out of hours advice line using a local hospice.
- Nursing staff on the wards told us they felt they had sufficient staffing to prioritise good quality end of life care when needed and that they had processes in place to escalate staffing concerns should they arise.
- The specialist staff told us they had plans to develop end of life care champion roles for ward staff with a special interest in end of life care.

Medical staffing

- There were five palliative care consultants employed across the trust at the time of our inspection. One consultant took the lead for acute inpatient services including wards at NTGH.
- There was seven day on call palliative care consultant cover.

End of life care

- We saw that ward based doctors were supported to deliver end of life care by the specialist palliative care team and we observed the specialist palliative care nurses discussing prescribing guidelines with doctors on the wards.
- Medical staff we spoke with told us the specialist palliative care team were available for specialist advice as needed.

Major incident awareness and training

- We saw that business continuity plans relating to the body store/mortuary included arrangements for times of increased mortality rates, for example in the winter months where capacity within the mortuary was increased to meet demand. The plans included the use of the mortuary and body stores across the trust.
- Major incident planning included the use of the chaplain in a support role and we saw that the on-call chaplain was included when a major incident occurs.

Are end of life care services effective?

Outstanding



We rated effective in end of life care as outstanding because:

People's care and treatment was planned and delivered in line with current evidence-based guidance, standards, best practice and legislation. Patients had comprehensive assessments of their needs using a Caring for the Dying Patient (CDP) document that included consideration of their physical, social, emotional and spiritual needs. There was a holistic, multi-disciplinary approach to the care of patients at the end of life. The palliative care operating model saw the combined approach of a specialist palliative care in-patient unit operating alongside a palliative care hospital liaison team for patients cared for in non-palliative care beds. This approach supported the delivery of high quality care for all patients at the end of life being cared for at NTGH.

We saw that clinical and national audits had been used to improve outcomes for patients and that information about people's care and treatment was routinely monitored and used to improve care. The learning needs of staff were identified through annual appraisals and we saw that training had been implemented to address these needs. A

range of end of life care specific courses were available to staff, including those for newly qualified staff nurses, health care assistants, staff working on the PCU and a three day course for general ward and community based staff interested in end of life and palliative care.

Systems to manage and share information to deliver effective patient care were in place with a new electronic record system used by the SPCT across all hospital sites that was aligned with the system used by community teams and GPs.

Evidence-based care and treatment

- The trust used the Northern England Strategic Clinical Networks guidance on caring for the dying patient and care planning document. The guidance included identifying patients at the end of life, holistic assessment, advance care planning, coordinated care, involvement of the patient and those close to them and the management of pain and other symptoms.
- The CDP document had been implemented to replace the Liverpool Care Pathway that had been discontinued in 2014.
- We saw that the CDP documentation had included national guidance from sources such as the Leadership Alliance for the Care of Dying People, the Department of Health End of Life care Strategy, and the National Institute of Clinical Excellence (NICE).
- The palliative care service had a local audit activity plan in place that included an audit of the appropriate use of emergency health care plans. They had also carried out audits of the care of the dying patient document throughout its implementation.

Pain relief

- Patients who were considered to be in the last days/ weeks of life were appropriately prescribed anticipatory medicines for the symptoms sometimes experienced at the end of life, including pain.
- 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.
- We found that patients received good pain relief. Patients and relatives we spoke to told us that their pain was under control and we saw that pain relief was administered in a timely manner. We did not observe any patients in pain during our inspection.

End of life care

- We viewed pain scales being used appropriately on the wards to assess the patients pain and to evaluate the effectiveness of medication administered.
- Patients and relatives we spoke with told us that the nursing staff supported them well in managing their pain.

Nutrition and hydration

- The 'MUST' Nutritional Screening and Assessment Tool was used. Staff were aware that nutrition and hydration plans at the end of life were focused on quality of life issues.
- The CDP document included an assessment of the patients nutrition and hydration status and guidance that it is the patients choice to eat and drink, even if they have swallowing difficulties.
- We observed staff on the wards offering patients food and drinks and encouraging relatives to be involved in that part of a patients care as appropriate, including the administration of mouth care when a patient was no longer able to eat and drink.
- Healthcare assistants we spoke with told us they had received training in nutrition, hydration and mouth care for patients at the end of life and they understood their role in supporting patients in this way.
- The matron of the SPCT told us they had been approved funding for a nutritional support post on the PCU where the post holder would support patients in a variety of ways to meet their nutrition and hydration needs.
- Palliative care staff worked closely with ward staff in the assessment of patients needs in relation to nutrition, hydration and mouth care.
- Staff we spoke with told us they were led by the patients wishes at the end of life with regard to nutrition and hydration. Staff told us that the catering staff at the nursing home where the PCU was based worked closely with them to ensure that patients nutritional needs were met and in particular that patients at the end of life were able to choose the food they wanted. We were given examples of when staff had gone out of their way to ensure patients had the food they wanted.

Patient outcomes

- The trust had taken part in the 2013/14 National Care of the Dying Audit (NCDAA) where they had not achieved 4 out of 7 organisational key performance indicators. These areas covered: education, training and audit; Trust Board representation; protocols covering privacy,

dignity and respect; and formal feedback processes regarding bereaved relatives views of care. We also saw that the trust had performed below the national average in clinical areas such as multidisciplinary recognition that the patient is dying and medicines prescribing for the five key symptoms during the dying phase. We viewed an action plan produced by the palliative care team to address the areas where improvement was required and were satisfied it would achieve the 4 organisational key performance indicators as well as the clinical indicators.

- We saw that the learning from the audit across the trust had been incorporated into all end of life care activity, including activity at NTGH.
- The trust ensured that there was timely identification of patients requiring end of life care on admission. Systems were in place where a patient admitted who was known to the palliative care team would generate an alert to the team. There was also an alert generated where a patient was started on the CDP document.
- The CDP document had been audited in October 2014 following initial implementation in July 2014. Action had been taken to make changes in response to findings with the current iteration of the document having been implemented following changes made as a result of the audit.
- We viewed Commissioning for Quality and Innovation (CQUIN) goals which had been set around increasing the proportion of patients with cancer or end stage chronic disease with a recorded emergency healthcare plan (EHCP) in place and an increase in the percentage of patients with a DNACPR with an appropriate mental capacity assessment or best interest decision in place.
- We saw data that demonstrated an increase in the number of patients with an EHCP in place and we saw evidence of mental capacity assessments and best interest decisions in place.

Competent staff

- The palliative care nursing team had completed advanced communication skills training or were scheduled to attend. The team received regular clinical supervision with a clinical psychologist every four to six weeks.
- Members of the specialist palliative care team had specialist training in palliative care including degree modules.

End of life care

- Consultants in palliative medicine had conducted research in a number of areas including the use of advance care planning at the end of life and exploring ethics of decision making and issues around sedation at the end of life.
- The specialist palliative care team provided a range of specialist training to general staff caring for patients at the end of life. This included a three day course on the effective management of palliative patients through a multidisciplinary approach. Specific subjects covered included spiritual care, communication skills, breaking bad news and symptom management.
- Specific training courses were designed around the needs of different staff groups, for example newly qualified nurses and health care assistants. Feedback from healthcare assistants included comments around the value of specific practical aspects of care such as mouth care, symptom control and supporting the spiritual and emotional needs of patients and their families.
- We viewed evaluation reports where 90% of attendees fed back that the course content was of an excellent standard.
- Healthcare assistants we spoke with confirmed they had attended end of life care training.
- Ward staff told us that the specialist nurses would support them in caring for patients at the end of life by working alongside them to ensure they were confident in the care they were delivering. Ward staff consistently told us that the specialist staff supported them in a way that helped them to develop the skills they needed to deliver good quality care.
- Staff working on the PCU attended an annual palliative care training day where they would receive specific training updates to support the care of patients at the end of life. Staff we spoke with told us the training was helpful in keeping them up to date and an opportunity to learn from the specialist nurses and allied professionals who participated in the delivery of the training.
- The manager of the hospital liaison palliative care team told us that the operating model they had adopted was deliberately designed so that specialist nurses were able to work alongside general staff to develop their competence using a hands on approach to supporting palliative and end of life care. This involved the

specialist nurses attending wards daily, attending a variety of multidisciplinary team meetings and working proactively to support general staff to identify patients at the end of life as early as possible.

- Specialist palliative care staff told us a significant part of their role was to work alongside acute hospital teams and teach them about focusing on managing patients symptoms to ensure quality of life.

Multidisciplinary working

- Multi-disciplinary team (MDT) working was an integral part of the aims and objectives of the SPC team.
- SPC staff regularly attended other disciplines MDTs for example, heart failure and respiratory.
- We consistently saw examples of staff working closely across departments to deliver care. This included across community and acute services. We observed MDT working across chaplaincy, psychology, nursing, medicine, and physiotherapy and occupational therapy services.
- We observed multidisciplinary working on the PCU across disciplines such as nursing, medicine, pharmacy, physiotherapy, occupational therapy and social work. In particular we saw effective MDT working relating to rapid discharge into the community for patients at the end of life.
- The SPCT held a site specific MDT meeting at NTGH every week and the team attended a SPCT MDT meeting on a weekly basis across the trust. The MDT was attended by staff from a variety of disciplines including medicine, nursing, physiotherapy, social work, occupational therapy, psychology services and the chaplaincy.
- The trust had implemented a new electronic record system for use by the SPCT across all hospital sites that were aligned with the system used by community teams and GPs. This enabled staff to access patient records and communicate around patient care in real time with other disciplines. While the system was not yet fully embedded staff we spoke with told us it enabled them to keep up to date with the care patients were receiving from other teams in the community.
- Members of the palliative care team also attended meetings with ward managers and said that there had been a focus on raising the teams profile in order to be more visible and accessible to ward staff. Ward staff we

End of life care

spoke with told us it felt to them like the palliative care staff were part of their team and as a result the palliative care nurses were able to work alongside them to deliver better care for their patients.

Seven-day services

- Inpatients at NTGH had access to specialist palliative care input seven days a week using a consultant on call rota. Adequate medical cover was available to provide a good level of service around the clock.
- Patients nursed on the PCU received care from staff trained in palliative and end of life care.
- Face to face specialist nursing input was available Monday to Friday using the hospital liaison team although telephone advice was available to ward staff from the palliative care inpatient unit and palliative care helpline based at a local hospice.
- The trust was working on an implementation plan to introduce a seven day rapid response service for palliative care. The primary aim was to introduce a community based service that would work between hospital and community provision to enable patients at the end of life to stay in their place of choice and access specialist input. Other aims included preventing avoidable admissions to acute care and assisting rapid discharges from acute care.
- At the time of our inspection there were no clearly identifiable plans to implement hospital based 7 day face to face specialist nursing services. However, staff consistently told us that they saw the rapid response programme working across both acute and community bases to meet the specialist needs of patients.
- The management of the specialist palliative care service told us that they had intentionally phased the introduction of new ways of working so as to manage the change more effectively. With this in mind they were focused on patient need in line with their strategy for improving end of life care in the community and the patients preferred place of care.
- The first phase of the rapid response service was due to be implemented in January 2016.

Access to information

- The trust had implemented a single electronic patient record system across both acute and community palliative care services to enable co-ordination and integration of care, eliminating six different record systems across the service and improving data

collection. We saw that the system was available at NTGH although was not yet fully embedded. We saw that embedding the system was incorporated into the service's action plans and staff told us of plans to ensure the system was used consistently.

- The aim of the development of the electronic patient record for all patients under the palliative care service was so that communication of information was timely.
- Further aims of the system included the ability to measure quality patient outcomes so that these could be used to evaluate and improve the service consistently over time. Staff told us the system also allowed for staff to access GP palliative care registers and access information when patients accessed the service irrespective of the time of day.
- Treatment escalation plans, DNACPR and advance care plans were discussed openly with patients and their families from the time of admission to NTGH. We saw that plans were reviewed and amended in line with changes to the patients condition and circumstances and that information regarding ceilings of treatment and care was to hand.
- The CDP document provided a clear guide to clinical staff in the assessment and identification of patients needs. Information was recorded in a clear and timely way so that all staff had access to up to date clinical records when caring for and making decisions about patient care.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- The trust had a policy in place that detailed the procedures for obtaining consent. This included the process for obtaining consent, recording and responsibilities. The policy included advance directives, the use of independent mental capacity advocates (IMCAs) and the use of mental capacity assessments.
- We viewed records where mental capacity assessments and best interest meetings had been undertaken. We viewed evidence of one patient where an IMC was used to support the best interest decision making process. We viewed a record of an application for a Deprivation of Liberty Safeguard (DoLS) for one patient. Records relating to capacity assessments and recording of consent were seen to be completed correctly, accurately and in a timely way.

End of life care

- Clinical staff we spoke with had a good understanding of mental capacity issues and were able to describe the process they followed to assess a patient's capacity to make decisions or to be involved in decisions.
- We viewed the records of two patients who had been identified as lacking mental capacity. While the assessments had not been specific to DNACPR decisions they did relate to the patient's ability to make decisions about their care. In both cases there was a clear assessment of their mental capacity recorded and best interest decisions had been made with the involvement of those close to them.
- Where patients did not have capacity to be involved in decisions we saw that decisions had been made in their best interest following discussions with family members or other representatives.
- During our inspection we saw that patients were treated with compassion, dignity and respect on the palliative care unit and in all other patient areas we visited in the wider hospital.
- Part of the role of the hospital liaison team was to support patients and relatives around being cared for in their preferred place. We were given examples from a range of staff where the team had taken patients home in order to facilitate a smooth and supported transfer. This had included staff working beyond the end of their shift to provide continuity of care and ongoing support.
- Patient experience surveys demonstrated a consistently high score on patient feedback regarding the PCU. For example, in the 2 minutes of your time patient survey feedback data for the quarter period from January to March 2015, 100% of patients said they had been treated with dignity and respect and 100% said staff had shown them kindness and compassion.
- The trust performed in the top ten NHS trusts in England in the 2014 National Cancer Patient Experience Programme national survey, with 95% of respondents rating the care as being excellent or very good.
- Patients and relatives we spoke with told us they were extremely satisfied with the quality of care they received. One relative told us staff had been fantastic and a patient fed back that staff had been brilliant and had done everything they could to make them feel at home.
- Staff told us of a number of weddings that had been conducted across the service for patients at the end of life who had wanted to marry before they died.
- We were told of how a patient wanted to travel to London to visit family so the specialist palliative care nurses supported them to change their end of life care medication and manage their symptoms so that they were able to travel.
- Porters told us they were given training on dignity and respect when transporting deceased patients to the mortuary.
- A healthcare assistant told us about a patient with advanced dementia who loved her dogs and was given a dog arm puppet by staff which gave her great comfort in her last days of life. Another member of staff told us that a patient on one of the wards in the hospital had wanted a cake so kitchen staff had made one for them.
- Staff were taught basic principles of hand massage as an intervention to provide support and comfort to patients.

Are end of life care services caring?

Outstanding



We rated caring in end of life as outstanding because:

Feedback from patients and their relatives was positive about the way staff treated them with one person telling us that staff really care and go above and beyond what they would expect. There was a strong person-centred culture within the hospital and staff consistently appeared to be committed to providing compassionate care and promoting people's dignity. The trust performed in the top ten NHS trusts in England in the 2014 National Cancer Patient Experience Programme national survey, with 95% of respondents rating the care as being excellent or very good.

There was a culture of partnership working with patients and those close to them and there were systems and processes embedded in the way staff worked relating to recording patient wishes relating to their treatment and care, advance care planning and appropriate escalation of treatment. Emotional, social and spiritual needs played an equal role to physical needs in planning treatment and care. This was apparent through the development of a tool to help staff better assess the spiritual needs of patients and elements of spiritual care being incorporated into end of life care training.

Compassionate care

End of life care

- We saw that care after death honoured people's spiritual and cultural wishes. Members of the chaplaincy team told us they were able to source expertise from the local community around different cultures and faiths and that there were staff within the trust that had specific knowledge in this area.
- We spoke with mortuary staff who told us they work closely with family members regarding care after death and all mortuary staff had attended bereavement training.
- Patients privacy and dignity was respected. We observed staff caring for patients in a way that demonstrated an awareness of privacy and dignity.
- Patients preferred place of care and their individual choices and preferences featured as a primary focus when planning care.
- Information was available for patients and their relatives around different aspects of care at the end of life. This included what to expect at the end of life and coping with bereavement.
- One patient told us that staff respected and encouraged them to vocalise their choices and preferences. A relative told us that staff take the time to explain things to them and involve them in aspects of care that they want to be involved in such as mouth care and supporting nutrition and hydration.

Understanding and involvement of patients and those close to them

- During a ward round on the PCU we saw that the approach was patient focused and that patients and their relatives were asked for their views and encouraged to communicate their wishes. Preferred place of care and quality of life was addressed routinely for each patient.
- We observed staff caring for patients in a way that respected their individual choices and beliefs.
- We saw that treatment escalation, emergency healthcare plans and advance care plans were in place to support patients and those close to them in making decisions at the end of life.
- We spoke to staff and heard stories of different situations where patients and their relatives had been involved in care. This ranged from supporting patients with meeting their hygiene needs on the wards, to supporting individual choices around going home to die.
- We observed interaction between families and staff and saw that staff worked hard to help people to understand what was happening and incorporate individual choices and preferences into the plan of care.
- Families were encouraged to participate in care and provide feedback through surveys. The patient experience team visited the PCU on a monthly basis speaking with both patients and relatives to ask for feedback on their care. We viewed the feedback which was on view on a wall in the unit. We saw that the trust clearly recorded both positive and negative feedback and actions taken to improve patient experience.

Emotional support

- Patients notes indicated they were kept actively involved in their own care and where appropriate relatives were also kept involved.
- A chaplaincy service was available with ministers from a variety of denominations employed. We were told there were 16 ministers within the chaplaincy team from different faiths that included Church of England, Roman Catholic, Muslim, Sikh, Hindu and Jewish Rabbi chaplaincy support. Comfort and support was available 24 hours a day through the service and was available for people of diverse faiths or no faith.
- We observed ministers visiting patients on the wards and staff told us they were encouraged to use the service to support patients irrespective of their faith.
- Chaplains would sometimes accompany relatives to the mortuary and we saw that chaplaincy support was a part of the trust's major incident plan. Chaplaincy staff told us they were available to provide emotional support to patients, relatives, visitors and staff alike.
- Spiritual care and support was seen to be important throughout the trust. The chaplaincy team had developed a spirituality assessment tool for staff on the wards and in the clinical areas to use. The tool involved identifying if a person had a belief system, how important it was to them and how they wanted their spiritual and emotional support to be a part of their care plan.
- Chaplaincy staff told us that a lot of time and resource had been invested in meeting the spiritual needs of patients and their relatives. They had spent time working on what spirituality means to people and had

End of life care

developed a tool to assess people's spirituality and emotional needs on admission. Staff training had included aspects of spiritual distress and the provision of support.

- The lead chaplain told us they had felt overwhelmed by the investment the trust had made in meeting people's spiritual needs.
- Volunteers worked with ministers to provide listening for patients who wanted to talk.
- A bereavement service was available across the trust for the families of patients who had died and dedicated bereavement support staff were based at NTGH.
- Members of the palliative care team had attended training in advanced communication skills. Additional support was provided to patients by a psychologist who worked as part of the MDT.

Are end of life care services responsive?

Outstanding



We rated responsive in end of life care as outstanding because:

End of life care at NTGH was planned and delivered to meet the needs of local people. Specific initiatives included the development of a specialist palliative care unit within the hospital and the development of a palliative hospital liaison team to meet the needs of patients not being cared for on the PCU. Integrated care was provided on the PCU and across the trust through staff working across hospital and community services to ensure patients needs were met, in particular in relation to rapid discharge into the community.

We saw evidence that resources had increased to meet an increasing demand on the service across the trust as a whole. Joint working with the third sector saw the trust working with and involving other organisations in the way that services were planned to ensure they met people's needs.

There was evidence that as a result of the trust's planning and delivery of services that more people were dying in their usual place of residence and there had been a reduction in the number of people dying in acute hospital beds.

When a complaint was made they were actively reviewed and taken seriously. Action was taken as a result with improvements to the service.

Service planning and delivery to meet the needs of local people

- The palliative care inpatient unit at NTGH was opened in 2009 to provide dedicated inpatient beds for patients at the end of life. The trust told us they had decided to open a palliative care unit after reviewing place of death data that showed the trust had a higher than national percentage of patients dying in acute hospital beds and a lower than national percentage of patients dying in hospice beds.
- The PCU was based away from the main hospital, co-located with a nursing home on the outskirts of the hospital grounds.
- The palliative care hospital liaison service was widely embedded throughout clinical areas in the hospital, including the emergency department, critical care and general wards.
- Across the trust as a whole we saw there had been significant investment in end of life care services. The development of hospital liaison teams where band 5 and 6 palliative care nurses worked alongside band 7 specialist nurses had enabled the teams to support more patients.
- Total referrals to palliative care went from 2013/14 (1024) to 2014/15 (2142). This increase included the hospital liaison team.
- Work had been undertaken to increase specialist palliative care support to patients with non-malignant disease. This had increased across the trust from 280 referrals in 2013/14 to 643 referrals in 2014/15. This increase included the hospital liaison team. The percentage share of patients with non-malignant disease being supported by the team had increased from 27% to 30%.
- There was a 24 hour electronic referral system in place and an alert that notified the SPC to patients admitted who were known to the team and those who were commenced on the CDP document to support their end of life care. This ensured that patients were assessed in a timely way.
- Trust data showed an increase in patient deaths in their usual place of residence. In Northumberland this had increased in line with the national average and in North Tyneside this had exceeded the national average. For

End of life care

example, since 2010 this figure had increased from 41.6% to 50.3% in 2014 compared to the national average of 44.7%. There was good integrated working across the acute and community services within the trust to achieve home deaths.

- The integration of the palliative care service across the trust and partnership working with third sector organisations to enhance services had seen a more 'joined up' way of working across acute and community services. Specific examples include the integration of the management structure with a head of service, operations manager and clinical matron covering the trust wide palliative care service.
- The palliative care strategic plan includes the imminent achievement of full seven day working (January 2016); initially focusing on the development of a community based rapid response service. The aim of the service was to "provide a comprehensive, "joined up" palliative care service to patients and their families in all settings." A particular focus for this was to assist rapid discharge from acute care and to prevent avoidable admission to acute care.
- The development of the hospital liaison team structure included the introduction of a band 5 palliative care nurse with a focus on rapid discharge that included escorting patients into the community and providing support through the transition into community services. Staff we spoke with gave us examples of where this approach had worked successfully in supporting patients through their discharge to their preferred place of death.

Meeting people's individual needs

- On the PCU patients were cared for in individual side rooms and in other ward areas in the hospital patients at the end of life had access to side rooms where possible.
- Personalised, individual care plans ensured that care was tailored to meet the needs of the individual at the end of life. An end of life care pack was available in all clinical areas and by using the hospital liaison team to provide guidance for staff.
- Staff told us that that dementia and learning disability passports were used on a regular basis when caring for patients with dementia or a learning disability.
- There were dementia and learning disability teams available within the trust for advice and support.
- Staff we spoke with were aware of translation services available for patients whose first language was not English. One member of staff told us they could use picture prompts to aid communication with patients where this was appropriate. There was also a list of hospital staff with a second language available.
- Patients and family members we spoke with told us that their care was individualised and we observed discussions around care and treatment decisions that demonstrated this.
- Emergency health care plans, treatment escalations plans and advance care planning were all seen to be in use and embedded in practice. The wishes, choices and beliefs of individuals were seen to be incorporated into all plans and we saw good evidence of recorded discussions with patients and their families about their care at the end of life.
- Mortuary, chaplaincy and ward staff told us they had access to information about different cultural, religious and spiritual needs and beliefs and that they were able to respond to the individual needs of patients and their relatives. We viewed an information booklet that had been compiled by the chaplaincy service detailing different cultural and religious beliefs and practices.
- We saw that chaplaincy services were described as being available to people of multiple faiths and those of no faith and we observed across the trust considerable respect for the cultural, religious and spiritual preferences of patients.
- Assessments documented by the specialist palliative care team included recording patients preferred location of care at the end of life.
- The hospital had a chapel and multi-faith prayer and quiet room available for patients, staff and visitors.
- The multi-faith room was appropriately equipped to meet the needs of a variety of religions.
- There was guidance in the mortuary on caring for people after death in line with their religious and cultural beliefs. Mortuary staff gave us examples of when they had supported families to ensure the religious and cultural needs had been met.
- Patients on the PCU were cared for in side rooms and patients on general wards were cared for in side rooms or in bays where privacy curtains were in use.

End of life care

- Comfort care packs and facilities for overnight stays were available for relatives of patients at the end of life. One family member told us they had been able to stay and had felt welcomed by staff and encouraged to spend time with their loved one.

Access and flow

- Patients at the end of life at NTGH were cared for on the palliative care unit with specially trained staff available twenty four hours a day, seven days a week. Patients at the end of life who were unable to be cared for on the PCU were cared for on general hospital wards with support from the palliative care liaison service.
- All patients we saw had gone through a process of assessment and risk assessment from both medical and nursing perspectives on admission.
- Ward staff we spoke with told us they knew how to access the specialist palliative care team and that the team were responsive to the needs of patients. We saw referrals being made in timely and appropriate ways and the use of the patient alert system meant that where patients were known to the palliative care team or where they were identified as needing to commence on the CDP document the team would be alerted straight away.
- It was the aim of the palliative care service to see patients urgently referred within the hospitals within four hours. We observed and staff consistently told us that the palliative care staff responded very quickly and that usually they would see patients within an hour.
- There was a waiting list for admission to the PCU. Staff told us that the criteria for admission was based on individual patient need. Staff told us that patients in the community would generally take precedence over a patient already in a hospital bed elsewhere in the trust because admission was based on patient need.
- We saw that resource folders on the wards included information for ward staff on how to access specialist advice outside of normal working hours when the specialist palliative care team were not available.
- We saw that advice given by the specialist care team was recorded in the patient notes with a sticker accompanying entries so that staff could quickly access the advice given.
- The chaplaincy service was accessible 7 days a week using an on call system.
- Staff across the trust told us they felt they were able to discharge patients quickly at the end of life if they chose

- to be cared for at home. We were told that arrangements with the pharmacy included the prioritisation of end of life medicines in this situation and that these could be available within a few hours.
- The service was recording preferred place of death in patients records when they were identified as being at the end of life. Since the implementation of a new electronic patient record system in September 2015 the trust had begun to record actual place of death in comparison to preferred place of death. At the time of our inspection there were limitations to the data available although we saw clear evidence that the trust was beginning to capture the data in ways that reflected patient choice and their performance against this.
 - A palliative care ambulance was available to transfer patients at the end of life so that they did not have to wait. Staff told us that the ambulance would generally be available when they requested it.

Learning from complaints and concerns

- Complaints relating to end of life care would generally be investigated by the service manager or palliative care matron and would be discussed at the hospital liaison team meeting, with learning used to develop practice.
- There were very few complaints relating to end of life care. We saw one complaint relating to NTGH where a patients family had been unhappy with the approach of the clinician. The complaint had been fully discussed with the clinician involved who had met with the family to effectively resolve their concerns.
- We saw that when a complaint was made they were taken seriously and that action was taken as a result.
- Staff were aware of their responsibilities in supporting patients and family members who wished to make a complaint.

Are end of life care services well-led?

Outstanding



We rated well-led in end of life care as outstanding because:

There was a clear vision and strategy that focused on the early identification of patients at the end of life, patients being cared for in their preferred place of care and the use of partnership working to develop services. The trust had clear leadership for end of life care services that was

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supported at the top of the organisation. Investment in end of life and palliative care services was apparent and staff we spoke with consistently told us they felt that end of life care was a priority for the trust.

We saw evidence of innovation and improvement in relation to the model of working at NTGH with patients cared for on a dedicated palliative care unit or on a general hospital ward with specialist involvement of the palliative care liaison service. In addition the partnership working with Marie Curie and joint management and nursing posts enabled the trust to provide prompt support and continuity of care for patients being discharged to their preferred place of care in the community. Further innovations were seen in relation to a focus on spiritual support and an assessment model.

Vision and strategy for this service

- A palliative care steering group was in operation to guide the trust in delivering effective palliative and end of life care. Membership of the group included key staff and representatives from a variety of specialities including elderly medicine, general practice and general medicine. This helped to ensure that responsibility for good quality end of life care did not solely sit with the palliative care team.
- Following the National Care of the Dying Audit of Hospitals (NCDAH) results, the trust developed an action plan on how they intended to address the areas identified for improvement. This included the appointment of a trust lead for end of life care. The executive lead for end of life care was the executive medical director.
- There was a clear vision and strategy for end of life care. This centred on the identification of all patients at the end of life, the provision of an integrated service between hospital and community services, the provision of a seven day service, enabling patients to stay in their place of choice and to improve patient outcomes and experience.
- Staff we spoke to consistently articulated the vision for good quality end of life care. Staff were aware of their role in delivering the strategy. For example, specialist nursing staff at NTGH worked collaboratively with other hospital teams to raise their profile and increase

awareness of their role in supporting general staff in delivery of good quality end of life care. They engaged well with other teams through opportunistic ward visits and attendance at meetings.

- Ward staff were engaged in the provision of end of life care and we saw that with support from the specialist palliative care team they had a good understanding of what constituted good quality end of life care.
- The trust had invested in end of life and palliative care with the introduction of initiatives such as the development of a palliative care inpatient service and a hospital liaison service in collaboration with Marie Curie. Staff we spoke to at NTGH consistently told us they felt that the service was excellent and that the development of the hospital liaison model was working well.

Governance, risk management and quality measurement

- Specialist palliative care reports within the directorate structure of community and social care.
- The service is held to account by the palliative care steering group. The group consisted of trust directors, senior trust staff from related services and lay representation to ensure accountability.
- We saw that end of life care was discussed at board level. For example, we viewed minutes of a meeting where a patient's story had been discussed. This helped to highlight to the board the importance of individualised care and a multi-disciplinary approach that supports meeting the wishes and needs of the patient and their family.
- There was representation from the SPCT at regular mortality review meetings. Their remit was to review and comment on the end of life care journey of patients and provide constructive feedback and advice in relation to ongoing learning and improving patient care.
- The service takes part in regular audits, locally and nationally. This included external NCDAH and national bereavement surveys.
- Internal measurements of quality included place of death data and use of other metrics including patient feedback and analysis of patient activity.
- Within the trust the Palliative Care service had won the Quality Award for 2014, recognising the Palliative Care Units (at Wansbeck and North Tyneside hospitals) and their commitment to improvement and the excellent patient experience feedback received.

End of life care

- We viewed a divisional performance report that examined elements of safety and quality. We saw that end of life care quality goals had been set and that discussions were ongoing with CCGs about specific targets. This included the use of emergency healthcare plans, monitoring of DNACPR decisions in patients identified as lacking mental capacity and the use of best interest decision making.

Leadership of service

- There was end of life care representation/leadership at trust board level. We also saw evidence of active engagement in end of life care at board level.
- The trust's palliative care steering group was chaired by one of the trust's executive medical directors which meant that the overall responsibility for the monitoring of end of life care did not sit entirely with the specialist palliative care team.
- There was comprehensive leadership within the palliative care service with clearly defined leadership roles. The palliative care service was led by a head of service (consultant in palliative medicine), matron in palliative care, a general manager and an operations manager.
- The head of service was responsible for the strategic leadership and governance of the service, working closely with CCGs to ensure the service meets patient need and national standards.
- The matron's post in palliative care was created jointly with Marie Curie Care. The aim of the role was to ensure that the trust has the highest standard of end of life nursing throughout the community and hospitals and to provide nursing leadership to the service.
- General and operational management worked to ensure that the infrastructure and resources were effectively managed to deliver the service aims.
- The hospital liaison teams received both managerial and clinical leadership support. Direct management support was provided by the Marie Curie service manager and clinical support from the band 7 SPC CNS.
- All the staff we spoke with felt their line managers and senior managers were supportive and approachable.
- Ward staff knew the names of the SPC liaison team members and were able to give a number of examples of how the team had worked with them to deliver end of life care.

Culture within the service

- All staff we spoke with demonstrated a commitment to the delivery of good quality end of life care. There was evidence that ward staff felt proud of the care they were able to give and there was positive feedback from nursing and care staff as to the level of support they received from the specialist palliative care team.
- There was evidence that the culture of end of life care was centred on the needs and experience of patients and their relatives. Staff told us they felt able to prioritise the needs of people at the end of life in terms of the delivery of care.
- Members of the specialist palliative care team told us they were proud of the care they were able to deliver and the opportunities they had to support the development of the service.
- One ward manager we spoke with told us they had been nervous about the structure of palliative care support at NTGH as it was a new way of working. However, they told us that the model had worked well in increasing the awareness of end of life care needs and developing the confidence of ward staff in delivering good quality care.

Public engagement

- The trust was in the top ten and came 6th out of all trusts in England for the quality of care reported by the Cancer Patient Experience Survey 2014.

Staff engagement

- We saw that the hospital liaison teams had regular monthly meetings and that these gave team members the opportunity to share information, ideas and learning.
- Staff we spoke with told us they felt they had an opportunity to feedback to management and that they felt listened to.
- Staff told us they felt valued by the management of the trust and that the service they provided was seen as an integral part of the work being undertaken by the trust as a whole.
- All specialist palliative care staff and those working on the PCU had received an annual appraisal and a personal development plan as a result.







Innovation, improvement and sustainability

- The specialist palliative care team were focused on continually improving the quality of care and we observed a commitment to this at ward level also.

End of life care

- The trust had developed services in partnership with Marie Curie which had allowed them to increase their palliative care service provision.
- The trust had rolled out a regional advance care planning approach 'Deciding Right' and had created a treatment escalation planning approach so that all patients had a very clear plan in place should their condition change.
- The trust had reconfigured the hospital palliative care service, to provide cover across all hospital sites. This included a new staffing model that was focused on providing support to all patients at the end of life who were on a palliative care register or being cared for in hospital. As well as having a band 7 specialist nurse to provide advice and support for the care of patients with complex palliative care needs, band 6 and band 5 posts had been created to provide additional support.
- Additional support included focused discharge planning and in particular the provision of support to ward nurses around the rapid discharge pathway and to support the transition from hospital to home. A particular innovation of this structure was the flexibility of the nurse to work across hospital and community settings and therefore accompany the patient home and provide support at home before handing over care to the district nursing teams and specialist nurses in the community.
- In particular at NTGH we observed examples of innovative ways of working where the specialist palliative care nurse worked alongside acute teams to provide palliative care input for patients who were receiving acute interventions. This meant that patients were able to receive support and intervention from palliative care specialists at an early stage in their hospital admission.
- Another area of innovation was the development of a tool for the assessment of a patients spiritual needs. This focused on providing staff with prompts that would make it easier for them to discuss spiritual needs with patients. The tool also helped staff to direct questions in a clearer way so as to ensure patients understood.
- Staff told us that by getting involved sooner with palliative care patients, including those in the accident and emergency department, they were able to support patients when they were acutely unwell and help manage their symptoms more quickly.
- The trust was in the process of developing a 24 hour rapid response service to get supportive and specialist care to patients wherever they are and whenever they need it.
- The trust demonstrated a commitment to working with other providers in partnership and across service boundaries within the trust to improve the quality of care.

Outpatients and diagnostic imaging

Safe	Good	
Effective	Not sufficient evidence to rate	
Caring	Good	
Responsive	Outstanding	
Well-led	Outstanding	
Overall	Outstanding	

Information about the service

North Tyneside General Hospital provided a range of clinics covering the majority of clinical specialities including orthopaedics, gynaecology, rheumatology, urology and respiratory services. The department had around 46 consulting rooms plus treatment and audiology facilities. The clinics were allocated into six separate areas the main department waiting area and number of sub-waiting areas. From January to December 2014 North Tyneside General Hospital undertook 162,121 outpatient appointments.

Outpatient services were part of the trust's Emergency Surgery and Elective Care Business Unit. The business unit director with support from a deputy director and a number of general and operational service managers, specialist clinical leads, and support services such as human resources, finance, information and administrative support led the business unit.

Outpatient opening times were from 8.30am to 6pm hours Monday to Friday and 8.30am to 12.30pm on Saturdays.

The main reception was at the entrance to the main outpatients department. Three medical records clerks/receptionists staffed it. Patients were booked in on arrival for their appointment and directed to the appropriate sub-waiting areas within the main department.

Radiology services were part of the Clinical Support Business Unit. The business unit director led the department with support from a deputy director, an Operational Services Manager, trust lead radiographer, Lead Consultant Radiologist with a site lead radiographer.

Diagnostic imaging services were open 24 hours a day, 7 days a week. The department offered several imaging techniques including plain x-ray, CT scanning from 8am to 8pm with a service for head CT scans overnight, diagnostic ultrasound from 8 am to 6 pm Monday to Friday, mammography (breast screening) and fluoroscopy (A computerised tomography (CT) scan combines a series of X-ray images or pictures taken from different angles and uses computer processing to create cross-sections, or slices, of the bones, blood vessels and soft tissues inside the body.)

A private company managed the MRI scanning department independently and provided a service from 8am to 5pm, 7 days a week. Trust radiologists provided reports for MRI scans. (Magnetic resonance imaging (MRI) is a technique that uses a magnetic field and radio waves to create detailed images of the organs and tissues within the body.

During our inspection we observed the services provided within each department. We spoke with 18 patients and four people who attended hospital with them, 23 members of staff including, consultants, qualified and unqualified nursing staff, radiographers, radiologists, porters, clinical specialists, medical records clerks, and receptionists. We looked at 4 sets of medical records and 2 electronic radiology records.

Outpatients and diagnostic imaging

Summary of findings

Overall, we rated North Tyneside General Hospital outpatients and diagnostic imaging services as outstanding because:

Staff and managers had a clear vision for the future of the service. They knew the risks and challenges the service faced. Staff we spoke with at all levels felt supported by their line managers, who encouraged them to develop and improve their practice. Staff embraced change and there was a real focus on patient experience and leaders and managers drove this. There were well embedded systems and processes for gathering and responding to patient experiences and the results were well publicised throughout the departments. There were effective and comprehensive governance processes to identify, understand, monitor, and address current and future risks. These were proactively reviewed. There was an open, honest and supportive culture where staff discussed incidents and complaints, lessons learned and practice changed. All staff were encouraged to raise concerns. The departments supported staff who wanted to work more efficiently, be innovative, and try new services and treatments and ways of engaging with the public.

Waiting times and cancellations were minimal and managed appropriately. Diagnostic image 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 emergency patients, inpatients, and outpatients. A radiographer discharge programme facilitated the discharge of patients having soft tissue injuries directly from radiology by suitably trained radiographers. Prior to emergency services moving to NSECH in June 2015, the radiology department had developed trauma image reporting, which was swift with an emphasis on “results within minutes” for emergency patients. This was the process that had been adopted at the new NSECH hospital and enabled medical teams to complete assessments and manage risks quickly. The department teams recorded concerns and complaints and used patient feedback proactively to prevent recurrence that might affect

others. They reviewed and acted on problems quickly and demonstrated an open and transparent outlook with the aim to learn from them and improve patient experience.

The hospital had good systems and processes in place to protect patients and maintain their safety. The departments were clean and hygiene standards were good. Medical records were stored and transported securely.

Patients were 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. Trust policies protected patients from the risk of harm by making sure they met any individual support needs. Staff demonstrated understanding of these policies and followed them.

Outpatients and diagnostic imaging

Are outpatient and diagnostic imaging services safe?

Good 

We rated safe as good because:

The department used an electronic system to report incidents and all staff knew how to use the system. Managers and governance leads understood risks relating to their own areas and across the trust, investigated incidents and shared lessons learned with staff. There was a good reporting and feedback culture. Departments displayed safety data, performance information, patient experience, and cleanliness audit data and information summarised that there was a good track record of safety in all areas of reporting.

The departments were visibly clean and hygiene standards were good. There was appropriate personal protective equipment in all the areas we inspected. Staff knew how to dispose of all items safely and within guidelines. Staff ensured equipment was clean and well maintained, so patients received the treatment they needed safely.

Staff knew the various policies to protect patients and people with individual support needs. Staff asked patients for their consent before treating them.

Clinics were consultant led. Medical staff were managed by each clinical speciality. A review of nurse staffing had recently been undertaken that involved a review on the number of clinics, tasks, and chaperone requirements. The outcomes from this review were not completed at the time of our inspection.

Medical records were stored and transported securely. Records showed patient notes were ready for patients attending clinics 99.8% of the time.

Staff we spoke to in all departments knew the actions they should take in case of a major incident or emergency with business continuity plans in place.

Incidents

- The trust used an electronic programme to record incidents and near misses. Staff knew how to use the

programme and how to report incidents. We saw within the business unit electronic system incident recording system that staff were reporting incidents appropriately by type, site, exact location, business unit, and date.

- There had been 58 incidents reported in outpatients from July 2014 to July 2015. Each incident was categorised by theme and the trust had assessed the majority of the outpatient department reports as causing no harm. The manager told us that they discussed incidents and brought them to the attention of the team at morning huddle meetings.
- Staff we spoke to could give examples of incidents that had occurred and investigations that had resulted in positive changes in practice. Staff we spoke to could give examples of incidents that had occurred and investigations that had resulted in positive changes in practice. Within Clinical Support and Cancer Services Business Unit, managers and staff reviewed incidents at weekly IR1 (Incident Reporting form) meetings. The incidents graded moderate and above were discussed at monthly governance meetings. Every three months the Surgical Business Unit met at a shared meeting with North Cumbria University Hospitals NHS Trust.
- Staff understood their responsibilities of the recently introduced Duty of Candour regulations and all staff we spoke to described an open and honest culture. We saw evidence of telephone call logs, letters to patients offering an apology as well as information about incidents and complaints.
- The majority of incident reports were related to delays in clinic waiting times. Managers had introduced waiting time escalation plans with actions attached for staff to follow in the event of clinic delays, as follows: if the delay was between 0 to 15 minutes the nurse in charge was to provide a visible presence and monitor; 15 to 30 minutes staff review, discuss with medical staff, and inform patients; 30 minutes and above review medical staffing, escalate to senior managers, offer patients refreshments, and record as an incident.
- Staff discussed recent learning from an incident that had resulted in effective actions taken to address the issues identified relating to requesting blood for transfusion. A member of staff had not completed the request for blood form correctly and therefore the request was not processed. The manager had prepared a correct example of a completed request form and was due to take this to the following day morning staff meeting, known as a “huddle”, and then to the

Outpatients and diagnostic imaging

subsequent morning huddles until all the staff members had signed to confirm they had received instructions on how to complete the request form correctly. The manager had also arranged a meeting for the following week for staff to attend further training from the specialist nurse for transfusions.

- Staff were aware of the need to be open and honest when dealing with patients concerns. The manager told us that they discussed the duty of candour principles at staff meetings and they had attached the duty of candour principles to the front of the staff off duty book as a reminder.

Diagnostic Imaging:

- There had been two radiological incidents reported by the trust under Ionising Radiation (Medical Exposure) Regulations (IR (ME) R) 2000 in the previous year. These were low level and included scanning the incorrect patient and one incident where more images were taken than necessary. Trusts must report to the Care Quality Commission (CQC) any unnecessary exposure of radiation to patients. There was evidence staff had checked these, taken actions, and produced action plans following learning. The radiation protection advisor had reported that the frequency and severity of incidents were within national standards for a trust of this size.
- There were a low number of general incidents within radiology and nine had been reported in the last year. There were no never events or serious untoward incidents.
- Consultants, reporting radiographers, and sonographers discussed radiology discrepancy incidents by case review at monthly education and learning meetings. Staff took the opportunity to learn, work as a wider team and liaised with the specialty medical teams across the trust. Images reported by an agency underwent discrepancy checks carried out by the agency and there was a reciprocal agreement in place for both parties to carry out quality assurance checks on randomly selected images.

Cleanliness, infection control and hygiene

- There were hand hygiene and 'Saving Lives' audits undertaken which demonstrated that staff working within the clinics were compliant with best practice

guidelines. Results showed that 100% of staff followed hand hygiene principles and practice. These audits were documented for each area in the Infection Control Accreditation Audit reports (April to August 2015).

- There were patient- led assessments of the care environment (PLACE) audits undertaken. The results from these audits were 99% in March and 95% in July 2015. Results demonstrated that the staff were achieving standards in compliance with national guidance. They were documented in the National Cleaning Specification Audit Reports 2014/15 and 2015/16. There was a policy and procedure to ensure that staff would report any results of 92% or below to the modern matron, senior manager and chief matron.
- The trust provided sufficient supplies of personal protective equipment (PPE) including disposable gloves and aprons. Staff disposed of used PPE safely and correctly. We saw PPE being worn when treating patients and during cleaning or decontamination of equipment or areas.
- We saw that staff washed their hands regularly before attending to each patient. Patients we spoke to also confirmed this. The departments provided hand gel stations for use by patients, relatives, and staff and we saw all these groups using the hand gel.
- Domestic services staff carried out daily and weekly cleaning regimes and followed an equipment cleaning schedule. Staff adhered to a standard operating procedure for setting up and clearing each clinic.
- All patient waiting areas, consultation and treatment rooms, as well as private changing rooms were visibly clean and tidy. The trust provided single sex and disabled toilets and these areas were visibly clean.
- We saw that staff ensured treatment rooms and equipment in all departments were cleaned regularly. Staff cleaned and checked diagnostic imaging equipment regularly. Staff cleaned and decontaminated rooms and equipment used for diagnostic imaging after use.

Environment and equipment

- All areas we inspected were clean, well kept and patient areas were spacious and bright. Staff ensured that consulting, treatment and testing rooms, store rooms and the plaster room were well stocked. All staff followed the standard operating procedure for cleanliness and infection control. We observed no obvious environmental hazards during our inspection.

Outpatients and diagnostic imaging

- Staff had completed risk assessments in March 2015 for the control of substances hazardous to health (COSHH), manual handling, caring for patients in beds, on trolleys and chairs and safe systems of work. They had submitted assessments to the health and safety risk officer for patient services for review who had recommended no further actions.
- Treatment and store rooms were clear of clutter and appeared clean, tidy and consumables were all in date.
- There were dedicated safe areas for children to play and the cleaning schedules for the play equipment and toys were up to date.
- We found that resuscitation trolleys and equipment including suction and oxygen lines were clean. Staff checked them weekly and checklists were signed and up to date. Staff locked and tagged trolleys and made regular checks of contents and their expiry dates. No drugs or equipment had exceeded expiry dates.
- Managers ensured equipment throughout the departments was calibrated and maintained with appropriate maintenance contracts and service level agreements for specialist equipment.
- The medical engineering department carried out testing of electrical equipment (safety testing) and on a rolling programme basis serviced all equipment. Confirmation of completion of servicing was on stickers on the equipment. We also saw a range of clinical equipment had been serviced such as blood pressure monitors.
- We saw, and staff confirmed that, there was enough equipment to meet the needs of patients within all departments. Staff told us they were encouraged by senior management to raise any immediate concerns to ensure they rectified them quickly or escalated them to the department manager.

Diagnostic Imaging:

- The design of the environment within diagnostic imaging kept people safe. There were radiation warning signs outside any diagnostic imaging areas. Imaging treatment room no entry signs were clearly visible and in use throughout the departments at the time of our inspection. However, on inspection we observed a door to an x-ray room that was without a lock which could be entered by staff and patients when a procedure was in progress. Staff informed us that the door had recently been replaced. The lack of a locking mechanism posed

a potential risk of exposure to anyone entering the room during a procedure. Staff immediately put the room out of use. A lock was ordered, duly fitted and an incident form completed all within an hour.

- Staff wore dosimeters (small badges to measure radiation) and lead aprons in diagnostic imaging areas to ensure that they identified and accurately recorded any exposure to higher levels of radiation than was considered safe. Radiology staff collected dosimeters and sent them for testing every month. Results were all within the safe range.
- The trust had a radiation safety policy, which met 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 as safe as reasonably practicable. We saw reviews against IR(ME) R and learning shared to staff through team meetings and training.
- Staff carried out, quality assurance (QA) checks in diagnostic imaging for all x-ray equipment. These were mandatory (must do) checks based on the Ionising Radiation Regulations 1999 and (IR (ME) R) 2000. These protected patients against unnecessary exposure to harmful radiation. The regional medical physics advisor had checked and measured all x-ray equipment and had found all to be safe.
- Radiation protection supervisors for each modality led on the development, implementation, monitoring, and review of the policy and procedures to comply with IR (ME) R. They carried out risk assessments with ongoing safety indicators for all radiological equipment and its use by staff. These were easily accessible to all diagnostic imaging staff.
- Staff demonstrated safe working methods to record patient doses for radiation.

Medicines

- We checked the storage of medicines and found staff managed them well. No controlled drugs or sedation were stored in x-ray or the main outpatients departments. Small supplies of regularly prescribed medicines were securely stored in locked cupboards and where needed, locked fridges. We saw the record charts for the fridges that showed that staff carried out temperature checks daily and that temperatures stayed within the safe range. All medicines we checked were in date.

Outpatients and diagnostic imaging

- Medicines management training figures were 91% for registered nurses across the outpatients departments.
- Pharmacists managed stock control on a monthly basis and staff told us that the pharmacists provided good support to the departments when requested.
- Internal prescriptions were provided to medical staff, the register of FP10s was seen, and these prescriptions were monitored.
- Patient group directions (written instructions for the supply or administration of medicines) for use in the outpatients clinics, radiological contrasts and drugs used in CT had been completed and reviewed.

Records

- The trust had a centralised medical records library open 24 hours each day, seven days a week to support urgent retrievals, requests and returns of patients medical notes. There were standard operating procedures in place for electronically tracking the movement of patient notes throughout all of the trusts locations.
- The clinic reception/administration staff were part of the medical records team. Staff assured us that it was rare for notes not to be available. The majority of notes were available at the time of the patients appointments. The annual audit report on the notes availability for the department at year ending March 2015 showed that 99% of the notes were available for the outpatient clinics.
- If a patients notes were unavailable, we were assured that sufficient clinical information was available to the clinician to see the patient, as records were accessible electronically including doctors' letters, x-rays, MRI, CT and pathology results.
- Records contained patient specific information about the patients previous medical history, presenting condition, personal information such as name, address and date of birth, medical, nursing, and allied healthcare professional interventions. We observed staff checking patient identification against their medical notes when booking in for their appointments at the trauma clinic.
- We reviewed six patient records which were completed with no obvious omissions. All contained patient demographics and contact telephone numbers.
- Nurses carried out assessments of blood pressure, weight, height, and pulse for patients according to clinical needs. We saw staff undertaking these checks during our inspection.

- One consultant stated that the medical records service was 24/7 and that there were no issues with the obtaining of the paper records. He added that medical records tended to only send the most recent volume of notes for out-patient review. When this occurred, access to the electronic system assisted.
- Medical and nursing staff confirmed that if patients notes were physically unavailable a range of health records were accessible electronically which enabled clinicians to access the patient.
- Staff managed the majority of patient notes in accordance with hospital policy during the course of our inspection. However, we did observe on one occasion that the patient notes in consulting room 9 were left unattended on the floor with the room lights off and the door left open. The notes were not visible from the corridor. Inspectors brought this to the attention of staff who dealt with them instantly and transferred the notes to the secure post room for distribution onto the appropriate medical secretaries.

Diagnostic imaging:

- Diagnostic images and reports were stored electronically and available to doctors using Picture Archiving and Communications System (PACS), Clinical Radiology Information System (CRIS) and Integrated Clinical Environment (ICE) systems. The requests populated the 'outstanding list' or current worklist and staff used these systems to automatically record procedure requests and rejections, examinations marked as complete and a record of the radiology activity undertaken. Staff referred patients for diagnostic imaging using the electronic system and radiology staff viewed details on the CRIS system.
- We reviewed six electronic patient records. All notes had full and complete patient demographics, the investigation requested, relevant clinical information, correctly completed contrast checklists and pre-investigation blood tests as required.

Safeguarding

- Staff told us they were up to date with both adult and children safeguarding training level 1 and 2. They knew how to escalate concerns. This was confirmed when we inspected the department's monthly training report for September 2015 which showed 93% of staff had completed safeguarding as part of their mandatory training. This was better than the trust target of 85%.

Outpatients and diagnostic imaging

- The imaging service used a variation on the WHO Safer Surgical Safety Checklist. Staff used additional compliance checklists for specialties including musculoskeletal and breast services.
- The trust provided a designated waiting area for patients attending the x-ray department from the wards who may be vulnerable. This area was also monitored by CCTV for added safety and reassurance.

Mandatory training

- Mandatory training was delivered in e-learning modules and some study days. Staff regularly used e-learning as an accepted method of learning. Subjects included fire safety, basic life support, essence of care, learning disabilities, mental capacity level 1 and 2, risk management, moving and handling, slips trips and falls. The overall departmental compliance score was at 90% against a trust target of 85%.
- Managers made sure staff attended training and allocated time in staffing rotas. The training and development department produced and distributed monthly reports on mandatory training and departmental managers checked compliance regularly.

Assessing and responding to patient risk

- The trust had clear policies and guidance in place for managing medical emergencies. Staff received basic life support training as a minimum.
- If a patient were to deteriorate on site, subject to the circumstances, the emergency crash team would be called using '2222' or the CCOT (Critical Care Outreach Team) would be called on '7777'. There was an anaesthetist on site. Should the patient require further care, staff would arrange an ambulance to convey them to the Northumbria Specialist Emergency Care Hospital (NSECH).
- We saw from the department training report shown to us by the manager that basic life support training was below the trust target at 76% to date. The manager was aware of this and had planned further training to meet training targets before the end of the financial year.
- In bariatric out-patients, the consultant consented patients for the bariatric procedure. As part of this consent he advised patients if they later required critical care then the care would be transferred to NSECH.
- There were enough resuscitation trolleys and defibrillators across all departments.

- Staff completed risk assessments including National Early Warning Score (NEWS), pre-assessment for procedures and pain assessments. Nurses recorded these in patient records and escalated any concerns to medical staff.

Diagnostic imaging:

- There were emergency assistance call bells in patient areas in radiology. Staff confirmed that, when patients activated emergency call bells, they answered them immediately.
- Staff followed the radiation protection policy and procedures in the diagnostic imaging department. Managers ensured that roles and responsibilities of all staff including clinical leads were clear and therefore managed and minimised risks to patients from exposure to harmful substances.
- The department had produced diagnostic imaging policies and procedures in line with the Ionising Radiation (Medical Exposure) 2000 regulations (IR(ME)R).
- Named and certified radiation protection supervisors (RPS) provided advice when needed to ensure patient safety. The trust had radiation protection supervisors and liaised with the radiation protection advisor (RPA).
- Arrangements had been agreed 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. Staff had written and agreed policies and processes to identify and deal with risks. This met with (IR (ME) R 2000).
- All radiology equipment had been risk-assessed and safety tested to ensure the safety of staff and patients. Specific testing and reporting on equipment included radiographic tubes and generators, ultrasound, CT and image intensifiers.
- 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 met with the radiation protection requirements and identified risks to an unborn foetus. Staff followed different procedures for patients who were pregnant and those who were not. For example, patients who were pregnant underwent extra checks and staff completed checklists to record them.

Outpatients and diagnostic imaging

- Diagnostic imaging and screening departments used adaptations of the WHO safer surgical checklist for all interventional procedures. Staff audited checklists for compliance and quality.

Nursing and allied health professional staffing

- Senior nursing staff told us that the trust had recently undertaken a comprehensive review of staffing that involved a review on the number of clinics, tasks, and chaperone requirements. The outcomes from this review were not completed at the time of our inspection.
- Three medical records clerks/receptionists covered reception as a minimum every day and additional staff could be provided if required.
- The overall staffing numbers for the department included the nurse manager band, nine qualified nurses, and 26 nursing assistants along with three plaster room technicians. Each of the four areas had a minimum of one qualified nurse to two nursing assistants on duty and staff worked flexibly to cover planned and unplanned absences. Agency staff were used to cover the plaster room.
- The trust had recently allocated a Matron specifically attached to outpatient's services across the trust. They had also recently recruited two new outpatient sisters to share the four main outpatient hospital sites.
- All department managers told us that staff were flexible to ensure they provided cover for each clinic and department. There were no departments with significant vacancies to affect the way they could function. However, rotation of radiology staff to the new hospital and departmental changes had caused some attrition.
- Staff completed trust and local induction which was specific to their roles. We saw completed documentation in staff files showing successful completion of local induction.

Diagnostic Imaging:

- The diagnostic imaging department has a lead radiographer based permanently at North Tyneside General Hospital. Radiographers worked on a rotational basis to staff the Northumbria Specialist Emergency Care Hospital and retain their range of skills.
- Recruitment in radiology was now well underway following previous shortages in ultrasound and rotation of staff to NSECH. Once the new staff were in post there

would be enough resources. Existing staff were working overtime and bank shifts to meet demand as well as providing enough time to give to support patients needs.

- Managers told us they monitored staff sickness and rates were consistently low.

Medical staffing

- Clinics were consultant led. Medical staff were managed by each clinical speciality.
- The trust had identified a number work streams to look at efficiencies around population of clinics and clinic reconfiguration. This work was ongoing at the time of our inspection.

Diagnostic imaging:

- There was a national shortage of radiologists. The trust had four vacancies and this was recorded on the risk register. The department used the services of a locum breast radiology consultant on alternate weeks and a new locum general radiology consultant had started in post on the week of our inspection. At the time of our inspection, there were enough staff to provide a safe service for patients, and managers used NHS Waiting List Initiative (WLI) work to manage staffing shortfall.
- All medical staff completed a full trust induction and we saw the programme for the newly appointed locum was underway.
- The sickness rate for radiologists in the previous year was 1.9%.
- Two consultant radiologists were on duty at NSECH and available to staff at all sites 8am and 8pm seven days a week. One radiologist provided out of hours cover on an on call basis. At weekends there was one consultant on call for the trust from 8am to 8pm and out of hours cover was outsourced.
- There were two radiology specialist registrars who were supernumerary in order to facilitate their training on Mondays to Fridays. Registrars told us that the department provided them with good working experience and radiologists and the department as a whole supported them well. The trust had secured funding for additional specialist registrar posts.
- Diagnostic imaging reporting was routinely outsourced to meet reporting time targets. There was a service level agreement, quality assurance agreement, and contract written for this and radiologists undertook quality checks in line with the departmental discrepancy policy.

Outpatients and diagnostic imaging

Major incident awareness and training

- We saw the major incident policies along with the business contingency plans were available and staff told us these had recently been updated and reissued. The manager told us that they were due to discuss the plans at the next staff meeting.
- There were cross-trust agreements for support services such as pathology and radiology with service level agreements with local trusts. Staff understood these and could explain how they put them into practice.

Are outpatient and diagnostic imaging services effective?

Not sufficient evidence to rate

We are unable to provide a rating for effective in outpatient and diagnostic imaging services. However, during our inspection we found the following:

The service used creative and innovative approaches and ideas for care and treatment of its patients. They used modern technology appropriately to review patients, provide testing at the point of care, and ensure safety and quality assurance and to communicate with patients and staff. Staff followed professional best practice guidelines to plan and deliver good quality care and took part in a wide range of national and clinical audits.

The service was committed to develop its staff through their skills, knowledge, and competence. Staff were able to make use of opportunities to learn, develop, and share good practice. Multidisciplinary teams met daily and included both medical and non-medical staff. Discharge and transfer of patients to other trust sites and GPs was assessed and planned well to meet their care needs in the best way possible.

Diagnostic imaging provided services for inpatients and emergency patients seven days a week and service availability was increasing and continuously improving. Staff undertook regular departmental and clinical audits to check practice against national standards. They also developed and checked action plans regularly to improve working practices when necessary.

Evidence-based care and treatment

- Senior staff shared National Institute for Health and Care Excellence (formerly National Institute for Clinical Excellence, NICE) guidance to departments. Staff we spoke with understood National Institute for Health and Care Excellence and other specialist guidance that affected their practice.
- Specialities were responsible for compliance with National Institute for Health and Care Excellence guidelines, Public Health England directives, and speciality specific guidance such as Royal Colleges at national, regional, and local levels. All policies and guidelines were stored on the trust intranet. As staff received new guidance and directives, the department managers ensured updates to clinical practice.
- Some specialities such as cardiology had rapid access chest pain clinics. The trust provided one stop multi-disciplinary breast service clinics including bone health assessments and screening.
- We spoke with one clinical nurse specialists in rheumatology and they described how they worked to NICE guidelines and best practice guidelines in their specialist field.
- A consultant rheumatologist confirmed that they based their practice on current guidance from NICE/British Society and the Royal College of Rheumatology. They added that they had created informal pathways to reflect best practice and current guidance.
- The departments were adhering to local policies and procedures.
- Staff followed standard operating procedures in line with best practice guidelines to determine each patients referral and ongoing treatment pathways based upon the diagnosis. Staff understood the impact they had on patient care.

Diagnostic Imaging:

- Procedures were followed to ensure the diagnostic imaging department were following National Institute for Health and Care Excellence guidance to prevent contrast induced acute kidney injury and evidence based documentation was completed before, during and after interventional procedures which included NEWS (national early warning system) assessments.
- The diagnostic imaging department carried out quality control checks on images to ensure the service met expected standards.

Pain relief

Outpatients and diagnostic imaging

- Pain relief advice was included as part of the patients outpatient consultation and ongoing treatment plans.
- The trust provided specific clinics for pain management and the x-ray department ran a pain clinic service once a week.

Nutrition and hydration

- The service provided water fountains for patients to use .There was a shop and a hospital café where people could purchase drinks, snacks, and meals.

Patient outcomes

- The trust report from February to July 2015 showed that for all clinical specialties they saw over 86% of patients within 15 minutes of their appointment times. This figure excluded patients who arrived late for their appointment or where time seen was not recorded. The trust reported overall that the percentage of patients waiting over 30 minutes to see a clinician was (5.8%).
- Waiting times within the clinic were monitored and there was a clear escalation plan in place with actions assigned for staff to follow if waiting times reached 15 to 30 minutes and from 30 minutes and above.
- We saw the waiting times at one of the clinics had risen to 30 minutes and staff escalated this in compliance with trust guidance. We also noticed that three patients had been booked into the clinic at the same time. The manager told us this was not acceptable and they escalated the matter of the clinic's delay and overbooking to the matron and recorded the event onto the electronic incident reporting system for investigation.
- The out-patient department was actively involved in local audit. A consultant, with assistance from their final year medical student, was compiling an audit of patients who had attended for ultrasound guided injections covering the previous 5 years and to ascertain readmission rates due to complications or symptoms related to the procedure. Managers would use this information to inform the trust and improve practice.
- The trust had a working group reviewing bariatric out-patient care for the previous 7 years and totalling in the region of 1,000 patients to inform future practice and service development. The bariatric consultant shared his "society produced data" with trust governance for quality improvement performance.

Diagnostic imaging:

- The x-ray department were actively involved in local and national audit; they displayed the results of some of these initiatives in the patient waiting area. We observed a published '15 steps' report (a NHS Innovation and Improvement initiative that captures data from the perspective of the patient to see what good quality care looks, sounds and feels like) in the patient waiting area. Managers in x-ray had compiled an audit and governance display board which was situated in the staff only area of the department.
- Audits included themes on correct completion of consent forms and health records including patient assessments in line with National Institute for Health and Care Excellence guidance. Where audits produced results different from what was expected or needed, managers reported results and made changes to procedures accordingly.
- Radiologists undertook a quality assurance audit on quality of reporting. They double reported 50 CT and MRI scans. Reporting radiologists and the clinical lead reviewed these.
- All diagnostic images were quality checked by radiographers before patients left the department. Staff followed national audit requirements and quality standards for radiology activity and compliance levels were consistently high.
- The Radiology department was part of all major pathways in the hospital. Examples included the stroke pathway and head injuries pathway, which staff developed through involvement of specialist staff.
- The diagnostic imaging department key performance indicators included waiting times in all modalities for both in and out patients as well as emergency and general practitioner (GP or family doctor) patients and all except ultrasound met national standards. Ultrasound results had affected the overall trust operational standard target for two months only and had improved significantly as additional staff were recruited.

Competent staff

- The 2015/16 trust wide appraisal report shows that the majority of the outpatient's staff were up to date with their appraisals. Staff we spoke with told us that they had received appraisals. Managers discussed training

Outpatients and diagnostic imaging

needs at annual appraisals and staff told us opportunities to develop and receive trust support was available. Staff were encouraged to attend courses to update their skills and knowledge.

- The trust had agreed all local protocols and competencies. Staff were encouraged to question practice if they had any concerns. Senior staff checked and documented staff competencies and medical devices training in all departments.
- Staff were actively encouraged to develop. One consultant stated that the trust supported their teaching and non-clinical duties, allowing them to continue with national and international research opportunities.
- Staff with specialist training managed a bariatric clinic.
- A member of nursing staff stated that they found the rotational element of their role “great for variety and I really like it. It is good for professional development especially trauma and orthopaedics”.
- Students were welcomed in all departments and students told us they felt supported and encouraged to develop when working within the departments. Several staff had chosen to work at the trust following student placements.
- The trust carried out medical revalidation for all consultants.

Diagnostic Imaging:

- Managers had created eight reporting radiographer posts and four trainee sonographer positions to train existing staff and improve skills pathways. The posts were introduced to improve ultrasound capacity, plain x-ray reporting levels and in response to the national shortage of radiologists.
- Consultant radiologists had annual appraisals with a named appraiser. They had dedicated SPA (supporting professional activities) time, study leave allowance and funding.
- 47% of radiographers had completed appraisals to date for the year 2015 to 2016. The manager was aware of this and provided support for the Site lead radiographer to ensure they planned appraisals for all staff by the year end.
- Nominated key staff led on specialist information and guidance in radiology on areas such as radiation protection and education for referrers. Radiation protection supervisors undertook annual training updates.

- Radiographers followed the trust competency framework where staff must perform a number of observed procedures to gain competency in that particular area. Designated supervisors then approved and signed off the competency framework.
- The trust offered newly qualified radiographers the opportunity for career progression to Band 6 using Annex T: a competency framework to be achieved within a set timescale of 23 months from recruitment. Radiographers told us the department supported them to complete competencies. They believed this programme helped with recruitment of new radiographers to this trust when in competition with other local trusts.
- Medical students spent a half day of training with a consultant radiologist.
- One radiography student told us the department had offered them good opportunities to achieve the required learning for their placement. A designated educational lead for radiology supported all radiography students.

Multidisciplinary working

- The trust provided one stop multi-disciplinary breast service clinics including bone health assessments and screening.
- The clinical nurse specialists running the rheumatology clinic explained how they worked with their respective multi-disciplinary teams.
- The trust held a bariatric out-patient clinic once a week at this location. This involved an extended MDT of medical, nursing, dietetics and psychology staff and they coordinated care in a holistic and timely manner.
- Staff maintained links with other departments and organisations involved in patient journeys such as GPs, support services, community services, and therapies.
- Staff worked together towards common goals, asked questions supporting each other to provide the best care and experience for the patient.

Diagnostic imaging:

- Medical staff could contact a duty Radiologist any time to discuss issues and to provide support to other doctors and staff throughout the trust. Doctors liaised with staff at other trusts and could refer patients with complex or specialist needs to regional centres such as oncology services.

Outpatients and diagnostic imaging

- Radiologists regularly liaised and worked with staff at another trust and shared good practice.

Seven-day services

- The trust had a centralised medical records library open 24 hours each day, seven days a week to support urgent retrievals, requests and returns of medical notes.
- Outpatient managers had not fully developed seven day working within the outpatients setting as they had judged there was currently no demand for this service. The majority of staff were employed with seven-day working terms and conditions. The department supported the delivery of outpatient clinics over a six-day service including Saturday and evenings when demand occurred. Such demand was mostly for extra capacity to support Waiting List Initiatives requested by specialties to help address shortfalls in capacity.

Diagnostic imaging:

- Diagnostic imaging provided services seven days a week. The trust provided a 24 hours a day, seven days a week service for emergency plain x-ray imaging, emergency CT (head scans only during the night), and out of hours portable images. Staff also provided radiology services to GP patients from Monday to Friday. Multiple Consultants were on duty on weekdays between 9am to 5pm.
- The diagnostic imaging department provided general radiography, CT and ultrasound scanning and for emergency patients, outpatients and inpatients every day. There was a rota to cover evenings and weekends so inpatients and emergency care patients could use diagnostic imaging services when they needed to.
- An external company provided MRI scans and the trust had secured a managed seven-day service. They held a service level agreement incorporating trust policies and protocols with the private company that ran the MRI service. MRI staff attended trust training programmes. The service ran from 8am to 5pm seven days a week. Trust radiologists reported the MRI scans but an outsourced reporting company provided reports out of hours; between 8pm and 8am.

Access to information

- The clinicians had access to a range of clinical information accessed electronically which was securely protected such as x-ray, MRI, CT, and pathology results.

- All staff had access to the trust intranet to gain information on policies, procedures, National Institute for Health and Care Excellence guidance, and e learning.
- Staff could find all patient information such as diagnostic records and reports, medical records and referral letters through electronic records. Staff followed procedures if patient records were not available at the time of an appointment.
- Staff used notice boards, emails, communications files, and diaries to pass messages and information between teams on different shifts. This made sure that information was documented and available for staff at any time.

Diagnostic imaging:

- Diagnostic imaging departments used picture archive communication system (PACS) to store and share images, radiation dose information and patient reports. Clinicians undertook training to use these systems and could find patient information quickly and easily. Staff used systems to check outstanding reports and staff could prioritise reporting and meet internal and regulator standards. There were no breaches of standards for reporting times.
- The diagnostic imaging department kept an electronic list of approved referrers and practitioners. Senior staff vetted internal and external staff against the protocol for the type of requests they were authorised to make.
- There were systems to flag up urgent unexpected findings to GPs and medical staff. This met the Royal College of Radiologist guidelines.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- Staff were able to identify patients with learning difficulties, memory impairment, or safeguarding concerns during their attendance at the emergency department and urgent care centres. Staff documented and escalated concerns at this point to the medical and safeguarding teams in compliance with trust policy.
- Nursing, diagnostic imaging, therapy, and medical staff understood their roles and responsibilities and knew how to obtain consent from patients. They could describe to us the various ways they would do so. Staff told us they usually obtained verbal consent from patients for simple procedures such as plain x-rays and phlebotomy (taking blood samples for testing). In some general cases this was inferred consent.

Outpatients and diagnostic imaging

- Staff obtained consent for any interventional procedures in writing according to the pre-assessment policy before attending departments for biopsy procedures. Staff checked and confirmed consent at the time of the procedure. Staff adhered to the Trust Consent Policy.
- There was a trust policy to ensure that staff were meeting their responsibilities under the Mental Capacity Act and Deprivation of Liberty Safeguards. We saw from the department's training reports that learning disabilities, mental capacity level 1 and 2 training was included. The overall departmental compliance score was 100% for level 1 training. However, the trust target was 85% and only 40% of medical staff in Radiology and 79% of radiographers had completed mental capacity level 2 training. Managers had action plans in place to ensure all staff achieved the required level for their role by the end of the year.
- Patients told us that staff were good at explaining what was happening to them before asking for consent to carry out procedures or examinations.
- We observed staff speaking to patients in a polite manner. Reception staff respected the patients privacy when they were checking personal details on arrival for their appointments.
- Staff interactions with patients in all areas we inspected were polite, courteous, and respectful. We heard staff introducing themselves when dealing with patients and relatives. Staff greeted patients in a kind and friendly manner.
- Reception staff respected patient privacy when they were checking personal details on arrival for their appointments.
- The patients and relatives we spoke with told us staff had treated them with dignity and respect and overall they were happy with the service provided. They also told us that the staff were friendly, and professional.
- Staff confirmed that the patient would have a chaperone made available when intimate examinations were performed or at any time on their request.
- Staff in all departments we inspected were caring and compassionate to patients. We watched positive interactions with patients. Staff approached patients and introduced themselves, smiling and putting patients at ease.
- We spoke with 18 patients and four people who attended with them and all said that staff were friendly with a caring attitude. There were no negative aspects highlighted to us.
- The trust used the Friends and Family Test (FFT) to obtain information from outpatients on their experience. Results demonstrated that staff were caring and 87% of people would recommend the outpatients service to others between April and October 2015 (slightly worse than the England average of 92%). However, 3% of patients or those close to them would not recommend it (the same as or slightly better than the England average of 3%).
- An extensive multi-faceted patient experience programme assisted the trust to obtain and gain a broad and deeper understanding of patient experiences. The 2014/15 outpatient experience results showed the department achieved an overall average score of 88% with the score for the top 20% in England standing at 84%. Results from quarter one, April to June 2015, showed the department had further improved its average score to 89%.

Are outpatient and diagnostic imaging services caring?

Good 

We rated caring as good because:

Staff respected patients privacy, dignity, and confidentiality at all times. Patients told us, and we saw without exception, that staff treated them kindly in a consistently caring and compassionate way at every stage of their journey. Staff spent time with patients and those close to them to give explanations about their care and encouraged them to ask questions.

There were a range of services and opportunities to provide emotional support for patients and their families. Staff at all levels were trained to identify when people needed emotional support with their care. Staff reacted compassionately to, or pre-empted, patient discomfort or distress by using appropriate communication methods to suit individual needs. Staff involved patients by discussing and planning their treatment and patients could make informed decisions about the treatment they received.

Compassionate care

Outpatients and diagnostic imaging

- Scores also showed that 90% of patients would recommend the trust and 98% of patients rated the trust as excellent, very good or good. There were variations between the specialties with scores ranging from the lowest at 83% to the highest at 96%.

Diagnostic imaging:

- Staff respected patients privacy and dignity. Staff took patients to private changing facilities with a lockable door to ensure privacy and dignity. Staff knocked on doors before entering and closed doors when patients were in treatment areas. Patients and relatives told us staff had treated them with dignity and respect.
- Staff in x-ray informed us that they spent the time necessary with patients to ensure they informed, supported, and reassured them about the procedure to be undertaken.

Understanding and involvement of patients and those close to them

- Patients told us they were involved in their treatment and care. Those people attending with patients said nursing and medical staff kept them informed and involved. All those we spoke with told us they knew why they were attending the departments and agreed with their care and plans for future treatment. We saw staff explaining treatment.
- Staff told us they would invite families into consulting rooms as long as the patient consented.
- Patients and their families were given time to ask questions.
- Staff in x-ray informed us that they spent whatever time necessary to ensure that the patient understood and consented to the procedure. Staff also confirmed that should they have any concerns about a patient who did not appear to fully understand what their care entailed then the procedure could be delayed or cancelled until the patient appreciated what their care involved.

Emotional support

- Staff gave several examples of providing extra support for patients and their families including patients with severe anxiety problems. They cared for a patient with learning difficulties recently who had a fear of needles. Staff built a rapport with particular support from the

patients mother. Not only was the procedure completed but staff also accommodated an additional request for a further investigation the same day rather than repeat the experience at another visit.

- Patients told us they felt supported by the staff in the departments. They reported that, if they had any concerns, they were given the time to ask questions.
- Staff made sure that people understood any information given to them before they left the departments. Medical, nursing, and allied health professionals provided support for individuals and their carers to cope emotionally with their conditions, treatments, and outcomes.
- One patient had written about his experience in the x-ray led pain clinic by letter to the department dated October 2015 which stated: “a rewarding experience...immediately put at ease...the repartee of staff a pleasure to behold”.

Are outpatient and diagnostic imaging services responsive?

Outstanding



We rated responsive as outstanding because:

The trust had worked with the local population, primary care, and commissioners to plan a new model of emergency care and had successfully reconfigured outpatients and diagnostic imaging services at North Tyneside General Hospital to ensure that the service met people's needs.

Staff made sure services could meet every patients individual needs, but in particular, those with conditions such as dementia, people with learning or physical disabilities, or those whose first language was not English. Staff knew how to support people living with dementia and had completed the trust training programme. The learning disability specialist nurse worked with departments in advance of patients with special needs attending for procedures.

Waiting times and cancellations were minimal and managed appropriately. Diagnostic image reporting times for urgent and non-urgent procedures consistently met or were better than national and trust targets for all scans and

Outpatients and diagnostic imaging

x-rays for emergency patients, inpatients, and outpatients. A radiographer discharge programme facilitated the discharge of patients having soft tissue injuries directly from radiology by suitably trained radiographers.

The department teams recorded concerns and complaints and used patient feedback proactively to prevent recurrence that might affect others. They reviewed and acted on problems quickly and demonstrated an open and transparent outlook with the aim to learn from them and improve patient experience.

Prior to emergency services moving to NSECH in June 2015, the radiology department had developed trauma image reporting, which was swift with an emphasis on “results within minutes” for emergency patients. This was the process that had been adopted at the new NSECH hospital and enabled medical teams to complete assessments and manage risks quickly.

Service planning and delivery to meet the needs of local people

- The trust provided a shuttle bus service running between Wansbeck and North Tyneside General and NSECH hospitals for patients and relatives to use.
- The trust provided a drop off area for patients directly at the main entrance. There is disabled parking near to the main entrance and large public parking areas.
- The departments were accessible for people with limited mobility and people who used a wheelchair. The main reception area held a store of wheelchairs and ‘meet and greet’ staff were in attendance to assist.
- The trust provided staff for the outreach clinics within the communities of Monkseaton and Molineux. The team also staffed the diabetic resource centre, the oncology, and haematology outpatients departments.
- All departments were well signposted and provided plentiful comfortable seating and areas for children. The trust had designed the reception area to the department to promote private conversation at the desk. There were drop leaf writing platforms attached to the reception desk for use by patients in wheelchairs. The reception area had a designated hearing loop.
- Three receptionists received patients and they managed flow efficiently by directing patients to the relevant sub-waiting areas once checked in for their appointments. Sub-waiting areas provided adequate seating arrangements and a quiet room was available for use by patients and relatives.
- Information was available and displayed publicly in relation to hand hygiene audit results, departmental ratings and patient experience results demonstrating staff met targets consistently.
- Patients attending outpatients had access to coffee and snack facilities. When clinics were delayed staff would provide the patients with refreshments.
- Patient toilets (including disabled facilities and baby changing) were all easily accessible. Outpatients provided a specific toilet and hand basin especially for children.
- Bookings staff sent out letters to all patients to confirm their appointment. They attached a comprehensive welcoming leaflet which included information on what to expect before and following arrival at their outpatient appointment. This included for example; transport, doctors in training, specific information for people with communication difficulties or special needs, appointment reminders and requesting feedback on their experiences.
- The out-patient rheumatology service responded to the feedback from patients regarding telephone access to the specialist nurse. The service implemented a telephone appointment service managed by the specialist nurse.
- The trust reported from July 2014 to August 2015 short notice clinic cancellations within six weeks was low (1.2%) and the percentage cancelled over six weeks was 11%. Some of the main reasons clinics were cancelled was due to annual leave, on call commitments, sickness, clinical and business meetings, training and study leave.
- Senior managers told us that changes to the consultant job plans and on call arrangements were still ongoing following the opening of the new NSECH hospital. The trust had identified a number of work streams to look at efficiencies around population of clinics and clinic reconfiguration. This work was ongoing at the time of our inspection.
- A new consultant had recently been appointed to oral surgery and the managers were confident this would serve to assist the trust to meet the referral to treatment (RTT) 18 week target in this speciality.
- Patients told us that they received appointment letters in a timely manner and provided the necessary information following referral; and the trust offered a choice of times for follow up appointments.

Outpatients and diagnostic imaging

- Posters and information in the waiting areas reinforced frequent patient, relative and carer concerns such as chaperones, privacy and dignity and use of gowns. An information poster about a 'day in the life of a radiographer' giving a behind the scenes overview of the journey through x-ray was on public display. Television screens provided information for patients and general health advice.
- Pathology staff provided a Point of Care Team (POCT) which was clinical pathology accredited for each blood test carried out.

Diagnostic imaging:

- The x-ray waiting area had chairs of different heights and sizes to suit differing patient needs.
- Diagnostic investigations and procedures were organised to meet patients needs. Teams worked together and specialist procedures were organised so all investigations and consultations happened on the same day. Doctors, nurses and therapists worked together to carry out joint assessment and treatment.
- The radiology department provided a workflow coordinator on each shift to assess activity and schedule procedures according to patient needs.
- Diagnostic imaging reporting and record keeping was electronic and the department used paperless methods to reduce time and administration.
- Turnaround times for urgent radiology reports were 60 minutes with an allowance of 90 minutes outside normal working hours (between 8pm and 8am) for general scans and 30 minutes for urgent images such as those for suspected stroke patients. Management of routine radiology reports ensured completion within national target times.
- The x-ray department was designed to ensure optimum privacy and dignity for all patients, in particular those who were undergoing more intimate investigations or procedures such as ultrasound, CT imaging, and fluoroscopy. Separate designated waiting areas partitioned from thoroughfares with private facilities were available.
- The trust had a low level of patients who failed to attend with a 'Did Not Attend' (DNA) rate (6%) which was lower than the 7% national average. The trust continually monitored this to enable adaptations and managers told us that the rate had improved since the onset of the automated voice system to remind patients seven days and again one day before attendance of their appointments. Clinicians made all decisions and actions for patients who DNA based upon the care they felt the patient needed.
- The trust's new to follow up ratios were similar to the rates of the majority of trusts at 1:2.2.
- The percentage of appointments cancelled by the trust within 6 weeks of an appointment date was consistently low with an average over the previous 12 months of 1.2% which was much better than the England average of 6%. The main reasons given for cancellations were medical staff annual leave, on-call commitments, attendance at clinical and business meetings, study leave, research, training, and sickness.
- The percentage of patients waiting for over 30 minutes to see a clinician in outpatients across the trust was 5.85%. There were no delays during our inspection at this site but staff told us they followed the trust protocol for delays and would tell patients about delays and the reasons for them. Outpatient's staff audited patient waits from the time patients booked in at reception.
- Staff followed waiting time escalation plans with actions attached in the event of clinic delays. These actions included monitoring, staff reviews, discussion with medical staff and informing patients, escalation to senior managers, offering patients refreshments and recording extended delays as an incident. There were no extended delays during our inspection.
- A consultant confirmed his awareness of escalation in respect of out-patient waiting times. He stated that while he had some complex reviews, it was "very uncommon" for clinics to exceed 15 minutes wait and if this was the case he would expect to be informed and in turn the operational service manager would be alerted.
- The monthly National Statistics on NHS Consultant led Referral to Treatment (RTT) waiting times April 2013 to May 2015 showed that the trust consistently performed at or above the national average of 95% of (non-admitted patients) starting treatment within 18 weeks and above the national average of 92% for patients waiting to start treatment (incomplete pathways).

Access and flow

- We observed that seating in the main and sub-waiting areas was sufficient to meet the demand of the patients attending appointments. Staff kept patients informed of any delays to appointment times.

Outpatients and diagnostic imaging

- The trust performed continually better than the England average in all three measures for cancer targets. Where individual speciality targets dipped below the national standard operational service managers were proactive in working with specialist teams to meet capacity and demand for patient referrals.
- The trust had missed the national 62 day target for upper gastrointestinal (GI) for June, August, September, November and December. Senior managers told us this was due to capacity problems caused by a sudden increase of patients through choose and book from another local area. Managers monitored all targets and reported to the trust board through their overall performance reports. These were escalated to the surgical risk register and actions assigned to improve the target. They did achieve 100% in July 2015 and had continued to achieve this to date.
- The percentage of non-admitted patients seen within 18 weeks of referral over the previous 12 months ranged between 95% and 97% and was continually higher (better) than the operational standard of 95% and the England average (apart from September 2015 when it was 93%). However, for the period between April and August 2015, general surgery, urology, Trauma and orthopaedics, oral surgery and plastic surgery was the only specialty at this hospital where results dipped just below the national standard (95%) at 94%.
- The percentage of patients with incomplete care pathways who had started their consultant-led treatment ranged between 92% and 93%. The operational standard in England is 92%. However, results for trauma and orthopaedics had declined from 91 to 85%. Managers had recorded these as a governance risk. Outpatient's staff had checked the results and found there were no delays in the appointment systems and this target was failing further along the patient pathways for treatment.
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Diagnostic imaging:

- Staff recorded the arrival time of every patient and explained any unexpected delays. Diagnostic waiting times for this trust had performed consistently better than the England average and for most months, less than 0.5% of patients had to wait longer than the 6 week target time.
- 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 emergency patients, inpatients, and outpatients. Prior to emergency services moving to NSECH, radiology staff reported images for 97% of patients with head injuries or trauma within one hour. Inpatient images were reported on the same day, urgent outpatients on the 62 day pathway within two weeks, and CT scans within 48 hours. Reporting was routinely outsourced and at night trauma images were reported within one and a half hours.
- Reporting radiographers completed "hot reporting" on skeletal images for emergency patients. One example of this was when a patient with a suspected broken ankle had an x-ray taken and the image had been reported by the time the patient returned to see the doctor in the emergency department.
- A radiographer discharge programme facilitated the discharge of patients having soft tissue injuries directly from radiology by suitably trained radiographers. This new and improved patient pathway provided many benefits including shorter waiting times and fewer trips between departments.
- There was a very low DNA rate in x-ray. The average rates for the previous 6 months were CT: 3.3%, plain x-rays: 1.9% and ultrasound: 7.5%. The ultrasound DNA rate had peaked in July to September 2015 which staff believed were due to longer waiting times. However, the rate had reduced to 5% as waiting times improved in October 2015.

Meeting people's individual needs

- Departments helped patients in wheelchairs or who needed specialist equipment. 'Meet and greet' staff were in attendance to assist people arriving at the main entrance. There was enough space to manoeuvre and position a person using a wheelchair in a safe and sociable manner. There were hoists for patients who needed help with mobility.
- Patients attending appointments with memory impairment and learning difficulties were identified through the appointment bookings and staff would ensure these patients were not kept waiting unduly. The learning disability specialist nurse worked with departments in advance of patients with special needs attending for procedures. The reception staff informed the nursing teams if patients had any additional needs.
- Staff offered a choice of appointment times for those with children or if a patient had a particular need such as dementia where waiting in a busy waiting area could

Outpatients and diagnostic imaging

be distressing. Staff used a private room should a particular patient need this type of waiting area. Staff confirmed that priority was generally given to people with additional needs should it assist in their time at the out-patients department.

- The bookings team arranged translation and interpreter services if requested and staff were aware of how to obtain this service. The trust used two providers to ensure they maintained effective communication at the appointment. The translator could be arranged in advance or immediately should the need arise. Staff told us they had used an interpreter to support a patient the day before our inspection.
- Staff used private areas to hold confidential conversations with patients and receptionists told staff quickly if patients had difficulties with speaking, listening, understanding, or needed extra assistance.
- Staff knew how to support people living with dementia and had completed the trust training programme. They understood the condition and how to be able to help patients experiencing dementia. Reception and Portering staff informed us that they had received training in caring for patients who were living with dementia alongside their mandatory training.
- Staff told us that they had recently received dementia clocks and signage to use in the department.
- The trust provided good quality patient information leaflets, condition specific information, health promotion information and trust information in all patient areas. The information was easily accessible to all visitors and patients to the respective departments and they could provide it in several different languages when needed.

Diagnostic imaging:

- A patient requiring bariatric investigations was two hours late for their appointment due to ambulance transport issues. Staff ensured that although the department should have been closed to outpatients, the patient still had their investigation. Staff arranged to perform a further scan on the same day rather than have the patient brought back for a second visit.
- There was bariatric furniture and equipment available in all departments (for people who were larger or heavier and could not use standard furniture). Staff had selected the new CT scanners and x-ray equipment to enable access for larger and heavier patients.

Learning from complaints and concerns

- We saw information on public display informing patients on how to provide feedback on their experiences through the 'We're listening' feedback for staff, patients and public to let the trust know how to make services even better. The trust provided its complaints policy on the trust web site.
- Staff understood the local complaints procedure and took a proactive approach to dealing with any patient concerns or complaints. The aim being to resolve concerns or informal complaints immediately and to ensure staff were confident in dealing with concerns and complaints as they arose. Staff in all departments told us they received very few verbal or informal complaints. They could identify patterns and themes from patient concerns and would help patients to use the patient advice and liaison service (PALS). Department managers kept logs of actions taken and shared lessons learned from complaints and concerns with their teams.
- The trust complaints report from September 2014 to August 2015 showed 35 complaints were made in outpatients. The majority of complaints were about clinical aspects of the patients experience but those attributed directly to outpatient services were about delays, or communication problems.
- The trust had systems and processes in place to learn from complaints and concerns. We saw evidence from weekly business unit governance meetings, departmental meetings, and safety and quality meetings that managers discussed complaints with staff during these meetings.
- None of the patients we spoke with had ever wanted or needed to make a formal complaint. Staff had listened and dealt with their concerns and, where possible, had taken action to address them. Patients and relatives were all happy with the experience they received from the departments.

Are outpatient and diagnostic imaging services well-led?

Outstanding



We rated well-led in outpatients and diagnostic imaging departments as outstanding because:

Outpatients and diagnostic imaging

All staff within the outpatients and diagnostic imaging departments were clearly engaged with the new model of specialist emergency care at Northumbria and its associated support services. Teams were motivated and had been involved in planning and preparation for new departments and services. They evaluated their performance continually against the plans and were preparing for the year ahead.

Staff and managers had a clear vision for the future of the service. They knew the risks and challenges the service faced. Staff we spoke with at all levels felt supported by their line managers, who encouraged them to develop and improve their practice. Staff embraced change and there was a real focus on patient experience and leaders and managers drove this.

There were effective and comprehensive governance processes to identify, understand, monitor, and address current and future risks. These were proactively reviewed.

There were well embedded systems and processes for gathering and responding to patient experiences and the results were well publicised throughout the departments.

There was an open, honest and supportive culture where staff discussed incidents and complaints, lessons learned and practice changed. All staff were encouraged to raise concerns.

The departments supported staff who wanted to work more efficiently, be innovative, and try new services and treatments and ways of engaging with the public. Staff had received nominations and awards for innovation and changes in practice. Staff were proud to work in the new hospital and its departments. Staff worked well together as a newly formed, productive team and had a positive and motivated attitude.

Vision and strategy for this service

- The trust in October 2015 launched 'The Northumbria Way' which linked together a number of existing key programmes of work that contribute to improving quality and delivery of high quality care. This information was publicly displayed throughout the hospital and available through the trust intra and internet websites.
- Staff we spoke to were aware of the trusts values and knew how to access this information from the intranet. Staff showed us and understood about the quality

strategy 2014 to 2016 outlining the aims and key objectives of the strategy which included 'The Northumbria Way' and how it linked to departmental objectives.

- The Emergency Surgery and Elective Care Business Unit Annual Plan (2015-2016) set out clear and realistic aims for quality, safety, patient centred care, efficiency, and growth. The strategy was able to show that from the patient experience data the trust had consistently performed higher than the top 20% of trusts.
- Teams were motivated and had been involved in planning and preparation for new departments and services in preparation for and following the opening of the new hospital; NSECH. They evaluated their performance continually against the plans and were preparing for the year ahead.
- All departments we inspected had good leadership and management and staff told us managers involved them in strategic working and planning.
- Staff were proud to work in the hospital and departments and they enjoyed the opportunity to propose and make changes for new ways of working in line with changing needs and demands of the local population. Teams worked together to agree local ideas about providing the best possible seven-day service for patients. They focused on patient experience and care, driven by the hospital, directorates, department leadership, and staff.
- A new member of staff was informed at induction of the vision and strategy for the service. They had the opportunity to meet the chief executive and ask questions regarding the trust vision and strategy.
- We saw business plans for all services and departments within outpatients and radiology. These included strategies for dealing with winter pressures and staff had contributed as teams towards these documents.

Diagnostic imaging:

- Radiology had presented a business case to provide a new service for small bowel radiology and were awaiting the result of this.
- The radiology department were looking at staff roles and responsibilities with an aim to improve and streamline their services across the trust for outpatients and GP patients. They had employed eight assistant practitioners. Operating department Practitioners had taken on extended roles and Radiographers were providing the relevant training.

Outpatients and diagnostic imaging

Governance, risk management and quality measurement

- In governance terms the outpatient services were part of the Emergency Surgery and Elective Care Business Unit. The unit had a number of groups all reporting to the governance group then to the assurance committee and onwards to the board.
- Staff reported on risk, incidents, and complaints and could influence what risks were included on risk registers. Serious incidents were discussed at departmental meetings, led by the operational service manager and senior staff attended. A governance system was in place with the production of incident summaries and themes, complaints, compliments, workforce statistics and data.
- A monthly strategy meeting took place that discussed finance, and performance data including quality and timeliness of procedures and reporting, changes to clinical practice and audit activity. Staff were clear about challenges for the departments and were committed to improving the patient care journey and experience.
- The department risk registers were available and regularly reviewed to record and show actions taken regarding current risks. A lead officer managed each risk and provided descriptions of key controls to mitigate risks.
- Managers shared learning from incidents across the organisation using regular directorate and operational service manager meetings, and staff emails.
- The 15 Steps Challenge is a toolkit with a series of questions and prompts in order to obtain first impressions of a ward or department. The challenge assists trusts to gain an understanding of how patients feel about the care provided and helps the trust to identify the key components of high quality care that are important to patients and carers from their first contact with the department. We looked at the results from the April 2014 assessment and assessors had rated the department good for safe, caring, and well-led with effective rated as outstanding. The department overall was assessed as good. The manager told us that the assessment was a positive learning experience.
- The business unit took part in the trust wide auditing programme and monthly performance met trust targets.

Diagnostic imaging:

- Diagnostic imaging staff carried out risk management as a team with modality (specialist diagnostic imaging services for example CT and ultrasound) leads and radiology protection specialists. The radiation protection advisor provided support and guidance in all aspects of risk assessment.
- The organisation checked up to date National Institute for Health and Care Excellence guidance to make sure they put any relevant guidance into practice in diagnostic imaging. This included radiology related stroke thrombolysis and non-thrombolysis imaging times. CT radiographers were following National Institute for Health and Care Excellence guidance on reducing the risk of acute kidney injury and carried out an ongoing compliance audit on checklists for the use of CT contrast. The teams had developed guidelines to help prepare patients for the safe use of contrast and how to care for them following the procedure.

Leadership of service

- The departments had clear management structures at both directorate and departmental level. There were clear lines of management support and accountability for the business unit as a whole.
- Leadership was strong, supportive and staff felt managers listened to their views. Local departmental leadership was reported to be positive and supportive. Staff told us they knew what managers expected of them and of the departments. Staff felt line managers communicated well with them and kept them up to date about the day-to-day running of the departments, their expectations of staff and the departments. Managers had planned some positive changes and some had already taken place.
- There was confidence and respect in the management. We saw good, positive, and friendly interactions between staff and local managers. Staff told us they were proud to work in the hospital and integrated teamwork was evident in all departments.
- Staff we spoke to had met the Chief Executive Officer (CEO) and the senior management team on more than one occasion and said they felt as though they could approach them with any issues or points they wanted to raise. Staff told us that the CEO brought a real energy and proactive approach to the service. Staff knew the executive team, who invited and listened to new ideas for change and sent out regular messages to staff.

Outpatients and diagnostic imaging

- A consultant stated “one of the strengths is clinical management”. Consultant leads met line managers weekly and the feedback from this forum integrated well into the overall structure.
- Nursing leadership of the outpatient’s service had been strengthened with the recent allocation of a Matron and the appointment of two band 7 nurses to share the four main hospital sites.
- Managers followed recruitment and selection procedures to ensure staff were skilled and had relevant knowledge. One manager explained the protocol for recruitment regarding Disclosure and Barring Service (DBS) checks for all staff.
- Staff told us they completed annual appraisals and were encouraged to manage their personal development. Staff could access training and development provided by the trust and the trust would fund justifiable external training courses.

Diagnostic imaging:

- Managers supported staff to carry out continuous professional development activities, complete mandatory training, and appraisal, and complete specific modality training, medical devices training, and competencies.

Culture within the service

- Staff said the culture was: “open, approachable, and receptive, all the way to the top”.
- Staff stated that they felt supported by the trust and wanted to stay to progress, one commented: “it’s the place to be”.
- Staff confirmed that they received lots of informal positive comments from patients and felt that: “we (the trust) should capture more of these”.
- Staff told us they were openly encouraged to report incidents and complaints and felt their managers would look into them consistently and fairly. Staff were all aware how to report.
- Managers asked staff for their ideas on how to improve their service and practice.
- Staff told us of an “open door” philosophy where staff are encouraged to speak with managers “on first name terms”. Staff commented that they felt listened to. Staff described the culture as open and transparent. Some staff felt they were working under pressure with new systems and different working conditions when they carried out shifts at NSECH but all were positive and

motivated to do their best for patients and the organisation. Staff felt there was a strong culture to develop and support each other. Staff were open to ideas, willing to change and would question practice within their teams and suggest changes.

- Staff commented on the strength of teamwork and everyone pulling together during the transition and opening of the ‘new hospital’. Staff told us there was a good working relationship between all levels of staff. We saw there was a positive, friendly, but professional working relationship between consultants, nurses, allied health professionals, and support staff. A staff member reported that working for the trust felt like being: “part of a family where everyone supports each other”.

Diagnostic imaging:

- Consultants throughout the trust used the radiology service for advice and guidance and we saw them regularly visiting departments throughout our inspection. Staff told us that emergency care doctors regularly accompanied patients for scans and that surgeons were happy with the service. There was good involvement of doctors with the radiology service across all the departments. Doctors approached radiology staff directly and we could see that staff worked well together as an extended team.

Public engagement

- The outpatient patient perspective survey results for the quarter April to June 2015 continued to show the service as being extremely good. On average the trust is in the top 20% of all Trusts in England. It is in the top 20% for 19 of the 20 most important questions to patients and in the middle 20% for the other one.
- The trust website enabled patients and the public to comment on the care they had received. Departments displayed compliments and complaints received.
- Staff told us of a recent survey undertaken in consultation with the patients with regards to the use of televisions within the waiting areas. The survey was completed but the results were not collated at the time of our inspection.
- The trust used a combination of methods as an approach to understanding the experience of patients including national patient experience surveys and a

Outpatients and diagnostic imaging

questionnaire found throughout the hospital called “Two minutes of your time”. Staff encouraged patients to use the comments boxes situated in out-patients and the results were well publicised throughout the hospital.

Diagnostic Imaging:

- The radiology department had designed and introduced a survey to capture the thoughts of young people. It had not been as successful as they hoped but the team were undaunted and were working on another version to try to engage this population group.

Staff engagement

- The trust had a number of internal communication and engagements with staff including; weekly staff updates through e-bulletins to all employees, monthly team briefs cascaded to staff from executive management and a quarterly staff magazine. Staff were aware of how to access all of this information from the intranet and extranet.
- Staff told us the executive team undertook road shows across the trust to update staff working at all units on major developments and to encourage them to ask questions. The trust posted outcome notes from road shows on the intranet.
- Business unit governance meetings were held weekly and local departmental meetings were held monthly. The agendas were standardised across the service to include a range of issues for example; incidents and complaints, staffing, clinical risks, patient involvement and patient experiences, education and training. This ensured staff were kept up to date with operational and performance delivery as well as the patient experience across the services.
- Staff told us they took part in team meetings and were confident to talk about ideas and sharing of good news as well as issues occurring in the previous days or planning for anticipated problems. Staff felt managers listened to their views and they had opportunities to contribute towards the development of the departments, the configuration of services and resource planning.

Diagnostic Imaging:

- Radiology staff contributed in the writing of standard operating procedures (SOPs) across the department and

invited theatre staff to provide input for procedures involving their practice. Lead radiographers for mammography and fluoroscopy controlled the SOPs for their own specialty.

- Staff had designed, modelled for, and produced posters for patient changing cubicles to demonstrate in step by step photographs how to put on a hospital gown.
- Staff had written information leaflets for patients on topics such as having a CT scan and a day in the life of a radiographer.

Innovation, improvement and sustainability

- Rheumatology services had recently developed a new service; the North East Adult Rheumatology (NEAR) group provided two full day sessions to help teenagers transition to becoming adults. The service provided practical support and advice to patients with finding GPs if for example they were relocating elsewhere. The consultant would write to their new GP to inform them of their condition.
- The trust displayed the top five things the outpatient service had achieved across all of the main outpatient locations. These included: privacy and dignity, with the installation of new nurse stations at two locations used for secure confidential areas for patient information, the virtual trauma clinic, charitable monies obtained to buy new toys and refurbish audiology, a staff ideas forum, and displayed waiting times.
- The service also had a top five list to inform patients and relatives of what they were going to achieve. These included: provision of chaperones for procedures including phlebotomy, sharing feedback from audits with service users, escalation plans for delay times, learning from incidents to improve patient pathways, and working towards a Dementia Alliance approved environment and a staff photograph board.
- Staff told us that they were consistently asked for their input into new ideas and service improvement initiatives.
- The DNA rate had improved since the onset of an automated telephone system to remind patients seven days, and again one day, before their appointments. Clinicians undertook a review of referrals and medical records for patients who DNA. They completed an outcome form to determine further follow up actions.

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- Radiologists and pathologists had developed a service with a North West of England trust to provide virtual autopsies which were done out of hours. CT and MRI protocols had been developed for post-mortem imaging.
- The radiology team had received the Health Education North East Allied Health Professional Service Improvement Award for their radiographer reporting service project which staff had developed at North Tyneside General Hospital before the emergency department was transferred to NSECH.
- Trust radiographers had received a Healthcare Innovation Award for their Radiographer Discharge programme by radiographer practitioners in minor injuries. This process facilitated the discharge of patients having soft tissue injuries directly from radiology by suitably trained radiographers. The idea was prompted by changes in the NHS such as the NHS Plan which encourages the crossing of professional boundaries to optimise expertise while improving patient care. This new and improved patient pathway provided many benefits including shorter waiting times and fewer trips between departments. The programme was in place at North Tyneside General Hospital and Wansbeck General Hospital when the Accident and Emergency departments were based there and the department planned to reintroduce it as soon as systems and processes settled at the Northumbria Specialist Emergency Care Hospital.
- In 2014, the trust was awarded the HENE Certificate (Health Education North East) for the 'Reporting Radiographers of the Year'.
- A student radiographer undertook an audit of the care of the patient living with dementia and a review of their journey through the department. The audit looked at 500 patients across two weekly blocks and shared results with the wider x-ray team by way of a presentation and paper to raise awareness. They also shared the audit findings with the Business Unit Governance Group.
- X-ray staff were completing an audit of WHO Safer Surgery Checklist usage across all sites with an aim to standardise the checklist they used for the benefit of all staff and patient safety. Initial feedback suggested they should develop a new WHO compliant checklist/ consent form and the team will complete this.
- As part of the trust's WOW initiative (Well Organised Workplace) a staff nurse devised out-patient clinic specific information files for staff. These comprised contact names and numbers, guidance on specific equipment relevant to the clinic and checklists for learning.

Outstanding practice and areas for improvement

Outstanding practice

In medical care:

- The joint working by the falls team, which has raised the profile of falls and engaged staff, patients and their relatives in trying to reduce falls.
- The role of nutritional assistants and the focus on the nutritional needs of patients which had improved the patient experience.
- The 'real time' data collected on patient experience to assess how each ward is performing.
- The inclusion of a psychological assessment for patients who require isolation for infection prevention reasons.
- The development of comfort care packs for relatives.

In surgery services:

- North Tyneside General Hospital is rated in the top five hospitals in the country for the treatment of emergency hip fractures.
- North Tyneside General Hospital was recently recognised by the General Medical Council as the best in the country for the quality of training for orthopaedic surgeons of the future.
- The service had developed a day case mastectomy service. This was proposed to save 201 bed days each year. Average length of stay had also reduced to between 2.7 and 4.2 days (depending on patient risk at the time of surgery). This compared to a national average of around 4.8 days.

In end of life care:

- The model of end of life care services saw that dedicated palliative care beds were operated alongside a specialist palliative in-reach service to general ward areas. This meant that specialist staff worked alongside general staff to deliver effective, coordinated care within a holistic approach.
- Services worked across both acute and community settings with a strong multi-disciplinary ethos.

- The trust had adopted an innovative approach to providing an integrated person-centred pathway of care in partnership to provide services that were flexible, focused on individual patient choice and ensured continuity of care.
- The trust had taken positive action to increase the number of patients who were dying in their usual place of residence.
- The trust was supporting increasing numbers of non-cancer patients.
- Partnership working with Marie Curie and joint management and nursing posts enabled the trust to provide prompt support and continuity of care for patients being discharged to their preferred place of care in the community.
- The leadership, governance and culture were used to drive and improve the delivery of high quality person-centred care through collaboration and partnership working. The trust had clear leadership for end of life care services that was supported at the top of the organisation.
- Investment in end of life and palliative care services was apparent and staff we spoke with consistently told us they felt that end of life care was a priority for the trust.
- Innovations were seen in relation to a focus on spiritual support and an assessment model that aimed to increase staff understanding of spirituality and confidence around assessment.
- The Palliative Care service had won the Quality Award for 2014 for their commitment to improvement and the excellent patient experience feedback received.
- The development of a tool for the assessment of patients spiritual needs that focused on providing staff with prompts that would make it easier for them to have this discussion with patients. The tool also helped staff to engage in a clearer way to ensure patients understood.

Areas for improvement

Action the hospital MUST take to improve

Action the hospital MUST take to improve

Outstanding practice and areas for improvement

- Complete a comprehensive gap analysis against the recommendation made for the University Hospitals of Morecambe Bay NHS Foundation Trust.
- The service must ensure that the maternity and gynaecology dashboard is fit for purpose, robust and open to scrutiny.

Action the hospital SHOULD take to improve

Action the hospital SHOULD take to improve

- Ensure that levels of staff training continue to improve in the hospital so that the hospital meets the trust target by 31st March 2016.

In the Emergency Care Centre:

- Consider circulating guidance to staff about when to stop using the 'see and treat' model when the department is busy and revert to the triage model, to ensure patient safety and improve responsiveness.
- Consider training for reception staff to help identify patients who may need to be brought to the attention of clinical staff more quickly.

- Consider increasing the number of independent nurse prescribers to enable more flexibility in prescribing of medication in the ECC when there are no doctors available.

In maternity and gynaecology:

- Ensure that the clinical strategy for maternity and gynaecology services which is embedded within the Emergency Surgery and Elective Care Annual Plan, sets out the priorities for the service with full details about how the service is to achieve its priorities, so that staff understand their role in achieving those priorities.
- Consider the provision of separate accommodation for women undergoing pregnancy loss and termination of pregnancy.

In outpatient's and diagnostic imaging:

- Ensure waiting time targets in ultrasound in diagnostic imaging continue to improve as more staff are appointed.

This section is primarily information for the provider

Requirement notices

Action we have told the provider to take

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

Regulated activity	Regulation
Maternity and midwifery services Treatment of disease, disorder or injury	<p>Regulation 17 HSCA (RA) Regulations 2014 Good governance</p> <p>Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 (Part 3).</p> <p>Regulation 17 (1) (a) (b): Good governance.</p> <p>The provider must:</p> <ul style="list-style-type: none">• Complete a comprehensive gap analysis against the recommendation made for the University Hospitals of Morecambe Bay NHS Foundation Trust.• Ensure that the maternity and gynaecology dashboard is fit for purpose, robust and open to scrutiny.