Gateshead Health NHS Foundation Trust

Quality Report

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This report describes our judgement of the quality of care at this trust. 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 trust	Good
Are services at this trust safe?	Good
Are services at this trust effective?	Good
Are services at this trust caring?	Outstanding
Are services at this trust responsive?	Good
Are services at this trust well-led?	Good

Summary of findings

Letter from the Chief Inspector of Hospitals

We inspected the trust from 29 September to 2 October 2015 and undertook an unannounced inspection on 23 October 2015. We carried out this comprehensive inspection as part of the CQC's comprehensive inspection programme.

We inspected the following core services:

- Emergency & Urgent Care
- Medical Care
- Critical Care
- Maternity & Gynaecology
- Services for Children and Young People
- End of Life Care
- Outpatients & Diagnostic Imaging

Overall, the trust was rated as good. Safety, effectiveness, responsive and well-led were rated as good. Caring was rated as outstanding.

Our key findings were as follows:

- The majority of areas inspected were clean: however, we did identify some infection control issues in the critical care unit and the waste disposal unit.
- Rates of infection were within an expected range for the size of the trust.
- Patients were able to access suitable nutrition and hydration, including special diets, and they reported that, overall, they were content with the quality and quantity of food.
- There were processes for using and monitoring evidence-based guidelines and standards to meet patients' care needs. Although policies and care pathways held electronically on the trust systems were in-date, some paper copies held in ECC and SCBU were out of date or had no review date.
- The trust promoted a positive incident reporting culture. Processes were in place for being open and honest when things went wrong and patients given an apology and explanation when incidents occurred.
- The trust was not meeting all its waiting time targets. The national target for two week cancer waiting times had not been met for a number of tumour sites for four consecutive quarters. This was identified by the trust as a governance concern.
- Systems and processes on some wards for the storage of medicine and the checking of resuscitation equipment did not comply with trust policy and guidance.
- Nurse staffing was maintained at safe levels in most areas. However, there were occasions on ward 23 where staff had asked for additional support to provide 'special' nursing care (individual attention) to meet the physical and mental health needs of patients and shifts had not been covered. The trust had a business case to increase staffing levels on ward 23 and had escalation processes when staffing fell below recommended levels.
- The trust had gaps in medical staffing because of national shortages in certain specialties. However, the trust was actively recruiting to these including international recruitment. This risk was further reduced by the use of advance nurse practitioners to support doctors.
- Safeguarding procedures were in place and staff could demonstrate an understanding of their role and what action to take if they were concerned about a person
- Feedback from patients and their relatives was very positive about the care they received and there were examples of some outstanding caring practice.
- Patient outcome measures showed the trust performed mostly within or better than national averages when compared against other hospitals. Death rates were within expected levels.
- Following an external review of governance processes, the trust was reviewing its service strategies to ensure that they remained achievable and relevant. The board had the experience, capacity and capability to ensure that the strategy was delivered.

Summary of findings

We saw several areas of outstanding practice including:

- A combined referral pathway document was being used by GP practices to refer into the trust's integrated diabetes service. It included advice and guidance for GPs, a specialist nursing helpline and multi-disciplinary clinical assessment. There were clear protocols to identify when a patient could be managed within primary or secondary care and when care transfer was appropriate and possible.
- The Rehabilitation after Critical Illness Team (RaCI) led by nurses, health care assistants and physiotherapists had developed new pathways to help patients recover from critical illness. The team provide rehabilitation while a patient was in the critical care unit, throughout their stay and following discharge.
- Therapy staff were part of the frailty model and worked in the emergency care centre to support elderly patients with mobility aids and discharge plans avoiding unnecessary admissions to hospital.
- Pathology services had achieved the national external quality assurance scheme (NEQAS) accreditation for cellular pathology and had been recognised as a national centre for excellence.
- Ward 23 was a 24 bedded acute ward providing specialist care to older people with physical and mental health illness (predominantly dementia care) in a dementia friendly therapeutic environment, respecting patients' dignity while also promoting their independence in preparation for discharge from hospital. A team of specialists who had both physical and mental health skills and knowledge cared for patients, their philosophy was to deliver holistic, timely care to patients and their carers.
- The design of the Emergency Care Centre was innovative and recognised by NHS England as a best practice model providing a single point of access for emergency care.

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

An action that a provider of a service MUST take relates to a breach of a regulation that is the subject of regulatory action by the Care Quality Commission. Actions that we say providers SHOULD take relate to improvements that should be made but where there is no breach of a regulation.

The trust **MUST**

- Ensure that a clean and appropriate environment is maintained throughout the critical care department and waste disposal unit for the prevention and control of infection, including the provision of appropriate personal protective clothing for staff working in the waste disposal unit.

The trust should

- Take action to meet the national 2-week cancer waiting time targets in all tumour sites.
- Ensure that staffing and skill mix is reviewed on ward 23 to take account of the dependency of patients and ensure that sufficient staff are in place, particularly where special one to one support is identified as being required.
- Ensure that processes are consistently followed in all areas for checking the storage of medicines particularly the recording of fridge temperatures and the signing and dating of medication entries.
- Ensure that SCBU moves towards introducing a National Early Warning Score chart.
- Ensure that there is a strategy for optimising patient outcomes from medicines in line with best practice guidance from the Royal Pharmaceutical Society that has Board approval and is reviewed regularly.
- Ensure processes are consistently followed particularly in SCBU and critical care for the checking of resuscitation equipment.
- Ensure where required, staff are up to date with Paediatric Immediate Life Support (PILS) and Advanced Paediatric Life Support (APLS) training.
- Review processes to reduce the number of clinic appointments cancelled.
- Continue to implement and strengthen governance processes in response to recommendations

Summary of findings

following an external independent review including strengthening the board assurance framework, clinical engagement and management of performance and risk.

- Review version control arrangements for the updating of paper copies of polices and care pathways held in clinical areas to ensure staff are using policies which are in date and reflect the latest best practice guidelines.
- Ensure cause for concern-safeguarding forms identify if a child is, or is not, subject to a child protection plan to enable swift and appropriate action.

Professor Sir Mike Richards
Chief Inspector of Hospitals

Summary of findings

Background to Gateshead Health NHS Foundation Trust

Gateshead Health NHS Foundation Trust was granted foundation trust status in January 2005. The trust provides the full range of acute hospital services at Queen Elizabeth Hospital. In addition, urgent and emergency services, medical care and outpatient services and diagnostics (where relevant) are provided at specific sites,including Dunston Hill Day Hospital, Bensham Hospital, QE Metro Riverside, Blaydon Primary Care Centre and Houghton Primary Care Centre. The trust is a tertiary centre for gynaecological oncology and a provider of specialist screening services, for breast, bowel and aorticaneurysm. The screening services are provided to the populations of South of Tyne, Northumberland, Humberside, Cumbria and Lancashire. The trust has 580 beds (538 general and acute, 30 maternity and 12 critical care) and employs 3,033 staff, of which 230.76 are medical, 880 nursing and 1,923 other.

In January 2015, the trust opened a new state of the art Emergency Care Centre (ECC) that provides a single point of entry for people who require medical, surgical or paediatric emergency care, short stay, frailty assessment and integrated diagnostic and support services. Walk-in centres for central Gateshead that transferred to the trust in 2014, are integrated into emergency services located in the new ECC.

The trust opened a new pathology laboratory in 2014, which processes non-urgent diagnostic pathology work for the whole of South of Tyne.

Our inspection team

Our inspection team was led by:

Chair: Robert Aitken, formerly a Non-Executive Director with the Whittington Hospital Trust Board

Head of Hospital Inspections: Amanda Stanford, Care Quality Commission

A team of 37 people including: CQC inspectors and a variety of specialists including: medical and surgical consultants, junior doctors, a paediatric doctor, senior managers, a paediatric nurse, nurses, midwives, a palliative care nurse specialist, a health visitor, and experts by experience who had experience of using 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 inspected the following eight core services at Queen Elizabeth Hospital:

- Urgent and emergency care
- Medical care (including older people's care)
- Surgery
- Critical care
- Maternity and Gynaecology
- Services for children and young people
- End of life care
- Outpatient and Diagnostic Services

We also inspected urgent and emergency care, end of life services, and outpatient services at the other sites the trust operated from including Dunston Hill Hospital,Blaydon Primary Care Centre and Bensham Hospital and ICAR (intermediate care) unit at Houghton-le-Spring.

Summary of findings

Prior to the announced inspection, we reviewed a range of information that we held and asked other organisations to share with us what they knew about the hospital. These included the clinical commissioning group (CCG), Monitor, NHS England, Health Education England (HEE), the General Medical Council (GMC), the Nursing and Midwifery Council (NMC), Royal Colleges, Overview and Scrutiny Committees and the local Healthwatch.

We held a listening event on 23 September 2015 in Gateshead to hear people's views about care and treatment received at the hospital. We used this information to help us decide what aspects of care and treatment to look at as part of the inspection.

We held focus groups and drop-in sessions with a range of staff in the hospital, including nurses and midwives, junior doctors, consultants, allied health professionals, including: physiotherapists; occupational therapists and administrative and support staff. We also spoke with staff individually as requested. We talked with patients and staff from all the ward areas and outpatient services. We observed how people were being cared for, talked with carers and/or family members, and reviewed patients' personal care and treatment records. We also held a focus group on 29 October 2015 for the Gateshead Jewish community.

We carried out the announced inspection visit from 29 September – 2 October 2015 and undertook an unannounced inspection on 23 October 2015.

What people who use the trust's services say

The results of the CQC Inpatient Survey 2014 showed the trust performed around the same as other trusts and in two areas, ('Operations and Procedures' and 'Leaving Hospital') the trust was amongst the better performing trusts.

The Cancer Patient Experience Survey 2013/2014 showed the trust was in the top 20% of trusts for 25 of the 34 indicators and the middle 60% of trusts for the other nine indicators.

Results from the CQC Maternity Service Survey 2015, showed the service scored better than other hospitals in two of the 19 questions about antenatal care, labour, birth and postnatal care, with the other areas scoring about the same as other hospitals.

The results of the CQC A&E Survey 2014 showed for 21 of the 24 caring indicators the trust was performing about the same as other trusts and performing better than other trusts in the other three.

The trust scored about the same as other trusts in 21 out of the 22 caring questions in the Children's Survey 2014, and better than other trusts for the remaining question about providing information when a child left hospital.

Results of the Patient-Led Assessments of the Environment (PLACE) 2014 showed that the trust scored, for cleanliness: 100, (the England average was 98) food: 87, (the England average was 90) privacy, dignity and wellbeing: 91, (the England average was 87) and for facilities: 94, (the England average was 92).

Between March 2014 and February 2015, the trust had higher recommendation percentages in the NHS Friends and Family Test than the national average for 11 out of 12 months.

The local Healthwatch reported that they were conducting a survey to gather evidence about people's experience going through the discharge process, but the themes coming out of engagement with local people about the trust's services were in the main positive.

Facts and data about this trust

The trust served 200,000 residents within Gateshead and its surrounding areas. During 2014/2015, the trust saw 30,047 inpatient admissions, 391,406 outpatient attendances, 106,617 accident and emergency attendances, 5,512 ambulatory care attendances and delivered 1,887 babies.

Summary of findings

Deprivation in the local area was significantly worse than the England average. The district was ranked 42nd out of 326 districts for deprivation. Life expectancy for the population of Gateshead was two years lower than the England average. Mortality rates for those under 75 due to cancer or cardiovascular disease was lower than the national average. The number of hospital stays due to alcohol related harm, and the number of smoking related deaths was significantly higher than the national average.

- The CQC intelligence monitoring report placed the trust at Band 6 since 2013, the lowest risk summary band.
- The CQC's intelligence monitoring report (May 2015) identified four risks and no elevated risks: in-hospital mortality for musculoskeletal conditions, hip and knee patient reported outcome measures (PROMS) and staff sickness rates.
- Between May 2014 and April 2015 there were two never events reported (an event so serious it should never happen) in maternity and outpatients.
- Between May 2014 and April 2015, the trust reported 64 serious incidents and 5,097 incidents, of which 97% were of low or no harm.
- In the same period, there was one case of Methicillin Resistant Staphylococcus Aureus infection and 33 cases of clostridium difficile.
- Between April 2013 and February 2015, there were 6,512 days delayed discharges of care. The top three reasons were: completion of assessment (27.3%); awaiting a nursing home placement or availability (24.7%); and awaiting a care package in own home (19.4%).
- The number of written complaints received had slightly increased from 234 in 2013/2014 to 245 in 2014/2015.
- The trust was performing within expectations in 24 of the 31 indicators of the 2014 NHS Staff Survey with five positive findings and two negative findings.
- The financial position (April 2014 – June 2015) showed:

  Trust Revenue - £263.697m

  Full Cost - £285.873m

  Surplus (deficit) – £8.485

Summary of findings

Our judgements about each of our five key questions

	Rating
Are services at this trust safe? We rated safety as good because: Nurse staffing was maintained at safe levels in most areas. However, there were occasions on ward 23 where staff had asked for additional support to provide 'special' nursing care (individual attention) to meet the physical and mental health needs of patients and shifts were not covered. The trust had a business case to increase staffing levels on ward 23 and had escalation processes when staffing fell below recommended levels. The trust had some gaps in medical staffing due to national shortages in certain specialties. However, the trust was actively recruiting to these including international recruitment and using advance nurse practitioners to support doctors. There were systems for incident reporting and staff received feedback and action taken to reduce the risk of reoccurrence. The requirements of Duty of Candour were followed and trust processes were open and transparent. The trust scored higher than the England average in the Patient Led Assessments of the Care Environment (PLACE), 2014 for cleanliness (Trust, 100 England average, 98) and for facilities (Trust, 94 England average, 92). Overall, the areas we inspected were clean and there were robust processes for the prevention and control of infection. However, we identified concerns regarding cleanliness and infection prevention in the critical care unit and the waste disposal unit. Checks for the storage of medicines and resuscitation equipment were not consistently completed in some areas. **Duty of Candour** • The trust had updated its Being Open policy, to comply with the new statutory requirements for Duty of Candour. The majority of staff were aware of the Duty of Candour and were clear about the trust processes for being open and transparent when things went wrong and patients were given an apology and explanation when near misses or incidents occurred. • Training was available to provide staff with a clear understanding of the Duty of Candour and to ensure that they	Good 

carried out the requirements appropriately. Training was included at induction, mandatory training and specific detailed sessions on Duty of Candour. The Trust Board had attended a training session.

- Monitoring of Duty of Candour was through the incident reporting system. Incidents for April 2014 – July 2015 showed of 148 incidents. Duty of Candour was completed in all cases with the exception of one case, as there was no relevant person (a person lawfully responsible for the patient following death).
- We reviewed six serious incident root cause analyses reports and saw examples of where the trust had informed the patient or relative of the harm and provided an apology.

Safeguarding

- The trust had combined the Adults and Children's Safeguarding Committee which was chaired by the Director of Nursing, Quality and Midwifery, and held on a bi-monthly basis. The purpose of the Committee was to ensure that national and local policy directives were included into the trust's safeguarding processes. The trust had a safeguarding policy for both children and adults. The children's safeguarding policy was updated in January 2015 and had a section specific to children who attended the emergency care centre. The adult safeguarding policy was updated in June 2015.
- The annual safeguarding work plan had recommendations from the CQC's multiagency review of health services for Looked After Children and Safeguarding in Gateshead, serious case reviews, the trust's Saville enquiry and actions required from the National Institute of Clinical Excellence guidance and Intercollegiate Document 2014. The Safeguarding Committee reviewed the work plans and annual safeguarding audit programme at each meeting to ensure ongoing progress.
- There was multi-agency working and trust representation on the Local Safeguarding Children's and Adult's Board and other sub-groups. For example, the named nurse provided relevant health information to the Missing, Sexually Exploited and Trafficked persons sub-group.
- The wards had safeguarding leads who had undertaken advanced investigation training. Staff demonstrated a good level of knowledge in relation to safeguarding triggers, forms of abuse and the processes followed. Matrons identified the level of staff competence when random safeguarding checks were completed. These checks included looking at records and talking to staff.
- There was appropriate action taken following completion of cause for concern forms, for example referrals to social care.

Forms were completed when the behaviour of an adult with parental responsibility presented a risk to a child. However, it was not clear from all the forms reviewed if staff had checked if a child was already the subject to a protection plan.

- There were effective processes for safeguarding mothers and babies. There was a dedicated midwife responsible for safeguarding who worked alongside the named nurse for safeguarding children.

Incidents

- The trust promoted a positive incident reporting culture. Between May 2014 and April 2015, the trust had reported 5,097 incidents, of which 97% were of low or no harm, and 64 serious incidents of which 23 were pressure ulcers Grade 3 or 4.
- Incidents reported equated to 9.1 per 100 admissions which was slightly lower (worse) than the national average of 9.4.
- The NHS Staff Survey 2014 demonstrated staff perception of fairness and effectiveness around incident reporting. Staff at all levels said they were actively encouraged to report incidents including grade one pressure ulcers. They were confident about reporting incidents, near misses and poor practices. Staff were able to describe recent incidents and the actions taken because of investigations to prevent recurrence.
- There had been two never events reported between May 2014 and April 2015, one in maternity and one in outpatients (both in June 2014). A root cause analysis (RCA) investigation was completed and learning and actions identified to reduce recurrence.
- Our review of six RCA investigations of serious incidents demonstrated comprehensive accounts of the root cause and contributory factors, a duty of candour where appropriate and there were detailed action plans.
- The trust's Serious Incident Panel or Pressure Damage Review Panel reviewed all serious incidents. The meetings took place fortnightly and chaired by the Medical Director or Director of Nursing. Staff from the business unit (or departmental team) who were involved in the incident, and where appropriate, the lead clinician, presented the incident details.
- The process of investigating RCA's and learning from experience was embedded within the organisation. The trust produced a complaints, litigation, incidents and PALS report (CLIPA report). The CLIPA reports were presented quarterly to the Patient, Quality, Risk and Safety (PQRS) Committee, Safe Care Council (the trust's governance structures) and six monthly to the Council of Governors. The Trust Board received a quarterly summarised report and quarterly update on serious incidents.

- The main themes in the CLIPA report included sharing lessons from incidents, such as actions to reduce the rate and level of harm because of patient falls and details on the trust falls work stream. The number of incidents of fractured neck of femur dropped from 32 in 2013/14 to 22 cases in 2014/15.
- The trust had a Mortality and Morbidity Steering Group, chaired by the Medical Director that set the strategic direction for corporate mortality and morbidity improvement work.The steering group reviewed and monitored mortality and morbidity across business units as part of the Safe Care Campaign. The trust's mortality reduction strategy focused on three areas for change recognised to be important to reducing in-hospital mortality: leadership; clinical care; and documentation and information.
- Reviews of deaths undertaken at a ward and departmental level showed improvement projects in areas such as: the appointment of a sepsis lead; education workshops; promoting the use of national screening tools; use of an electronic patient observation system; and the appointment of additional nurses to improve the care of respiratory patients.

Staffing

- The trust had systems and processes in line with the National Institute for Health and Care Excellence (NICE) and the National Quality Board to ensure nurse and midwifery staffing capacity and capability within the organisation was sufficient to deliver safe and effective care.
- The Trust Board received assurance on nurse staffing through a monthly report on workforce information, including the number of actual staff on duty during the previous month compared to the planned staffing level, the reason for any gaps and the actions being taken to address these.
- The trust utilised the Safer Nursing Care Tool, an acuity and dependency tool endorsed by NICE as part of its approach to reviewing staffing levels. This was first rolled out in the trust in April 2014 and further data collection had taken place in September 2014, April 2015 and November 2015. A number of medical wards had seen an increase in beds in 2014/15 and therefore further data collection was required to understand if the increase in staffing to support these areas met requirements.The trust identified that acuity and dependency of patients on wards 14, 11 and 23 required additional investment and this has resulted in an increase in establishments in these areas.
- The maternity service used an acuity tool to assess workload.The head of midwifery and managers reviewed

staffing levels and skills mix each month. There was a safe staffing and escalation protocol to follow should staffing levels by shift fall below the agreed roster. The service was innovative in managing workloads and could utilise staff flexibly, for example, using non-clinical midwives (including the Head of Midwifery and Matron) where necessary.

- The service met the national benchmark for midwifery staffing set out in the Royal College of Obstetricians and Gynaecologists guidance (Safer Childbirth: Minimum Standards for the Organisation and Delivery of Care in Labour) with a ratio of 1:28 across both community and hospital staff against the recommended 1:28.
- Where a ward dropped below recommended levels this triggered a red flag, and was reviewed by the duty matron. Staff moved around the trust to cover shortages in other areas to ensure all patients were safe. The trust had its own nurse bank to cover any shortages and they did not use any agency nurses.
- On most wards, nurse-staffing levels were as planned. On ward 23, there were gaps in some shifts, where staff had asked for additional support to provide 'special' nursing care (individual attention) to meet the physical and mental health needs of patients. This happened on 10 shifts between 18 and 23 October 2015. The trust was undertaking a business case to increase the staffing establishment of ward 23 to reflect this added staffing requirement. In the meantime, the ward used additional bank staff in excess of targeted staffing levels.This was reflected in the average fill rate for nursing assistants of approximately 175% for day shifts and 130% for night shifts based on the monthly average fill rates for the ward.
- Children's services met the Royal College of Nursing guidance in relation to paediatric nurse staffing levels.
- We reviewed the Nursing & Midwifery Staffing Exception reports for January, February, April and May 2015. The Board was advised of those wards where staffing capacity and capability frequently fell short of what was planned, the reasons why, any impact on quality and the actions taken to address gaps in staffing. In terms of exception reporting, the Board was informed if the safe planned staffing dropped below 75% or was above 125%. Overall, trust-staffing levels for January, February, April and May showed the number of registered nurses and non-registered care staff on most wards was met (fill rates were between 89% and 107%). In areas where a qualified nurse could not be sourced to cover a shift, a nursing assistant had filled this short-term gap in some areas.
- Daily bed meetings discussed staffing identifying any shortfalls, and a plan put in place to move staff from other areas.

- Actual staff on duty on a shift-to-shift basis compared to planned staffing was clearly displayed on the ward 'time to care' boards. These 'time to care' boards were located in an area visible to the public.
- The trust did not use agency staff, however they had their own nurse bank and their use of bank was lower than the England average at 2.7% compared to 6.1% (England average).
- Medical staffing skill mix was in line with the England average, with 40% of the total representing Consultant posts. The trust had a slightly lower percentage of middle grade doctors (4% compared to England average of 9%).The trust however had shortfalls in medical staffing particularly in emergency medicine and radiology, due to national shortages. Recruitment was ongoing and the trust had appointed an emergency medicine consultant.
- The neonatal service had 24-hour availability from a consultant paediatrician and 24-hour resident cover from an experienced specialist trainee with a minimum of four years specialist training.
- We viewed recent medical rotas. The trust had developed nursing roles to mitigate the risks of consultant vacancies, such as, the appointment of five emergency nurse practitioners in the Emergency Care Centre. These roles were developed to support doctors in the department.

Medicines

- The trust used a medication dispensing system in the ECC. This central pharmacy automation system was checked and replenished on a daily basis by pharmacy. It was connected to the trust IT system that ensured that every drug withdrawal was connected to a patient.
- We observed the dispensing of medication to a patient. There were appropriate checks to ensure patients received medicines safely, and as prescribed in the notes. The hospital used a comprehensive medication administration record for patients, for the safe administration of medicines. We reviewed five medication charts on medical wards, all of which were completed accurately. In children's services, however, we found three out of 11 prescription sheets where there was an omission in recording that vitamin drops had been administered.
- The trust had processes for staff to report medication errors and incidents through the electronic reporting system.
- There were areas where daily monitoring of maximum and minimum temperatures to ensure safe storage of medicines

were not taking place This meant staff would only be able to see the current temperature of the fridge and would not be aware if the temperature had been outside of the 2-8 degree range.
- In the ECC patient group directives were all within review dates however, paper copies in the department were older versions and the trust was addressing this.

Cleanliness, infection control and hygiene

- Arrangements were in place to manage and monitor the prevention and control of infection. Staff working in clinical areas had access to hand washing facilities and hand gel dispensers were in place.
- The trust scored higher than the England average in the Patient Led Assessments of the Care Environment (PLACE), 2014 for cleanliness (Trust, 100 England average 98).
- The trust reported one case of MRSA in January 2015 and 33 cases of C. Difficile, 16 of which had been identified as unavoidable. The trust also reported nine cases of MSSA between October 2014 and February 2015.
- During the unannounced visit, we attended the clinical waste disposal unit ('the compound') and found that anatomical waste was not stored in line with the trust's policy due to broken refrigeration, which was an infection risk. Staff working in this area were also not sufficiently protected because the quality of clothing and footwear was not offering the right level of protection for the conditions of the job.
- In critical care, checklists for the flushing of sinks and showers to avoid the build-up of waterborne bacteria were not consistently recorded, which indicated flushing had not occurred on a number of occasions. It was not clear how often patient cubicles had been cleaned as there was no recording of cleaning in 40% of shifts for one cubicle and 50% in another cubicle.Also, there was high level dust in these areas which meant cleaning was not being undertaken on a regular basis. In the kitchen area there was chipped laminate on cupboards and no dishwasher to wash patient cutlery and crockery. These areas had not been identified during audits, which showed 100% compliance.

Environment and equipment

- In all of the services, we found that there was adequate equipment to support the delivery of safe care.
- The trust scored higher than the England average in the Patient Led Assessments of the Care Environment (PLACE), 2014 for facilities (Trust, 94 England average, 92).

- We found access to cots and incubators in the two special care rooms was restricted as one side (the long side) of each cot was against the wall. This restricted access in an emergency. To mitigate this risk, staff transferred babies to the high dependency unit (HDU) (along the corridor in the same building) for resuscitation and stabilisation. Senior managers in the trust were aware of the space issue. Although the current compliment of cots in SCBU was 12, the median occupancy per day was eight. There was a plan to reduce the number of cots to eight on a permanent basis from April 2016, which would increase the amount of space on the unit. Babies were transferred in and out of the unit to maintain the capacity levels of the cots and staff followed the Neonatal Inter-Hospital Transfer policy if a baby required specialist intensive care.
- There were processes in place for the checking of resuscitation equipment. However, in Special Care Baby Unit (SCBU) and critical care unit resuscitation equipment checks were not consistently completed in line with policy.

Assessing and responding to patient risk

- The trust used the National Early Warning Score (NEWS) risk assessment system and had recently implemented a new electronic method for recording and monitoring NEWS scores. This allowed staff on the ward to electronically record observations, with trigger levels to generate alerts, which helped with the identification of acutely unwell patients.
- Midwifery staff identified women as high risk by using an early warning assessment tool known as the Maternal Early Warning System (MEWS) to assess their health and wellbeing. This assessment tool enabled staff to identify and respond with additional medical support if necessary. We reviewed nine records and saw all contained completed MEWS tools.
- The trust ensured compliance with the Five Steps to Safer Surgery through application of the World Health Organisation (WHO) surgical checklist. The WHO checklist audit showed note completion at 100%, sign in at 91%, time out at 99%, and sign out at 93%. We observed that theatre staff followed the 'Five Steps to Safer Surgery', and completed the World Health Organisation (WHO) checklist appropriately.
- Staff used a variety of different tools such as risk assessments for nutrition, alcohol consumption and pressure care. Stickers were used to identify patients at risk of developing pressure damage, ('Save our Skin') and falls, ('Fallen Stars'). We observed these in use during the inspection.

- The trust had implemented the Safety Thermometer and displayed information on the ward performance boards. All boards we observed were up to date. Staff told us that individual ward performance was regularly discussed at staff meetings. We saw evidence of discussion of safety thermometer results from minutes of staff meetings in medicine.
- The maternity service had started using the national maternity safety thermometer. This allowed the team to check on harm and record the proportion of mothers who had experienced harm-free care. A review of the maternity safety thermometer found mixed results. The results for combined harm free care between September 2014 and August 2015 showed between 62% and 92% of women received harm free care. The median value was 73%; this means that in average 27% of women had some harm during their care.
- A handover process to the wards was used known as SBAR. (This is used to describe patients' medical Situation, Background, Assessment and Recommendations). It enables staff to clarify what information should be communicated between members of the team and enhanced patient safety.

Major incident awareness and training

- The trust had a Business Continuity Management Response Plan, which had been effective from April 2015. There was also a Major Incident Plan, which could be accessed through the trust intranet. Plans provided clear command and control procedures and lines of responsibility.
- The clinical areas maintained service specific business continuity plans, which outlined how the business continuity was maintained in the event of disruption. We saw examples of these plans during the inspection.For example in Accident & Emergency there were protocols in place for dealing with patients suspected of having Ebola virus and equipment was clearly identified in the major incident store room.
- Major incident rehearsals were undertaken in the Accident & Emergency Department every two years.
- The trust and regional partners had escalation/resilience plans, which were used when situations required it. For example, when bed capacity was reduced the North East Escalation Plan (NEEP) was used.This graded one (normal) to four (severe pressure) on beds.

Are services at this trust effective?

Good

The trust used a wide range of data to monitor and measure clinical outcome information. This included clinical audit (local and national), external and internal information systems and service

specific improvement projects. This data was reported through local and corporate governance arrangements. Although electronic versions of policies and care pathways were in-date, some paper copies held in clinical areas were out of date or had no review date.

Patient outcome measures showed the trust performed mostly within or better than national averages when compared with other hospitals. Where outcomes were worse than the national average, the trust ensured measures were in place to make improvements. There was effective multidisciplinary working across and between clinical teams. The trust had a clear policy to provide guidance for obtaining consent from patients within the organisation including from those patients who lacked capacity to make their own decisions.

Evidence based care and treatment

- Policies and procedures for care and treatment were based on National Institute of Clinical Excellence (NICE), national and Royal College guidelines. These were accessible to staff across the trust, through the trust's intranet site.
- Staff were aware of the local policies and procedures and there were mechanisms to update policies as guidance changed. However, although electronic versions of policies and care pathways were in-date some paper copies held in clinical areas were out of date or had no review date.
- The trust had a system in place to audit its performance and participated in national clinical audit programmes. The Annual Safe Care Audit Plan 2015/16 specified a range of planned audits. According to the trust's Quality Accounts, there were 33 national clinical audits and five national confidential enquiries during 2014/2015, which covered relevant health services the trust provided The trust participated in 100% of national audits it was eligible to take part in compared with 94% in 2013/14 and 100% national confidential enquiries.
- The trust participated in the Sentinel Stroke National Audit programme (SSNAP) 2014/2015 so it could benchmark its practice and performance against best practice and other hospitals. The trust was rated as D overall, with the lowest score being E. The main areas of improvement were therapy staffing levels and discharge processes. The trust had an action plan in place to improve these services.
- In 2015, the critical care department received an award from the intensive care audit and research centre (ICNARC) for the most improved critical care department for data collection. We reviewed the data from ICNARC between January 2015 and March 2015 which showed the department was within

statistically acceptable limits for hospital mortality and within the limits for unplanned admission within 48 hours when compared to national and peer critical care department averages.
- Local auditing of practice took place across care treatments and staff practices, with action plans developed and any issues identified for improvement.
- The trust had achieved stage one accreditation in the United Nations Children's Fund (UNICEF) Baby Friendly Initiative.

Patient outcomes

- The level of mortality calculated using the standard Summary Hospital-level Mortality Indicator (SHMI) showed the trust to have death rates in line with expected levels. Using the HSMR standard (a risk-based assessment of 56 conditions, which account for 80% of deaths) the trust was below (better than) the national average of 100 deaths with 91.84. The trust reviewed mortality cases on an ongoing basis and held regular meetings with clinicians to identify issues.
- Surgical outcomes for patients were mostly within or better than the national average. Where outcomes were worse than the national average, the trust identified measures to make improvements.
- Performance in the National Diabetes Inpatient Audit (NaDIA) showed that out of the 20 indicators the trust was performing better than the England median in 12 and worse than the median in eight. The worst performing indicators were: visits by the specialist diabetes team; medication errors; prescription errors; admitted with foot disease; meals suitable; choice; and able to take control of diabetes care. We spoke with the medical core services team who were fully aware of these results and were rolling out specific training in the next few months.
- Two out of three non-ST-Segment-Elevation Myocardial Infarction (nSTEMI) indicators were better than the England average. For example, a cardiologist saw 96.4% of nSTEMI patients (compared to the national average of 94.3%) and 65.8% of patients were admitted to the cardiac unit compared with the England average of 55.6%.
- The Severe Sepsis and Septic Shock Survey showed the trust was in the top quartile (best) for eight of the 12 indicators and in the middle quartiles for the other four.
- The trust performed better than the England average for nine of the 10 clinical performance indicators in the National Care of the Dying Audit 2013/2014.

- Maternal outcomes were measured, and the proportion of delivery methods were in line or better than national expectations.
- Results from the CQC Children and Young People's Inpatient and Day Case Surgery Survey 2014 showed the trust performed better than other trusts in three of the five questions measuring the effectiveness of the service. Parents and carers of babies and children aged up to 15 said staff agreed a care plan with them, staff worked well together and all staff caring for and treating the child were aware of their medical history.
- Pathology services had achieved the national external quality assurance scheme (NEQAS) accreditation for cellular pathology and recognised as a national centre for excellence.
- The NHS Safety Thermometer results for venous thromboembolism (VTE) showed the trust was consistently meeting its target of 95% of admitted patients who received a VTE risk assessment.
- The trust wide average length of stay for non-elective admissions was better than the England average in all areas.

Competent staff

- In October 2015, the trust dashboard showed that 86.32% of staff had received an appraisal / personal development plan (PDP) and 100% of staff had received a corporate induction. Appraisal rates for nurses were just below the trust target of 90% at 83%.
- Student nurses told us a university educator supported them; they said they received good support from their ward-based mentors and received a good balance of practical skills and theoretical knowledge. The students we spoke with advised us of recent job offers and support with the preceptorship programme.
- Allied health professionals and support staff experienced support to participate in external training relevant to their role.
- The trust had revalidation processes in place for doctors.
- All midwives had a named supervisor of midwives.Staff said they had access to and support from a midwifery supervisor. The ratio of SOM to midwives was one to 12 which was in line with recommendations.The 2014/15 local supervisory authority (LSA) report identified that SOM's did not have protected time to undertake annual reviews with staff in a timely manner. This was addressed to give SOM's one day a month to undertake their supervisory role.

Nutrition and hydration

- Patients had their nutritional needs assessed, and patient weights were recorded on admission and weekly thereafter. We saw completed records and referrals to dieticians as required in medical and surgical services.
- Ward staff met with the catering department and nutrition link nurses to discuss patient feedback regarding choice and portion size. All patents we spoke with stated the food was good. Patients felt the choice and quality of food was satisfactory.
- There was a public health midwife with a strategic lead for infant nutrition; this role included training staff and breastfeeding peer supporters. When we inspected, there were 14 peer supporters providing breastfeeding support in the community and 12 ready to start training.

Multidisciplinary working

- There was good multidisciplinary (MDT) team working across and between clinical teams. There were well-established MDT meetings for all cancer pathways, orthopaedic care and vascular services.
- The nutrition team assessed complex nutrition needs using an MDT approach, which involved a Consultant Gastroenterologist, Nutrition Nurse, Senior Dietician, and Speech and Language Therapist. The team worked with all trusts across the North of England, performing regional audits with the Northern Nutrition Network. The Network had received national recognition for its shared working.
- In maternity services all necessary staff, including those in different teams and services, were involved in assessing, planning and delivering women's care and treatment. The service participated in regional and local multidisciplinary team networks in areas such as fetal medicine.
- There was effective MDT working in outpatients and diagnostic services. Specialty MDT meetings were attended by staff from 12 specialist clinical areas and the outpatients department including nurses, consultant leads and radiologists. In addition, medical staff requiring advice or support could contact a duty radiologist.
- There was evidence of good in-reach working from nurse specialists across clinical areas in the trust. For example, the Non-Invasive Ventilation nurse specialist fast tracked respiratory patients from ECC to an appropriate in-patient bed for treatment.

- Paediatricians worked with health services in the community to meet the needs of children and young people. For example, monthly multidisciplinary feeding clinics were held and included staff from speech and language therapy, dietetics and children's community nursing.

Seven-day services

- Consultant cover was available Monday to Friday on all the medical and care of elderly wards where daily ward rounds took place. After 8pm, there was a consultant on-call.
- An on-call physician along with an acute physician working out of the Emergency Care Centre provided seven-day cover on the EAU.
- The trust had implemented a 'physician of the day' initiative. Additionally the trust also had a matron in charge of the hospital site seven days per week working 8am – 8pm.
- There was a gastroenterology GI bleed service on call rota 365 days per year.
- An acute response team was based within the main hospital to provide 24/7 nursing support and overnight bed management.
- An obstetric theatre team was staffed and always available. A team was also on call out of hours. One consultant anaesthetist was allocated to the delivery suite Monday to Friday 8am to 6pm. In addition, a duty anaesthetist was available for maternity services 6pm to 8am.

Consent, Mental Capacity Act & Deprivation of Liberty safeguards

- Consent for surgical and other procedures was in place for adults and children. Staff received training in consent during their induction programme.
- In the Health Education North East 'Your School, Your Say Foundation Trainee Survey March 2015' report 100% of foundation doctors confirmed that they had never been required to obtain written consent without appropriate supervision for a procedure with which they were unfamiliar with.
- There were 12 Mental Capacity Act (MCA) champions in the trust and two members of staff had completed a MCA module run by Northumbria University.
- The trust had 66 Deprivation of Liberty (DoLs) applications between January and June 2015. Staff across the organisation had awareness of their roles and responsibilities to comply with the MCA and DoLs legislation.
- Records reviewed during the inspection showed that out of 39 'Do Not Attempt Cardiopulmonary Resuscitation' (DNACPR)

forms, 33 (89%) were fully completed. The Resuscitation Group audited DNACPR once a year. An audit in March 2015 to examine the documentation of discussions around DNACPR following the legal ruling 'Tracey's Judgment' (A legal duty for doctors to consult with and inform patients if they want a DNACPR) showed the majority of DNACPR decisions, discussions with patients/families were documented. However, the audit found that discussions could have been approached earlier in the patients' admission. The trust had taken action to train and educate junior doctors about how to discuss clinical deterioration with patients and families.

Are services at this trust caring?

Outstanding ☆

We rated caring as outstanding.

Feedback from patients and their relatives was continually positive about the care they received. Staff were highly motivated and inspired to offer care that was kind and promoted people's dignity. We observed patients being treated with dignity, respect and kindness during all interactions with staff. Patients felt supported and said staff cared about them. Staff responded compassionately when patients required support for their basic personal and emotional needs.

Patients were involved and encouraged to be involved in their care and in making decisions. They received sufficient information in a way they could understand.

Compassionate care

- The trust was in the top 20 per cent of trusts for 25 of the 34 indicators in the Cancer Patient Experience Survey 2014, and in the middle 60 per cent of trusts for the other nine indicators.
- Between March 2014 and February 2015, the trust had higher recommendation percentages in the NHS Friends and Family Test than the national average for 11 out of 12 months.
- Results from the CQC Children and Young People's Inpatient and Day Case Surgery Survey 2014 showed the trust scored the same as other trusts to questions about compassionate care. Parents and carers of babies and children aged up to seven years felt their child received privacy when receiving care and treatment and was well looked after. Staff were friendly, listened to parents and treated them with dignity and respect.

Summary of findings

- Results from the CQC Maternity Service Survey 2015, showed the service scored better than other hospitals in two of the 19 questions about antenatal care, labour, birth and postnatal care, with the other areas scoring about the same as other hospitals.
- A local patient survey of families whose babies received treatment in the special care baby unit showed 100% of parents surveyed found staff were friendly and approachable. They felt they received adequate information; their baby was well cared for; they were involved in decisions about their baby's care; had someone to talk to about their worries and fears and had their baby's treatment explained to them in way they understood.
- The trust had signed up to a new initiative welcoming carers with the launch of the carer's passport across wards. The inpatient wards displayed signage to welcome carers enabling them to attend outside visiting times and staff worked in partnership with them to help care for their relatives.
- Ward 23 was a 24 bedded acute ward providing specialist care to older people with physical and mental health illness (predominantly dementia care) in a dementia friendly therapeutic environment, respecting patients' dignity whilst also promoting their independence in preparation for discharge from hospital. A team of specialists who had both physical and mental health skills and knowledge cared for patients, their philosophy was to deliver holistic, timely care to patients and their carers. Patients identified with ongoing mental health needs and assessment, challenging behaviours, or with environmental risk factors on an acute older persons ward were identified as potential admissions on to Ward 23.

Understanding and involvement of patients and those close to them

- Results from the CQC Children and Young People's Inpatient and Day Case Surgery Survey 2014 showed the trust scored the same as other trusts to questions about understanding and involvement of children, young people and their families. The trust scored better than other trusts when parents were asked if a member of staff told them what would happen when their child left hospital.
- The In-patient Survey 2014 showed the trust was about the same as other trusts to questions about involvement in decisions about care, treatment, and obtaining answers about care in a way patients were able to understand.The trust scored better than other trusts to questions about receiving information for operations and procedures.

Summary of findings

- Parents attending children's services said staff understood the impact a condition and treatment had on their children. Staff constantly offered reassurances and support throughout the treatment process.
- Patients admitted for end of life care had the opportunity to discuss their wishes for their future with staff for example, resuscitation, preferred place of care at the end of life, decisions to refuse treatment and emergency health care plans.
- The End of Life team have worked together with another provider to introduce the research 'Family's Voice' Diary Multi-Centre Research Project. The diary improved communication between family and health professionals. Family members completed a diary, prompted by six questions about their relatives care. The diary provided 'real-time' information and healthcare professionals could offer support quickly if a family identified a concern. After an evaluation period, the trust planned to roll out the diary to other wards.
- The department had an initiative, rehabilitation after critical illness (RaCI). Care and support was given to the patient where families and patient diaries were used to support patients' recovery. Patients' relatives, nurses, doctors, completed these diaries plus physiotherapists and anyone involved in the patients care. Information helped patients understand their stay in the critical care department and to fill the gap in their memories of their time in hospital.

Emotional support

- The trust scored about the same as other trusts in the In-Patient Survey 2014 to questions about the emotional support they received from hospital staff during their stay.
- Access to spiritual guidance, religious and multi faith services were available. Staff recognised and respected patients' needs. For example, on the critical care unit staff received teaching sessions from the chief Rabbi about the beliefs of the Jewish faith community to organ donation, brainstem death, and withholding and withdrawing treatment.
- On ward 23, an activity co-ordinator provided support to patients, especially those living with dementia and memory loss. The post provided therapeutic care and support. Families we spoke with said the support was 'fantastic'. In addition, support was provided for patients' emotional, psychiatric, physical, social and cultural well-being with access to a senior clinical psychologist for specialist therapeutic interventions and management advice.

Summary of findings

Are services at this trust responsive?

Good

The trust was meeting most of the national waiting time targets; however, targets for two week cancer waiting times had not been met for four consecutive quarters. The percentage of cancelled outpatient clinic appointments was worse than the national average.

There were delayed discharges from the critical care unit because of bed pressures on the wards and some patients elective operations were cancelled because no critical care bed was available. These areas were on the risk register and action was being taken. The trust had approved additional critical care nurses and two extra beds were planned to open in December 2015; this would improve the position.

Services were planned around the needs of local people and there were good relations with local commissioners. Systems were in place for the management of complaints, and there was evidence of improvements following complaints.

Service planning and delivery to meet the needs of local people

- The trust worked closely with its commissioners on service re-design and the transformation agenda. Examples included: reducing admissions and avoidable re-admissions to hospital; integrated pathways for people with long term conditions based upon principles of single point of access; right place right time care; reducing duplication and improving outcomes for patients; multi–disciplinary assessment; GP education; supporting self-management;and signposting and health promotion.
- Involvement in the completion of the diabetes integrated service re-design showed an early best practice model of integrated working. There was a unified referral pathway and standardised documentation used by GP practices to refer into this tiered service. It included advice and guidance for GPs, a specialist nursing helpline and multi-disciplinary clinical assessment. Clear protocols were in place to identify when a patient could be managed within primary and/or secondary care and when care transfer was appropriate and/or possible.
- The trust was working with the local authority and commissioners to build on accessible services for the elderly population to meet their health and social care needs. Improvement work included: a single point of access nurse; intermediate care; improving planned discharge and assessment; care home initiatives and working with commissioners to become vanguard sites for new care models.

Summary of findings

- As part of the North East Urgent Care Network, the trust was involved in the Northern regional whole-system transformation vanguard for urgent care. The planned outcomes were to create and implement one urgent and emergency care model providing consistent care, wherever patients presented with no difference in the clinical outcomes delivered.
- The service worked in a multiagency partnership with other agencies to support young mothers for example the Family Nurse Partnership (FNP), the Clinical Commissioning Group (CCG) and the antenatal early help pathway for vulnerable young women. All partners worked together to improve education, care pathways and clinical outcomes for teenage parents.
- The trust had recently been part of a reorganisation of children and young people's services across the region following a three-year review led by NHS South of Tyne and Wear. The review looked at the changing pattern of childhood illness, hospital admissions and challenges linked with the current workforce to provide a safe level of cover across the configuration of services. The outcome of the review led to the development of the paediatric emergency assessment pod and short stay unit and the closure of the inpatient unit.

Meeting people's individual needs

- The adult safeguarding team included a full-time specialist nurse for people with learning disabilities, with additional support provided by a specialist nurse from a neighbouring trust.
- The trust's electronic system flagged vulnerable patients allowing early identification and reasonable adjustments for care and treatment prior to admission.
- A monthly report monitored the number of patients admitted with a learning disability and patients completed an exit survey. Wards and departments received themes and comments for improving patient care.
- The Disability Forum at the trust worked with stakeholders and provision of a shower facility in the emergency care centre was a direct result of responding to the needs of patients with learning disabilities. There was a picture menu and easy read information leaflets available on the wards.
- A range of nurse specialists worked within clinic settings on the wards and in the community.For example, patients diagnosed with cancer received support, symptom control and education

throughout the patient pathway and the respiratory nursing assisted discharge team who were an integral part of the acute hospital, provided a large percentage of care in the patients' home.

- The trust had a good relationship with the large Jewish Community in Gateshead and understood the cultural requirements in terms of meeting patient needs.For example, there was lay representation on the labour ward-planning forum and a community midwife attached to the Jewish community centre.
- The Rehabilitation after Critical Illness Team (RaCI) had led in developing new pathways to help patients recover from critical illness. The team provided rehabilitation while a patient was in the critical care unit, throughout their stay and following discharge. The team held monthly clinics at Bensham Hospital for discharged patients to allow them to discuss their journey and answer any concerns.
- The paediatric area of ECC had a play therapist as part of the team for some shifts. The play therapists supported children through distraction to facilitate medical treatment. There was also a 3D television, used as a distraction tool during treatment to reduce stress and anxiety for children and their families.
- Breast and bowel screening services offered a one-stop-shop approach to appointments where all investigations and consultations happened on the same day and patients left with a diagnosis and treatment plan.

Dementia

- The trust had a dementia strategy approved in March 2014. This agreed four strategic aims to improve the care of patients with dementia, their families and carers across hospital and community settings, and reflected the national direction of travel in dementia care. The four work streams reflecting the four strategic aims were: environment; education; nutrition; and compliance, each reporting bi-monthly into the steering group chaired by the Director of Nursing, Midwifery and Quality.The membership of the group also included a carer, acting as a patient voice and an advocate for other patients and families in the trust.
- Progress against the dementia commissioning for quality and innovation target (CQUIN) was being sustained, with the 'find, assess and investigate' element of the CQUIN routinely performing well in excess of the 90% target.The 'clinical leadership' and 'supporting carers of people with dementia' CQUIN indicators were also on course to be achieved this year.

- The dementia work stream for nutrition and dietetics introduced a number of improvements for patients including dementia friendly cutlery and crockery, picture and finger food menus and bedside information regarding nutrition.
- There were improvements to the environment for patients with dementia on ward 23, outpatients and in the emergency care centre, including appropriate flooring, signage and lighting.
- The trust was supporting 'John's campaign' a national campaign for the right of carers to stay with patients with dementia in hospital. Wards and departments were positively engaged in the campaign.

Access and flow

- The trust had not achieved its two-week cancer waiting time for some tumour sites for quarter two which represented a fourth consecutive fail of this indicator. Performance for breast symptomatic referrals was achieved. Service line managers were carrying out root cause analysis investigations to review the underperforming areas with weekly escalation meetings chaired by the Director of Strategy and Transformation.
- The percentage of clinic appointments cancelled by the trust was consistently high with an average over the previous four months of 11.5%, which was worse than the England average of 6%.
- A trust audit in November 2014 identified in the critical care department (CCD), that around 81% of patients had a delayed discharge over the recommended four hours and 31% of patients were delayed over 24 hours. The demand for critical care beds had increased which contributed to a rise in the number of cancellations of elective operations for patients requiring critical care beds post-operatively and in the number of out of hour discharges to the wards. A business plan for the expansion of CCD capacity was approved with extra nurses and two additional beds planned to open in December 2015.
- In September 2015, the trust achieved the 95% threshold for the 4 hour waiting time in A&E with performance of 95.03%. The performance achieved in July to September gives quarter two-performance rates of 95.9%.
- Data for September 2015 in achieving the 18-week referral to treatment standard showed that performance was achieved with a rate of 92.5% and for the quarter was achieved with 92.2% against a target of 92%. The specialities showing performance below the 92% threshold were cardiology, plastics and gastroenterology. Action plans and escalation meetings were in place.

- Between April and September 2015, there were 30 'black breaches' (number of patients with an ambulance handover to A&E over 60 minutes).
- The percentage of patients leaving A&E without being seen had followed the national average for the last two years. In March 2015, this increased to 8%, which was higher than the national target of 5%.
- The trust had a dedicated patient flow team with a 24-hour presence in the trust. The team consisted of a patient focused bed management team supported by a duty matron working 12 hours a day, seven days a week and offering clinical support. Overnight the bed management responsibility was with the acute response team. A senior manager on-call was also available 24/7 to respond to bed pressures. The team met three times a day to monitor the flow of patients in the trust, this role was led from EAU.
- Teams worked to ensure patients avoided multiple moves to other wards during an admission.We reviewed trust data, which identified 29% of inpatients, had one inpatient move between the period of April 2014 and June 2015. 15% of patients experienced two or more inpatient moves in the same period.
- There were 1,025 days delayed discharges trust-wide from April 2015 to July 2015; data showed the main reason for these was waiting for the provision of social care packages.

Learning from complaints and concerns

- For July 2014 to June 2015, the trust received 245 formal complaints, which was slightly higher than the previous year of 234. Of the 245 complaints, the trust upheld 36% of these. Staff graded complaints according to their urgency and severity. Six complaints were currently with the Health Service Ombudsman.
- The trust had a nominal internal timescale to deal with complaints within 25 working days; 24% of complaints met this target for this period.
- Data showed 109 complaints had taken one year to resolve, 79 complaints took 50 days and 78 were resolved in 100 days. Clinical treatment was the subject of more than half of complaints, followed by admission, discharge and transfers, communication and information.
- A CQC specialist advisor reviewed a selection of 20 closed formal complaints. All but two related to care and treatment. The Chief Executive had signed all final responses, which were

of a good standard. For all those relating to care and treatment, the patient or their relative had been offered a meeting to help to resolve the complaint. There was good evidence of keeping the patient or relative informed of progress.

- There was learning from complaints and lessons shared through the CLIPA report. Senior staff nurses used examples of real complaints during training to highlight the patient and family perspective during the care pathway.
- Information from governance and staff meetings showed sharing of information from complaints with learning and improvements to services. For example, the introduction of a cancellation letter in surgery; changing a red-flag notification system so consultants received further prompting of un-actioned red flag radiology results; changes to the assessment of aids to avoid delayed discharges and changes to prescribing to enable dieticians to add food supplements for patients without the need for a doctor's signature.

Are services at this trust well-led?

Good

There was a clear vision embedded across the organisation. Different levels of staff knew and understood the vision and goals. The trust had a Strategic Plan (2014-2015) that set out its strategic direction, however, following the recent appointment of the Director of Strategy, further work was continuing with an external consultant regarding strategy development. The service strategies were also under development and were due to be completed in October 2015.

The trust was strengthening its arrangements for the corporate oversight of risk. At the time of inspection, non-executive directors did not chair the assurance committees that formed part of the governance framework. An external governance review identified that this needed to be addressed and the trust were in the process of reviewing committee structures and chair arrangements.

Some staff groups expressed concern regarding the lack of meaningful data available to enable effective management of services. The Trust Board had recognised this and worked proactively to improve the quality of data including the investment in a live operational dashboard system that gives real time data to the operational managers and clinicians to support their decision-making.

There were reporting arrangements and governance systems up to the board. Financial pressures were managed so that they did not compromise the quality of care. The service was transparent, open and worked with all relevant stakeholders about performance. The

board and other levels of governance within the organisation interacted with each other appropriately although clinical engagement particularly in managing performance could be stronger.

Public and staff engagement took place and there was evidence of improvements to services using patient feedback. There was a strong focus on continuous learning and improvement at all levels of the organisation. The trust had developed a number of innovative practices to improve the quality of patient care.

Vision and strategy

- There was a clear vision in the organisation, which focused on the patient and the quality and safety of care. The trust vision was displayed in staff areas and teams had worked together to agree local plans for patient care and provide the best service possible. The trust had held a recent senior staff conference in September 2015 to review the vision and values of the trust. The vision and values focussed on the delivery of services that put the patient 'at the heart'.
- The Executive team and Non-Executive Directors including the chairman gave a well-articulated and consistent story about the vision and values of the trust and the strategic direction of the organisation, including the need to look beyond the trust and work with other external stakeholders to ensure financial and clinical sustainability.
- The trust had a Strategic Plan (2014 – 2019) in place that set out the strategic direction however, following the recent appointment of the Director of Strategy, further work was ongoing with an external consultant regarding strategy development. The service strategies were also under development to feed into a three year clinical services strategy, supported by corporate priorities, and these were due to be completed in October 2015. The plans at a specialty level included, service redesign and quality improvement, clinical and financial sustainability, ensuring care in the right place, effective patient flow and best use of resources.
- The trust had a 'Safe Care Strategy' 2014 – 2017, which combined quality and risk management into a single strategic document.
- The trust had a Nursing Strategy, which had four key domains, patient safety, workforce, experience and clinical care.
- The trust had a 'Mortality Reduction Strategy' 2013 -2016 that focussed on the delivery of safe care through provision of robust assessment, handover processes and seven-day services.

Summary of findings

- The trust was part of the Urgent and Emergency Care Vanguard programme in the North East.

Governance, risk management and quality measurement

- In January 2015, the trust commissioned an external independent review of its governance arrangements. The current Board Assurance Framework (BAF) presented corporate and strategic risks in a single document; this was raised as a concern in the independent review. Changes to the design and content of the BAF were undertaken as part of the actions required following the recommendations from the independent review. The Trust Board currently reviewed the BAF twice a year.
- The trust discussed and approved changes to the BAF format at the Trust Board timeout on 15 September 2015. This included reducing the previous 80 risks to only significant risks and strengthening arrangements for the corporate oversight of risk. At the time of the inspection, Non-Executive Directors did not chair the assurance committees that formed part of the trust governance framework. The external review identified this as needing to be addressed and the trust were in the process of reviewing the committee structure and chair arrangements.
- The trust used the term 'Safe Care' to describe its clinical governance programme. Business units submitted a Safe Care Annual Plan to the Safe Care Council who monitored progress against six quality indicators. Areas of significant risk were referred to the PQRS Committee through the Director of Nursing, Midwifery and Quality. The key priorities for quality improvement in 2015/16 were linked to patient safety, effectiveness of care and patient experience.
- The divisions had SaferCare Leads attached to them to provide support and challenge regarding the quality agenda.
- Divisions had risk registers and processes in place to ensure that risks were reviewed and mitigated, for example in surgery the risk register for the business unit was updated frequently, with high risks reviewed with input from medical staff, ward staff, and senior management. The associate director met monthly with matrons, service line managers, and the risk manager to review incidents, which had occurred, and any wider risks were identified.
- The trust had a risk management policy, which set out how clinical and non-clinical risks were managed at an operational level. A number of associated policies underpinned the overarching Risk Management Policy and this included the trust Incident Reporting and Investigation Policy. There was a clear

process for risks to be escalated to the Patient Quality, Risk and Safety Committee. Responsibility for risk was delegated to three assurance committees, finance, human resources and the patient, quality, risk and safety committees.

- The maternity risk management strategy set out clear guidance for the reporting and monitoring of risk. It detailed the roles and responsibilities of staff at all levels to ensure that poor-quality care was reported and improved.
- The trust's Care Quality Accreditation Programme measured ward and departmental progress against four domains (clinical care, patient safety, workforce and patient experience). The programme recognised, and rewarded the provision of excellence as a standard.
- Following discussions with the chief pharmacist the trust did not have a strategy for optimising patient outcomes from medicines that had Board approval and was reviewed regularly.This was not in line with best practice guidance from the Royal Pharmaceutical Society.
- Maternity services were compliant with the majority of the recommendations of the Kirkup Report. A gap analysis was completed and actions documented and presented to the Trust Board.
- The trust were forecasting a £7.5million deficit for the financial year 2015 –2016. There was a cost improvement programme in place. The Medical Director and Director of Nursing were responsible for ensuring cost improvement schemes were assessed for impact on quality. Examples were provided where schemes had been rejected due to the potential impact on quality.
- There was a performance management framework in place with divisional management teams being held to account through a formal performance-monitoring contract, which was being developed, to focus on finance, quality, workforce and performance. Divisions were held to account at 'board to board' meetings between the divisional management team and the executive directors.This was being strengthened through monthly performance review meetings. Service Line reporting was being developed.
- Some staff groups expressed concern regarding the lack of meaningful data available to enable effective management of services. The Trust Board had recognised this and worked proactively to improve the quality of data. This included the investment in a live operational dashboard system that gives real time data to the operational managers and clinicians to support their decision-making.

- We were told that although business cases are submitted to the Trust Board for approval they were not always shared across services to assess impact.
- The external review identified the lack of challenge at board level although this was not felt to be the case by the majority of the executive and non-executive directors.
- A patient story was routinely presented to the Board and assurance sought to ensure that any issues identified had been addressed.
- The trust was part of the 'Sign up to Safety' campaign that set out five pledges focussed on the delivery of safe care to people using the services.

Leadership of the trust

- The Trust Board currently had seven Non-Executive Directors (including the Chairman) with one vacancy and six Executive Directors (including the Chief Executive). Three additional Associate Directors also supported the Board in its work.
- Each of the three business units had managerial and clinical leadership. Clinical leaders were receptive to change, however, clinical engagement particularly in managing performance could be stronger.
- The Council of Governors expressed a strong commitment and enthusiasm about the trust. This included 16 public governors and 1 patient governor elected by members of the trust. Hospital staff elected six staff governors. Nine nominated representatives from partner organisations joined them.
- Governors were consulted on various trust operational and strategic plans, including financial, clinical and quality performance measures. Governors had specific responsibilities to the appointment and remuneration of the Chairman and Non-Executive Directors and the holding to account of Non-Executive Directors individually and collectively for the performance of the Board of Directors.
- Governors said they visited ward areas to listen to patient and staff concerns and were encouraged to give feedback to the Board about quality of patient care and felt this was taken seriously and acted on by the Board.
- The trust had a Leadership Strategy 2013 – 2016, whichset out behaviours, a pathway for leadership and training to support leadership with an implementation plan. We saw examples of leadership training. The associate director, service line managers, clinical leads and matrons in the Surgical Business

Unit had completed a range of leadership qualifications which included the NHS North East Leadership Academy (NELA) courses which involved sharing information and learning with colleagues from other trusts.

- The Executive Director of Strategy and Transformation had human resources within their portfolio. The Deputy Director of HR and the CEO had regular 1:1 meetings, which provided professional advice and oversight of business.
- The trust used values based recruitment.
- The trust made a commitment to achieve the highest level of Investor in People accreditation. A six-day assessment took place; which included staff interviews in which assessors gathered the views of staff on how they applied the trust's vision and values; the quality of leadership and management; staff involvement and recognition; learning and development and how investment in people contributed to the overall performance of the organisation. The trust achieved gold status. The trust continues to network with other gold award holders through the Champion network and provides other trusts and organisations with information, advice and guidance to improve their own people practices.

Culture within the trust

- There was a culture of being open, honest, and learning from mistakes in the trust.
- The chief executive (CEO) said they carried out walkabouts, attended the corporate induction day and spend 'back to floor' days in clinical areas. The CEO personally conducted CEO roadshows and the executive team including non-executive directors (NEDs) participated in a programme of visits to clinical areas. Some NEDs felt that they could be more visible in the organisation. The majority of staff knew who the executive team were.
- Staff were proud to work for the trust and felt supported to work at the organisation; staff described leadership at a local level as good.
- Sickness levels during quarter two (July - September 2015) were 4.44%.This was above the trust target of 3.4% however this was the strongest quarterly result since 2013. The current sickness absence policy was under review and Health & Wellbeing meetings were in place to enable closer working with the business units to understand factors contributing to sickness absence. The trust had developed an ergonomics team in response to the high numbers of back problems reported in the sickness absence data.

Summary of findings

Fit and Proper Persons

- The trust was prepared to meet the Fit and Proper Persons Requirement (FPPR) (Regulation 5 of the Health and Social Care Act (Regulated Activities) Regulations 2014). This regulation ensures that directors of NHS providers are fit and proper to carry out this important role.
- Directors completed an annual fit and proper person declaration; this was presented to the Trust Board.
- We reviewed the personal files of the Executive Directors and found that records showed that there were assurance processes in place. Employment contracts for Executive Directors and Service Agreements for Non-Executive Directors reflected the regulations. Pre-employment checks, declarations of fitness to continue and appraisals were completed.

Public engagement

- The trust participated in the 'Think Safe' Project, a programme involving patients and their carers in improving patient safety. This was well-developed in orthopaedics through the use of patient-held 'Healthcare Logbooks' that contained tools to help patients and staff share information at key times in their care to discuss their treatment, queries and concerns with a member of staff.
- The trust developed a 'live' patient feedback survey in partnership with patients to gather information on what patients believed were important areas of care. Each question asked three key areas (communication, care and compassion). Results for 2014/2015 showed the overall average score across specialties was 5.91 with six being the highest.
- The trust participated in the Institute for Innovation and Improvement 15 steps challenge, a toolkit to look at hospital care through the eyes of patients. The team consisted of one non-executive director of the Trust Board, one member of non-clinical staff and a patient representative. The team made 34 visits between April 2014 and March 2015 and covered a range of areas including inpatient wards, day case areas, outpatient clinics, children's services, maternity services and mental health wards. Improvements included a board identifying who wears which uniforms and new colour coded signage.
- During the planning and development of the paediatric emergency assessment unit, the Youth Council were involved in designing a suitable environment to meet the needs of children

of all ages. A public consultation took place before the change in the pathway for children, and members of the public who wanted to understand the changes in the provision of service attended this.
- There were good links with the board of governors at the trust who provided public engagement and input into developments.
- Maternity services had lay representation on the labour ward planning forum and identified a community midwife attached to the Jewish community Children's Centre.
- The Council of Governors held 'surgeries' in Gateshead to allow the public to drop in and share information regarding the services provided by the trust.

Staff engagement

- The 2014 NHS Staff Survey indicated only two out of 31 indicators scored worse than the national average and there were five positive findings. The two negative findings were the percentage of staff able to contribute towards improvements at work and staff motivation at work. The overall staff engagement score was 3.72, and this was similar to other trusts nationally at 3.75. The National Staff Survey of 2014 showed the overall staff engagement score was in line with the national average.
- In 2015 the trust were finalists in the Nursing Times awards for improving staff experience with the roll out of the ENERGI programme of improvement and staff engagement. The ENERGI programme is 'Excellence in Nursing Everyone Realising Great Innovations' and through a structured approach improves the culture, quality and productivity in wards. This programme was being introduced across the trust and shared with others.
- The trust had a programme of visits for Non-Executive Directors to the clinical areas.

Innovation, improvement and sustainability

- The Pathology Centre of Excellence opened in July 2015. The new centre provided diagnostic and screening services. The service processed up to 10,000 samples every day using up to 7,000 different processes. An example of the standard achieved was that 94.35% of histopathology samples were processed and results provided within one week and 99.95% within two weeks.
- The design of the Emergency Care Centre (ECC) was innovative providing a single point of access. NHS England had recognised this as a best practice model in design.

Summary of findings

- The ECC was in the top three of the CHKS Top Hospital Awards for Accident and Emergency, which recognised the consistent delivery of A&E performance targets.
- The ECC used a wireless communication system, to communicate with each other. Staff could call and speak to clinical and nursing staff across the department, including ambulatory care. Staff used the system to give regular updates to the shift co-ordinator about patients in order for them to manage access and flow through the department.
- There was a clinical skills centre which provided multi-professional clinical education in a state of the art facility. This included a three bedded ward area and a fully equipped simulation room providing a wide range of simulation training and technical support.
- There had been a recent introduction of a virtual trauma clinic, where staff contacted patients by telephone to inform them if they would need to attend a clinic or not. The team aimed to improve the service for patients as well as reduce the number of those who did not attend their appointments.
- Therapy staff were part of the integrated frailty model and worked in the emergency care centre to support elderly patients with mobility aids and discharge plans avoiding unnecessary admissions to hospital.
- The ECC had developed a care pathway to promote early treatment for neutropenic sepsis (a condition in which the numbers of white blood cells (called neutrophils) in the blood to help the body to fight infection, are low). Nurses received training to prescribe and administer first dose antibiotics to improve the time to initial treatment and improve patient outcomes.
- The trust had developed a Recovery Programme in terms of financial sustainability. There were no breaches with Monitor.

Overview of ratings

Our ratings for Queen Elizabeth Hospital

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

Our ratings for Gateshead Health NHS Foundation Trust

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

Notes

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

Outstanding practice and areas for improvement

Outstanding practice

- A unified referral pathway and standardised documentation was being used by GP practices to refer into the diabetes-integrated service. It included advice and guidance for GPs, a specialist nursing helpline and multi-disciplinary clinical assessment. Clear protocols were in place to identify when a patient could be managed within primary and/or secondary care and when care transfer was appropriate and/or possible.
- The Rehabilitation after Critical Illness Team (RaCI) led by nurses, health care assistants and physiotherapists have developed new pathways to help patients recover from critical illness. The team provide rehabilitation while a patient is in the critical care unit, throughout their stay and following discharge.
- Therapy staff were part of the frailty model of care and worked in the emergency care centre to support elderly patients with mobility aids and discharge so avoiding unnecessary admissions to hospital.
- Pathology services had achieved the national external quality assurance scheme (NEQAS) accreditation for cellular pathology and were recognised as a national centre for excellence.
- Ward 23 was a 24 bedded acute ward providing specialist care to older people with physical and mental health illness (predominantly dementia care) in a dementia friendly therapeutic environment, respecting patients' dignity while also promoting their independence in preparation for discharge from hospital. A team of specialists who had both physical and mental health skills and knowledge cared for patients, and their philosophy was to deliver holistic, timely care to patients and their carers.
- The design of the Emergency Care Centre was innovative and recognised by NHS England as a best practice model providing a single point of access for emergency care.

Areas for improvement

Action the trust MUST take to improve

Please refer to the location reports for details of areas where the trust SHOULD make improvements.

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
Treatment of disease, disorder or injury	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment Ensure that a clean and appropriate environment is maintained throughout the critical care department and waste disposal unit for the prevention and control of infection; including the provision of appropriate personal protective clothing for staff working in the waste disposal unit. HSCA 2008 (Regulated Activities) Regulations 2014, Regulation 12, (2) (h)