County Durham and Darlington NHS Foundation Trust

Darlington Memorial Hospital

Quality Report

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

Ratings

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

Summary of findings

Letter from the Chief Inspector of Hospitals

Darlington Memorial was one of two acute hospitals forming County Durham and Darlington NHS Foundation Trust. This trust was one of the largest hospital and community healthcare providers in the NHS. It served around 600,000 people across County Durham, Darlington, North Yorkshire, the Tees Valley and South Tyneside services including health and wellbeing services, community based services and acute and planned hospital services.

In total, the trust had 1,331 beds across two acute hospitals and the community, and employed around 7555 staff. Darlington Memorial Hospital had 410 beds.

Darlington Memorial Hospital provided medical, surgical, critical care and maternity services, and services for children and young people, for people in County Durham, Darlington, North Yorkshire, the Tees Valley and South Tyneside. The hospital also provided emergency and urgent care (A&E) and outpatient services.

We inspected Darlington Memorial Hospital as part of the comprehensive inspection of County Durham and Darlington NHS Foundation Trust, which included this hospital, University Hospital of North Durham and the trust's community services. We inspected Darlington Memorial Hospital on 5 and 6 February 2015.

Overall, we rated Darlington Memorial as 'requires improvement'. We rated it 'good' for being caring, effective and responsive, but it required improvement in providing safe and well-led care.

We rated medical care, surgical services, critical care, services for children and young people, maternity and gynaecology, and outpatient and diagnostic imaging services as 'good', with A&E, and end of life care as 'requires improvement'.

Our key findings were as follows:

- Arrangements were in place to manage and monitor the prevention and control of infection, with a dedicated team to support staff and ensure policies and procedures were implemented. We found that all areas we visited were clean. Rates of Methicillin-resistant staphylococcus aureus (MRSA) and Clostridium difficile (C. difficile) were within an acceptable range for the size of the trust.
- Patients were able to access suitable nutrition and hydration, including special diets, and they reported that, on the whole, they were content with the quality and quantity of food.
- There were processes for implementing and monitoring the use of evidence-based guidelines and standards to meet patients' care needs.
- There was effective communication and collaboration between multidisciplinary teams.
- There were staff shortages, particularly on some medical wards, mainly due to vacancies for nursing and medical staff. The trust was actively recruiting following a review of nursing establishments. In the meantime, bank, agency and locum staff were being used to fill any deficits in staff numbers, and staff were working flexibly, including working overtime.
- Mortality rates were within acceptable limits for a hospital of this size.

There were areas of poor practice where the trust needs to make improvements.

Importantly, the trust must:

- Review the achievements and actions taken to address the targets set nationally within A&E.
- Review consultant levels against CEM guidance.
- Ensure that the A&E department meets cleanliness, infection control and hygiene standards, particularly relating to high and low level dust, blood stains, equipment and floors.
- Ensure that the area outside the accident and emergency decontamination facility is free from dirt, litter and debris.
- Be able to demonstrate that all toys are cleaned properly to reduce the risk of infection within the A&E department.

Summary of findings

- Ensure that staff regularly check all resuscitation drugs and equipment within the A&E department.
- Ensure medicine fridges are locked and temperatures are checked regularly within the A&E department; this will include recording maximum and minimum fridge temperatures.
- Ensure that medical gases are stored in a secure facility within the A&E department.
- Ensure that there are sufficient numbers of suitably skilled, qualified and experienced staff on medical wards, in line with best practice and national guidance; taking into account patients' dependency levels, particularly where patients are receiving non-invasive ventilation (NIV) and require Level 2 intervention. Also, ensure that actual staffing levels meet planned staffing levels.
- Ensure that patients are placed on the most appropriate ward to meet their needs, including a review of the care of patients requiring NIV to ensure that they are admitted to a suitable ward with appropriately skilled and experienced staff, in line with best practice guidance.
- Ensure that patient records, including those for patients awaiting discharge, are maintained and up to date, are patient-centred, contain the relevant information about their treatment and care, and serve to eliminate unnecessary delays.
- Ensure that staff are conversant with the syringe driver policy and carrying out/recording syringe driver checks in line with this policy.
- Add audits of syringe driver administration safety checks to the annual end of life audit programme.
- Ensure that medical staff record mental capacity assessments for patients who are unable to participate in decisions about do not attempt cardiopulmonary resuscitation (DNACPR).
- Ensure that audits of mental capacity assessments are incorporated into audits of DNACPR forms.
- Ensure robust implementation of structural changes to the specialist palliative care team to support the development of the end of life care services.
- Ensure that data is available to identify and demonstrate the effectiveness of the end of life service.

In addition the trust should:

- Continue to review College of Emergency Medicine (CEM) audit data to ensure patient outcomes are met.
- Direct medical staff to check resuscitation equipment and drugs before the start of their shift even when nursing staff have completed the checks within the A&E department.
- Extend its safeguarding assessment processes and consider child sexual exploitation for all age appropriate children.
- Encourage all relevant staff within the A&E department to attend violence and aggression training.
- Ensure that patients have their medicines reconciled in accordance with trust targets.
- Review access to patient information in languages other than English.
- Review dedicated management time allocated to ward managers.
- Review the patient flow of higher dependency patients through the hospital to ensure care is given in the most appropriate setting.
- Consider ways of improving engagement between staff and managers within the care closer to home directorate, with a view to achieving a joined up approach within maternity and gynaecology services. Also, consider ways of improving responsiveness and efficiency in respect to service level decisions within this service.
- Consider ways in which it can identify the required standards within the maternity service dashboard.
- Consider timelines for review and achievement within the maternity and gynaecology services clinical and quality strategy for 2014–16 .
- Consider ways of developing a coherent plan for joint working on improvements to maternity and gynaecology services.
- Consider ways for improving timely and responsive human resource management processes, including personnel issues that affect service delivery in maternity and gynaecology services.
- Ensure that the paediatric high dependency room has specific standard operating procedures or protocols available to guide the suitably trained staff required to deliver high dependency care.

Summary of findings

- Ensure that advanced paediatric nurse practitioners have a set of standard operating procedures available to guide their practice and care.
- Formally nominate an executive or non-executive director to represent children at board level. This should be separate from the safeguarding children executive lead role.
- Review access and security arrangements to theatres and recovery areas.
- Review the servicing of all equipment within the theatre and recovery areas to ensure maintenance and service arrangements are within required timescales.
- Improve the systems in place to remove out of date stock or stock no longer used from store cupboards in the outpatient department.
- Ensure that actions against the 'National care of the dying' audit and other identified actions to develop the service are carried out in a planned and timely way with continued evaluation.
- Ensure that systems support ways of identifying when incidents and complaints relate to end of life care so that specialist input can be provided and recorded in terms of investigation and learning.

Professor Sir Mike Richards
Chief Inspector of Hospitals

Summary of findings

Our judgements about each of the main services

Service	Rating	Why have we given this rating?
Urgent and emergency services	Requires improvement 	Overall, emergency and urgent care services at this hospital required improvement. Some areas of the department were not visibly clean and we found high and low level dust around the department. We found resuscitation equipment and fridge temperatures were not checked regularly and some types of medication were not stored securely. There were appropriate nurse staffing numbers but consultant numbers were lower than the recommended level. Systems were in place for investigating incidents, learning the lessons of those incidents and communicating those lessons to staff. A programme of mandatory training was in place and managers were working towards training targets. Policy and protocols were underpinned by national guidelines but the department did not meet several patient outcome targets. The trust had a clinical audit programme and categorised its centrally coordinated clinical audit activity according to priorities. We saw evidence that further clinical audits had been carried out and the results and actions were awaited. There were good arrangements in place for patients to obtain food and drinks. There was a rolling programme of regular training and appraisal for staff. Multidisciplinary team arrangements were in place. Between October 2013 and October 2014, the department did not meet national targets. It did not meet the standard of admitting, transferring or discharging 95% of patients within 4 hours. The trust also had a higher than England percentage average for patients waiting 4–12 hours in the department from the decision to admit until being admitted into an inpatient bed. In addition, the standard that 95% of ambulance patients should be handed over within 15 minutes of arrival was not met. It was evident that staff understood that access and flow was a top priority and they worked well together to try to comply with national standards. Systems were in place for investigating complaints, learning the lessons of those complaints and communicating lessons to staff.

Summary of findings

Patients received a caring service in the department. We observed respectful and courteous interactions with patients that showed patients were treated well and with compassion.
There was clear management structure in the department and senior managers worked closely together to meet strategic objectives, monitor and improve care. Regular governance and information-sharing meetings were held and staff told us they felt empowered to take responsibility for issues. We found a number of risks in the department and found no evidence that they had been effectively mitigated. Staff were focused on giving patients a positive experience.

Medical care

Good

We rated medical care at this hospital as good. However safety required improvement. Medical staffing was made up of a higher proportion of junior doctors and was higher than the England average. The proportion of consultants, middle career and registrars were all lower than the England averages. The trust was working towards compliance with the National Institute for Health and Care Excellence (NICE) draft guidance for safe nurse staffing. Nurse staffing establishments were determined using the Safer Nursing Care Tool (SNCT), however, actual staffing numbers on duty were sometimes below the planned level. We were particularly concerned about the staff to patient ratios for patients requiring non-invasive ventilation (NIV) who were being nursed in general ward areas.
Wards were visibly clean and cleaning schedules were in place. A recent patient-led assessment of the care environment (PLACE) rated the hospital as achieving over 90% compliance in all of the four areas of: cleanliness, food, privacy/dignity and wellbeing as well as condition/appearance and maintenance.
Systems were in place to report incidents and wards monitored safety and 'harm-free' care. Results were positive, overall, and were prominently displayed at the entrance to wards for staff, patients and visitors to view. Planned and actual nurse staffing levels were also clearly displayed.
Patients were happy with the care they received and found the service to be caring and compassionate. Most patients and relatives spoke

Summary of findings

very highly of staff and told us that they, or their relatives, had been treated with dignity and respect. It was reported that patients felt safe and relatives said that their loved ones were well cared for. Nutrition, hydration and comfort needs were met. Ward 44 had recently been awarded the "Quality Mark for Elder-Friendly Hospital Wards".
The trust had consistently achieved its referral-to-treatment times (RTT) for all care groupings with the exception of gastroenterology. RTT were better than the England average. The trust had consistently achieved their performance targets for national cancer waiting times.
Clear governance structures were in place to facilitate analysis of information from incidents and complaints, identify themes and ensure communication from ward to board. Key messages from incidents and complaints were communicated across the trust via staff meetings, training and newsletters.
There had been a number of developments made and there were projects ongoing to improve services, outcomes and patient experience. Most staff were clear about the vision

Surgery

Good

Overall, surgical services at this hospital were good.
We saw effective arrangements in place for reporting patient and staff incidents and allegations of abuse, which was in line with national guidance. Staff were encouraged to report incidents and most received feedback on what had happened as a result.
Staffing establishments and skill mix had been reviewed to maintain optimum staffing levels during shifts. Effective handovers took place between staff to ensure continuity and safety of care.
There were arrangements in place for the prevention and control of infection and the management of medicines, but we saw that not all equipment had been serviced within required timescales and issues were identified with the kitchen on the theatre corridor.
Care records were completed accurately and clearly and in line with patients' needs.
There were processes in place for implementing and monitoring the use of evidence based

guidelines and standards to meet patients' care needs. Surgical services participated in national clinical audits and reviews to improve patient outcomes and had developed a number of local audits.
Processes were in place to identify the learning needs of staff and opportunities for professional development. There was effective communication and collaboration between multidisciplinary teams. There were kind and caring interactions on the wards and between staff and patients. Patients spoke positively about the standard of care they had received. All patients we spoke with felt they understood their care options and were given enough information about their condition.
Services were available to support patients, particularly those with dementia, a learning disability or a physical disability. There were also systems in place to capture concerns and complaints raised within the division, review these and take action to improve the experience of patients. There was evidence that the service reviewed and acted on information about the quality of care that it received from complaints and we saw effective arrangements in place for collaborative working between surgical teams.
The trust vision, values and strategy had been communicated to wards and departments and staff had a clear understanding of what these involved. Staff were aware of their roles and responsibilities and there was good ward leadership. The service recognised the importance of patient and public views and there were mechanisms in place to hear and act on patient feedback. Staff were encouraged and knew how to identify risks and make suggestions for improvement.

Critical care

Good

Overall we rated the intensive care unit as good. The environment was clean and the unit complied with the trust's infection control policy. Medical and nursing staffing levels were adequate and there was evidence of a cohesive team working approach to patient care. The senior sisters on the unit were supernumerary so staff working on a 1:1 basis with patients could rely on the sister's individual support when needed. Staff told us this made them feel safe. Staff were aware of the systems and processes

Summary of findings

in place for reporting patient and staff incidents. Staff we spoke with told us they were encouraged to report incidents and we were given examples where staff demonstrated an open and transparent culture of doing so. Staff regularly received feedback from an incident either by email or through staff huddles. All aspects of care delivered in the unit were audited and reviewed and could demonstrate continuous improvement. The unit had an outreach team to identify and monitor deteriorating patients, although this was not well resourced. Patients received treatment and care according to national guidelines. The unit was obtaining good-quality outcomes as evidenced by its Intensive Care National Audit and Research Centre data. We found there was good multidisciplinary team working across the unit. Staff were actively engaged in reviewing patient outcomes through research and audit activities, peer review and benchmarking.
Staff cared for patients in a compassionate manner with dignity and respect. Relatives we spoke with told us their loved ones had all their care needs met by dedicated staff that 'went the extra mile'. For those patients who were on the unit for exceptionally long periods of time due to their illness, we observed some very special relationships which had developed over time. We observed individualised care and attention to detail given to patients and relatives, evidenced by their work with the end of life team, their visitor's charter, care of patients with learning disabilities and implementation and consideration of the deprivation of liberty safeguards standards.
The unit was responsive to patients' needs. Staff worked across the ITU1 and ITU2 wards to ensure the required patient-to-nurse ratio was met. They also had a bed occupancy rate of 80–85% which enabled them to plan admissions and accept emergencies. The unit occasionally experienced a delay in discharges, often due to the lack of available beds on a ward, but also because of difficulties determining who the parent team was when patients were admitted via the emergency department.
We found there was a real commitment to working as a multidisciplinary team delivering a high quality and safe service. Feedback was valued as a way of

Summary of findings

improving the service. On a number of occasions the team went over and above what would be expected in order to keep patients feeling safe and at ease. There was strong medical and nursing leadership within the unit. Staff felt well supported within an open, positive culture. However, the process for governance was still to be embedded. The trust had recently identified a designated executive director to take lead responsibility for critical care services and a critical care delivery group (CCDG) had been set up. The first meeting of the CCDG took place in January 2015.

Maternity and gynaecology

Good

Overall, maternity and gynaecology services at this hospital were good. However, the well led domain required improvement. The care closer to home organisational structure and associated channels of communication impacted on the decision making processes and effective leadership.

Nursing and midwifery staff considered their direct line leadership to be good, with respected and supportive leaders who understood and shared their aims to deliver quality care. Staff were aware of the trust's values and expectations. Staff felt the service encouraged and supported learning and development.

There were effective arrangements in place for reporting adverse events and for learning from these.

Patient access to designated gynaecology beds was sometimes limited by availability of beds as the ward was used for medical outliers.

Staffing arrangements ensured sufficient numbers of skilled and knowledgeable staff were on duty to meet people's individual needs.

Consent was sought from patients before treatment and care delivery. Patients received consultant-led care and staff had the support of specialist staff for advice and guidance. Procedures were in place to continuously monitor patient safety and recommended guidance was followed by staff.

Maternity outcomes were monitored and information was communicated through the governance arrangements to the trust board.

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The experiences of the care provided by nursing and midwifery staff and medical personnel was positive with regard to the attention received, involvement in decision making, the provision of information and caring approach.
Individual care needs of women using the services were fully considered by staff and respected as far as they could. Physical and mental health needs were addressed by staff with support from those with expertise. Nutritional, religious, cultural and medical dietary needs were met.
The views of the public and stakeholders were sought in relation to developing services. Staff were encouraged and supported to consider better ways of working and to develop the service.

Services for children and young people

Good

Overall, services for children and young people at this hospital were good.
The children's services actively monitored safety, risk and cleanliness. The levels of nursing staff were adequate to meet the needs of children and young people.
Children's services had made improvements to care and treatment where the need had been identified using programmes of assessment or in response to national guidelines.
Children, young people and parents told us they received compassionate care with good emotional support. Parents felt fully informed and involved in decisions relating to their child's treatment and care.
The service was responsive to children's and young people's needs and was well led. The service had a clear vision and strategy. The service was led by a positive management team who worked together.
The service had introduced innovative improvements with the aim of improving the delivery of care for children and families.

End of life care

Requires improvement

End of life care services at this hospital required improvement. Monitoring of the safe use of syringe drivers for end of life medication was not being recorded consistently or in line with the trust's policy. Do not attempt cardiopulmonary resuscitation (DNACPR) forms were generally being completed accurately and comprehensively, but

mental capacity assessments were not being recorded when there was an indication that patients did not have capacity to be involved in decision making.
Staff were seen to be caring and compassionate and we saw that the development of pastoral and spiritual services were planned for as part of the end of life care steering group. We saw that the specialist palliative care team had addressed issues around staff attending specialist training by attending the wards on a regular basis every day and supporting staff to develop the skills needed to care for people at the end of life through a mentoring programme. Education had been identified as a priority area by the trust, and recruitment to a dedicated end of life educator post had been included in service action plans.
Structural development of the services had begun in terms of the identification of workforce needs and plans were being developed to address these needs, but at the time of our inspection we saw that staffing difficulties had affected the ability of the specialist palliative care team to take action to develop the service.
The specialist palliative care team provided support for patients at the end of life and for the ward staff caring for them. We observed specialist nurses and medical staff providing specialist support in a timely way that was aimed at developing the skills of non-specialist staff and ensuring the quality of end of life care. Staff were caring and compassionate and we saw the service was responsive to patients' needs. There were prompt referral responses from the specialist palliative care team and a good focus on the preferred place of care for patients at the end of life wishing to be at home.

Outpatients and diagnostic imaging

Good

Overall the care and treatment received by patients in the Darlington Memorial Hospital outpatient and imaging departments was safe, effective, caring, responsive and well led. Patients were very happy with the care they received and found it to be caring and compassionate. Staff were supported and worked within nationally agreed guidance to ensure that patients received the most appropriate care and treatment for their conditions. Patients were

Summary of findings

protected from the risk of harm because there were policies in place to make sure that any additional support needs were met. Staff were aware of these policies and how to follow them.

There were some areas for improvement, such as the systems in place for checking storage cupboards for expired equipment. A number of patient information leaflets across the departments were past their review date.

The departments took part in the NHS Friends and Family Test (a satisfaction survey that measures patients' satisfaction with the healthcare they have received) and another satisfaction scheme called 'I want great care'. There were comment boxes in waiting areas.

On the whole, the services offered were delivered in an innovative way to respond to patient needs and ensure that the departments worked effectively and efficiently.

Darlington Memorial Hospital

Detailed findings

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

Contents

Detailed findings

Background to Darlington Memorial Hospital

Darlington Memorial was one of two acute hospitals forming County Durham and Darlington NHS Foundation Trust. This trust was one of the largest hospital and community healthcare providers in the NHS. County Durham and Darlington NHS Foundation Trust served around 600,000 people across County Durham, Darlington, North Yorkshire, the Tees Valley and South Tyneside services including health and wellbeing services, community-based services, and acute and planned hospital services.

In total, the trust had 1331 beds across two acute hospitals and the community, and employed around 7555 staff. Darlington Memorial Hospital had 410 beds.

Darlington Memorial Hospital provided medical, surgical, critical care and maternity services, and services for children and young people, for people in County Durham, Darlington, North Yorkshire, the Tees Valley and South Tyneside. The hospital also provided emergency and urgent care (A&E) and outpatient services.

The A&E department was open 24 hours a day, 7 days a week. Between April 2013 and March 2014, A&E provided a service to 58,335 patients of which 11,658 were children under the age of 16 years. The department was originally established for the purpose of caring for and treating 35,000 patients annually and since April 2014 had seen 45,052 attenders of which 9132 were children under the age of 16 years. Daily attendance rates for this time period for this hospital were157.

Medical care at Darlington Memorial Hospital was provided by the care group Acute and Long-term Conditions and comprised of seven medical wards, an acute medical unit (AMU) and ambulatory care provision and also a discharge lounge. The medical directorate included a number of different specialties, such as general medicine, care of the elderly, cardiology, respiratory medicine, gastroenterology, endocrinology and haematology.

The hospital provided elective and non-elective treatments for ear nose and throat, colorectal surgery, oral and maxilla facial, breast surgery, trauma and orthopaedics, plastics, and ophthalmology. The intensive care unit (ICU) at this hospital was an 11-bed facility with five level three and six level two intensive care beds. However, there was a twelfth bed space which could be used if the demand arose.

The maternity department and women's services offered a range of healthcare provision to meet the needs of the communities of Derwentside and surrounding villages of Bishop Auckland, Weardale and Teesdale. In addition to early pregnancy services including foetal medicine and antenatal care, there was provision for intrapartum and postnatal services. Facilities were available to support women in all aspects of motherhood, from early pregnancy, ultrasound scanning through breast feeding and pregnancy loss.

The children's service at this hospital was responsible for inpatient services for babies, children and young people. Services at Darlington hospital included one children's ward (ward 21) which included 24 inpatient beds, a six-bed day surgery unit and four assessment rooms. Adjacent to ward 21 was a dedicated children's outpatient department. Within the same building block located next to maternity services was the special care baby unit which had 12 level one (special care) cots. The service was also responsible for the provision of community neonatal and paediatric outreach services.

Based on statistics provided by the trust ,the Darlington services paediatric medicine specialty (not including sub specialties or surgery) had a total of 3,998 non elective admissions, 76 elective admissions and 59 day case admissions during the period January to December 2014. The special care baby unit had a total of 365 admissions in the same period. Outpatient attendances in the same period for paediatric medicine were 6,182.

The hospital did not have any wards that specifically provided end of life care. Patients requiring end of life care were identified and cared for in ward areas throughout the hospital with support from the specialist palliative care team. Specialist palliative care was provided as part of an integrated service across hospital and community teams. At Darlington Memorial Hospital, the specialist palliative care team comprised one 0.6 whole time equivalent (WTE) palliative care consultant and two WTE specialist palliative care nurses. All patients

Detailed findings

requiring end of life care could have access to the specialist palliative care team. We saw that referrals to the integrated service from April to October 2014 totalled 1,852, 98% of whom were patients with cancer.

Outpatient departments and the imaging department were situated on the main hospital site. There were a total of 212,073 outpatient appointments between April 2013 and March 2014. The ratio of new appointments to review appointments was approximately 1:2. Radiology was part of the trust's surgery and diagnostics care group directorate. Radiology provides a trust-wide diagnostic imaging service. The acute work of the trust is concentrated at the University Hospital of North Durham and Darlington Memorial Hospital, which offer a full comprehensive range of diagnostic imaging and interventional procedures, as well as a substantial plain film reporting and ultrasound service. Radiology services were managed by a clinical lead radiologist, head of service for imaging and radiology manager.

Our inspection team

Our inspection team was led by:

Chair: Iqbal Singh, Consultant Physician in Medicine for Older People.

Head of Hospital Inspections: Amanda Stanford, Care Quality Commission (CQC)

The team included CQC inspectors and a variety of specialists: consultant in emergency medicine, consultant paediatrician, consultant physician, consultant obstetrician and gynaecologist, consultant surgeon, consultant anaesthetist, consultant in oncology, junior doctors, senior nurses, student nurses and experts by experience.

How we carried out this inspection

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

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

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

- Accident and emergency
- Medical care (including older people's care)
- Surgery
- Intensive/critical care
- Maternity and family planning
- Services for children and young people
- End of life care
- Outpatients and diagnostic imaging

Before visiting, we reviewed a range of information we held about the hospital and asked other organisations to share what they knew about the hospital. These organisations included the clinical commissioning group, local area team, Monitor, Health Education England and Healthwatch.

We carried out an announced visit on 5 and 6 February 2015. During the visits we held a focus group with a range of hospital staff, including support workers, nurses, doctors (consultants and junior doctors), physiotherapists, occupational therapists and student nurses. We talked with patients and staff from all areas of the trust, including from the wards, theatres, critical care, outpatients, maternity and A&E departments. We observed how people were being cared for, talked with carers and/or family members and reviewed patients' personal care or treatment records.

We held listening events on 26 January and 2 February 2015 in Darlington and Durham to hear people's views about care and treatment received at the hospitals. We used this information to help us decide what aspects of care and treatment to look at as part of the inspection. The team would like to thank all those who attended the listening events.

Detailed findings

Facts and data about Darlington Memorial Hospital

One of the largest hospital and community healthcare providers in the NHS, County Durham and Darlington NHS Foundation Trust serves around 600,000 people across County Durham, Darlington, North Yorkshire, the Tees Valley and South Tyneside services included health and wellbeing services, community-based services and acute and planned hospital services.

Inpatient activity at this trust was 121,346, with A&E attendances being 126,239, split between this site and University Hospital of North Durham. There were a total of 252,705 outpatient appointments between April 2013 and March 2014. The number of outpatient attendances in the same period for paediatric medicine was 4,764.

Darlington is ranked 75, and Durham 62, out of 326 local authorities which means there are high deprivation levels within these areas. County Durham has high levels of health deprivation with 71% of the population classed by the Department of Health as being within the most deprived nationally. Deaths from smoking and early deaths from cancer, heart disease and stroke are all higher than the England average.

Detailed findings

Our ratings for this hospital

Our ratings for this hospital are:

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

Notes

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

Urgent and emergency services

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

Information about the service

Darlington Memorial Hospital is part of the County Durham and Darlington NHS Foundation Trust. The Accident & Emergency department (A&E) was open 24 hours a day, 7 days a week. Patients were cared for in three main areas: ambulatory care, which included 'see and treat', 'majors' and resuscitation. There were two resuscitation areas; the adult area had three bays and the paediatric area had one bay. Majors had 11 cubicles and the ambulatory care area had four cubicles. The department also had one relative's room.

Between April 2013 and March 2014, A&E provided a service to 58,335 patients of which 11,658 were children under the age of 16 years. The department was originally established for the purpose of caring and treating 35,000 patients annually and since April 2014 had seen 45,052 attenders, of which 9,132 were children under the age of sixteen years. Daily attendance rates for this time period for this hospital were157.

During our inspection, we spoke with 13 patients and their relatives, 31 staff, including doctors, nurses, allied healthcare professionals, managers and domestic staff. We observed care and treatment and reviewed 16 sets of care records. Before and after our inspection, we reviewed a range of performance information about the department.

Summary of findings

Overall, emergency and urgent care services at this hospital required improvement. Some areas of the department were not clean and we found high and low level dust. We found resuscitation equipment and fridge temperatures were not checked regularly and some types of medication were not stored securely. There were appropriate nurse staffing numbers but consultant numbers were lower than the recommended level. Systems were in place for investigating incidents, learning the lessons of those incidents and communicating those lessons to staff. A programme of mandatory training was in place and managers were working towards training targets.

Policy and protocols were underpinned by national guidelines but the department did not meet several patient outcome targets. The trust had a clinical audit programme and categorised its centrally coordinated clinical audit activity according to priorities. We saw evidence that further clinical audits had been carried out and the results and actions were awaited. There were good arrangements in place for patients to obtain food and drinks. There was a rolling programme of regular training and appraisal for staff. Multi-disciplinary team arrangements were in place.

Between October 2013 and October 2014, the department did not meet national targets. It did not meet the standard of admitting, transferring or discharging 95% of patients within 4 hours. The trust also had a higher than England percentage average for

Urgent and emergency services

patients waiting 4–12 hours in the department from the decision to admit until being admitted into an inpatient bed. In addition, the standard that 95% of ambulance patients should be handed over within 15 minutes of arrival was not met. It was evident that staff understood that access and flow was a top priority and they worked well together to try to comply with national standards. Systems were in place for investigating complaints, learning the lessons of those complaints and communicating lessons to staff.

Patients received a caring service in the department. We observed respectful and courteous interactions with patients that showed patients were treated well and with compassion.

There was clear management structure in the department and senior managers worked closely together to meet strategic objectives, monitor and improve care. Regular governance and information-sharing meetings were held and staff told us the felt empowered to take responsibility for issues. We found a number of risks in the department and found no evidence they had been effectively mitigated. Staff were focused on giving patients a positive experience.

Are urgent and emergency services safe?

Requires improvement

The safety of patient care required improvement. Some areas of the department were not visibly clean and we found high and low level dust. We found resuscitation equipment and fridge temperatures were not checked regularly and some types of medication were not stored securely. There were appropriate nurse staffing numbers but consultant numbers were lower than the recommended level. Systems were in place for investigating incidents, learning the lessons of those incidents and communicating those lessons to staff. A programme of mandatory training was in place and managers were working towards training targets.

Incidents

- Nursing staff were knowledgeable about the reporting process for incidents using 'Safeguard' (the hospital incident reporting system). Staff said they were encouraged and supported to report incidents. We saw evidence of post-incident feedback to staff through our review of departmental communication processes.
- There were no 'never events' in the department in 2013/14, (never events are serious, largely preventable patient safety incidents, which should not occur if the available, preventable measures have been implemented).
- In 2014, the department reported 19 serious incidents to the strategic executive information system. The highest number of serious incidents reported related to ambulance handover delays. Senior staff informed us that all serious incidents were investigated, a full root cause analysis was conducted and action plans were put in place as a result of the analysis. We read the 'Incident Actions Report' for quarters 1 and 2 of 2014/15, which confirmed that action plans were in place and staff confirmed that actions from these plans were being completed.
- One hundred and eight general incidents were reported between 01 August 2014 and 30 November 2014. Incident themes reported included violence and aggression towards staff, security issues and ambulance delays.
- The department had experienced 12 child deaths in 2014. The multidisciplinary team attended case reviews

organised by the paediatric rapid response team. The trust informed us that new procedures had been developed; for example, the lead consultant in charge of resuscitation would conduct debriefing sessions for staff after an event. This allowed for actions to be identified and acted upon.

- Specific departmental mortality and morbidity meetings were not held. However, staff informed us mortality and morbidity was discussed at a quarterly clinical governance meeting attended by consultants and senior nurses. Minutes of these meetings confirmed this. Deaths that occurred in the department did not form part of the trust's regular weekly mortality review process.

Cleanliness, infection control and hygiene

- We found the environment was not visibly clean in all clinical areas. We saw that the linen cupboard floor was dusty and there was a soiled cushion on the floor. There was high-level dust on the clocks in rooms 10 and 15. Within the adult resuscitation area we found dust on trunking, on monitor arms and on top of the drug cupboard. The Resuscitaire machine was dusty and there was dust on top of a cupboard in room 10.
- We saw dried blood on a clinical trolley. We raised the issue of the dried blood and dust with senior managers and while we were at the hospital, the managers were taking action to clean the areas.
- We saw a doctor handling blood cultures on the staff desk where patients and the public had access. The blood cultures were not in a protective bag to prevent cross contamination. We raised this with senior managers who immediately spoke with the member of staff.
- We found a bedpan soiled with blood and a dirty commode. We raised this with members of staff who immediately cleaned the equipment while we were there.
- There was no daily toy-cleaning schedule to show staff had cleaned the items.
- We read the departmental cleaning schedule that outlined a high and low level daily dusting schedule. The trust had previously informed us that senior staff had met with the domestic manager to define responsibility of staff for cleaning equipment.
- The department was also developing the use of a display board to show how many times cleaning was carried out along with a poster to show who the cleaners were and what hours they worked. These improvements had not been implemented at the time of our inspection.
- We asked when the last deep clean was carried out in the department but senior staff did not know.
- Hand washing facilities were readily available and we saw staff washing their hands and using hand gel between patients. Personal protective clothing such as gloves and aprons were available in all clinical areas and the 'bare below the elbow' policy was adhered to.
- We looked at the department's hand hygiene audit results and saw it had recorded 86% compliance in January 2015 and 92% compliance in February 2015. We spoke with a senior nurse who told us they intended to improve hand hygiene compliance by regularly auditing practice and feeding back to staff.
- We read an infection control audit dated September 2014 and noted a 78% compliance score (environmental). Among other issues, there had been evidence of dust on the floors around the nurse's station and litter on the floor of the waiting room. An action plan was put in place and the department was re-audited in November 2014 and most actions relating to the environment were met but floors were still in need of cleaning. At the time of our visit, standards of cleanliness and hygiene had not been maintained.
- There had been no cases of hospital-acquired Clostridium difficile or MRSA/MSSA between April 2013 and December 2014.
- The minors/majors area had appropriate facilities for isolating patients with an infectious condition.

Environment and Equipment

- There was no dedicated ambulance entrance to ensure direct access to the resuscitation and majors areas. People who self-referred used the same entrance as the ambulance entrance. The space was limited for queuing patients brought in by ambulance.
- There were 31 gaps for the completion of resuscitation equipment checklists from 01 November 2014 to 05 February 2015. The staff had introduced a new check board to deal with the issue. However, there were no checklists in place for the resuscitation 'grab bags'.
- The paediatric 'see and treat' bay and waiting area was isolated and patients could not be observed adequately when nurses were not in attendance. The trust had installed CCTV in the waiting area to mitigate the risk.

- We spoke with staff from the trust's clinical engineering department. They told us electrical safe testing was carried out every 2 years. Staff we spoke with were unclear about the procedure for testing and servicing electrical equipment.
- We found that the toilet in a patient waiting area had been out of use for a month. Staff informed us they had difficulty getting it repaired and had made several attempts to resolve the matter.

Medicines

- We found the paediatric drug fridge within the paediatric resuscitation bay unlocked. Fridge temperatures were not checked regularly and records showed that in paediatric resuscitation, fridge temperature checks were not done on 01 February 2015.
- Other drugs were stored correctly in locked cupboards.
- Medical gases were stored in a corridor next to an exit door and were not secured to a wall. We raised the issue with senior members of staff who told us the storage of medical gases in the department had been an issue for some time. They did not assure us that this matter would be dealt with in the short term.
- Intravenous fluids were not stored securely in the adult resuscitation bay.
- We asked nursing staff about standards of checking medications before, during and after administration and found they understood the Nursing and Midwifery Council (NMC)'s 'Standards for Medicines Management'.
- Guidelines for the use of antibiotics were on the trust intranet and staff told us they routinely accessed the guidelines as a point of reference.
- Ninety-nine per cent of trust A&E medical and nursing staff had completed medicines management training.

Records

- Patient care records were in an electronic format on a system known as 'symphony' and all healthcare professionals documented care and treatment using the same document.
- We reviewed 11 adult and five paediatric patient records and we found that records had assessments recorded, including risk assessments, observations, care and treatment and, where necessary, discharge plans. However, all the patient notes we read did not have the type of allergy reaction to particular drugs documented.
- Seventy-five per cent of trust A&E medical and nursing staff had completed health record keeping training.

Safeguarding

- Staff told us they were aware of their responsibilities to protect vulnerable adults and children and described the processes to follow.
- The trust informed us a more robust risk assessment form was under development with improvements planned such as reception staff asking more questions of patients. They told us further development was required to fully implement all of the recommendations and a 'task and finish' group, led by paediatrics, was in place in order to complete the changes required.
- There was no child sexual exploitation assessment tool in place.
- Safeguarding children training was part of the mandatory training programme. Seventy-nine per cent of medical and nursing staff had completed level 1 safeguarding training.
- We read the trust's safeguarding training record, which showed that relevant staff members received level 2 safeguarding training. Senior nursing staff and doctors received level 3 safeguarding training. This meant senior decision makers within A&E had received additional safeguarding training and were aware of the processes to follow if they had concerns about a patient.
- There was a safeguarding adults training programme in place and 74% of trust A&E staff had completed it.

Mandatory training

- We looked at trust data for A&E staff mandatory training relating to the period 2014/15. The majority of staff were up to date with their mandatory training.
- Seventy-four per cent of medical and nursing staff had completed fire safety training.
- Seventy-nine per cent of medical and nursing staff had completed hand hygiene training and 66% had completed hand wash assessments.
- Seventy-nine per cent of medical and nursing staff had completed moving and handling training.
- Mandatory training was provided in different formats, including face-to-face classroom training and e-learning. Managers were informed when staff did not attend training, to help to ensure staff completed all modules.

Assessing and responding to patient risk

- Bed management staff were employed within the hospital and worked closely with departmental staff.

Managers said missed targets were usually caused by not enough inpatient beds being available. We observed examples of the escalation plan having been implemented. This meant that the department used its internal escalation plans to manage the number of patients queuing.

- Adult patients were assessed and managed using a variety of risk assessment tools, which included the use of the early warning score. Children were risk assessed with the paediatric early warning score system.
- Reception staff used a 'sift tool' to stream ambulatory patients into either triage or 'see and treat'. Patients seen by the triage nurse were referred to either the emergency care practitioners (ECPs) for treatment of a minor illness or injury, or emergency nurse practitioners (ENPs) for treatment of minor injuries. ENPs/ECPs are advanced trained nurses or paramedics able to see, treat and discharge certain categories of patients so that patients do not have to wait to see a doctor. Referrals were also made to the urgent care centre, which was staffed by GPs until 6pm. After 6pm, a GP was available overnight but they had to cover home visits as well.
- Ambulatory paediatric patients were seen in triage by a paediatric nurse practitioner (PNPs) between the hours of 9am to 11pm, 7 days a week.

Nursing staffing

- Nursing numbers were not assessed using an acuity tool although senior managers told us they were working towards compliance with the National Institute for Health and Care Excellence (NICE) draft guidance for safe nurse staffing in A&E departments (February 2015).
- There were five PNPs in the department but not all shifts had a paediatric-trained nurse on duty. Advice and support was provided from the nursing staff on the paediatric wards if required.
- The overall nursing skill mix was appropriate and included clinical sisters, senior sisters/charge nurses, ENPs/ECPs, band 5 nurses and healthcare assistants.
- ENPs and ECPs were employed in the department, but were not counted in the shift nursing numbers due to their role being to assess, diagnose and treat patients.
- At the time of our visit 66.38 whole time equivalent (WTE) nurses were employed. The establishment's WTE for the department was 62, which meant there were enough nurses employed.
- Senior managers informed us that they used agency nurses from two main agencies to assure themselves that agency nurses were competent and knowledgeable about the department.
- Handovers and information sharing sessions were held twice a day. Any complaints, concerns or incidents were also discussed.

Medical staffing

- The College of Emergency Medicine (CEM) recommends a minimum of 10 consultants in each emergency department. The department employed 6.5 WTE consultants.
- Consultants were on duty from 8am to 9pm, 7 days a week with middle grade doctors on duty 24 hours a day. There was an on-call rota for consultants out of hours.
- There was some reliance internally to cover shifts using overtime. Locum doctors were also used but the department tried to cover shifts with doctors who had worked in the department before.
- Consultant handovers took place twice a day.

Major incident awareness and training

- There was a major incident plan and business continuity plan for the department.
- A senior nurse in the department was responsible for coordinating the plan and overseeing the decontamination trailer and equipment.
- The trust informed us there was an Ebola exercise every Monday where key departmental staff walked through an Ebola scenario to identify and share learning.
- There were appropriate security arrangements in the department. CCTV had recently been installed in the paediatric waiting area and CCTV was evident throughout the department. Security staff were employed within the hospital 24 hours a day, 7 days a week, and could be summoned easily to support staff as they were located close to the department.
- Only 9.2% of trust A&E staff had completed violence and aggression training.

Urgent and emergency services

Are urgent and emergency services effective?
(for example, treatment is effective)

Good

Policy and protocols were underpinned by national guidelines. The trust had a clinical audit programme and categorised its centrally coordinated clinical audit activity according to priorities. We saw evidence that further clinical audits had been carried out and the results and actions were awaited. There were good arrangements in place for patients to obtain food and drinks. There was a rolling programme of regular training and appraisal for staff. Multidisciplinary team arrangements were in place.

Evidence-based care and treatment

- We found that the service followed NICE guidelines as part of its practice and protocols. These guidelines were discussed at quarterly clinical governance meetings.
- The department had several specific protocols such as for the management of a fractured neck of femur, stroke, sepsis and rapid access chest pain assessment.

Pain relief

- Patient group directives were used in the department. A recognised pain scale for children and adults was in use. Nursing staff confirmed they used patient group directives to manage pain.
- The Care Quality Commission (CQC) (2014) accident and emergency survey rated the trust as about the same as other trusts for administering pain relief in a timely way and for staff doing everything they could to help control pain.

Nutrition and hydration

- A hot meal service was available to patients.
- In the CQC (2014) accident and emergency survey the trust was about the same as other trusts for supplying suitable food or drinks.

Patient outcomes

- The hospital participated in national CEM audits so it could benchmark its practice and performance against best practice and other A&E departments.
- In the CEM vital signs in majors audit of 2010/11, the department almost met the four of the six standards for measuring and recording vital signs after arrival/triage by scoring between 96% and 98% (CEM standard 100%). It scored 88% for measuring and recording a temperature (CEM standard 100%) and 69% for recording the Glasgow Coma Scale (CEM standard 100%). The department did not meet any of the six standards for observations being repeated and recorded within 60 minutes. They did not meet the standard for abnormal vital signs being communicated to the nurse in charge (CEM standard 100%) and only scored 29% for the standard for appropriate actions being taken (CEM standard 100%). It should be noted that this audit was undertaken in 2010/11.
- The department did not meet CEM standards for renal colic in the 2012 audit. The standards relating to the re-evaluation of pain were not met, and neither was the standard for recording an initial pain score. They did not meet standards in relation to the 20 and 30-minute targets for providing analgesia to patients in severe pain but scored 85% in relation to the 60-minute target, (CEM standard 100%). Three of the five standards for carrying out and recording appropriate investigations prior to discharge were not met but it scored 90% for considering a radiological investigation and 88% for dipstick urinalysis (CEM standard 100%). It should be noted that this audit was undertaken in 2012.
- In the CEM fractured neck of femur audit of 2012, the department did not meet the standards for the provision of analgesia to patients in severe pain after they arrived into A&E at 20 minutes or 30 minutes, but scored 69% for providing analgesia within 1 hour (CEM standard 98%). They did not meet the two standards for the provision of analgesia to patients in moderate pain after they arrived into A&E at 30 minutes or within 1 hour. It scored 34% for the standard for time to imaging and admission (CEM standard 75% within 60 minutes) and scored 100% for patients to be admitted within 4 hours (CEM standard 98%). It should be noted that this audit was undertaken in 2012/13.
- In the CEM severe sepsis and septic shock audit of 2013/14, the department met the standard for vital signs being measured and recorded by scoring 100% (CEM standard 100%). It scored 76% for capillary blood glucose measurements taken and recorded on arrival to A&E (CEM standard 100%), scored 48% for high flow oxygen being initiated before leaving A&E (CEM standard

100%), 80% for blood cultures being obtained,(CEM standard 100%), 96% for the administration of antibiotics before leaving A&E (CEM standard 100%) and 56% for evidence that urine output measurements were instituted in A&E (CEM standard 100%). It scored 16% for the standard relating to evidence in the notes that first intravenous crystalloid fluid bolus was given in A&E in under 1 hour (CEM standard 75%) and scored 90% for the same intervention before the patient left A&E (CEM standard 100%). It nearly met the standard by scoring 96% for evidence that serum lactate measurements were obtained (CEM standard 100%). It nearly met the standard for the administration of antibiotics before the patient left A&E by scoring 96% (CEM standard 100%) but only scored 8% for the administration of antibiotics in under 1 hour of arrival into A&E (CEM standard 50%).

- The department met three of the six CEM fever in children standards relating to the measurement and recording of vital signs. It scored between 74% and 92% on the other three standards relating to the measurement and recording of vital signs (CEM standard 100%). It met the standards for providing written advice to parents/carers and having an accessible copy of the NICE traffic light system.
- In the CEM pain in children audit (2011), the department did not meet the standard that 75% of patients in severe pain should receive medication within 30 minutes as it scored 50%. It scored 80% for giving analgesia within 60 minutes (CEM standard 98%). It scored 0% for re-evaluating analgesia for patients in severe pain within 30 minutes, 10% within 1 hour and 20% within 2 hours (CEM standard 90%). It should be noted that this audit was undertaken in 2011.
- The trust did not take part in the last CEM consultant sign-off audit. This audit related to three types of patient groups that should be reviewed by a consultant. These were adults with non-traumatic chest pain, febrile children less than 1 year old and patients making an unscheduled return to the department with the same condition within 72 hours of discharge.
- We read the clinical audit annual programme dated 2014/15. It showed that the department had a clear clinical audit programme with timescales for each clinical audit activity. The CEM severe sepsis and septic shock audit had been repeated in November 2014 and a meeting had been arranged between clinical audit department staff and the A&E lead to review the findings. Trauma Audit and Research Network (TARN) 2014/15 data collection was underway with the results due out in June 2015.
- The trust informed us they made use of a coder who reviewed all records to help ensure accurate coding and submitted trauma audit research network (TARN) data. There were plans to employ another TARN coordinator in March 2015 to help with trauma audits.
- Results of CEM audits were discussed at a quarterly clinical governance meeting and actions were written to improve outcomes for patients.
- The trust met the national standard of less than 5% unplanned re-attendances to A&E within 7 days (January 2013 to May 2014).

Competent staff

- There was a rolling programme of regular training for staff in the department and we read an outline for the junior doctor teaching programme 2014/15 that detailed regular training topics.
- Medical and nursing staff told us they felt well supported with training.
- The trust was ranked as good in the latest junior doctors training survey.
- Nursing and medical staff were appraised regularly. Within the trust's emergency medicine directorate, 68% of appraisals were in progress within guidelines, 14% had been successfully completed and 18% of appraisals were overdue. Managers told us they were working towards 100% completion by the end of March 2015.

Multidisciplinary working

- We saw evidence of multidisciplinary working with different healthcare professionals. An example included joint working with a local mental health trust – Tees, Esk and Wear Valleys NHS Foundation Trust. Over the winter period this involved staff from the mental health teams working closely with the department, 24 hours a day, 7 days a week. The objective was to provide patients with timely assessments and referrals as well as trying to reduce or avoid unnecessary admissions to hospital. Staff had also access to the Child and Adolescent Mental Health Services (CAMHS).
- The alcohol and drugs team reviewed patients within the department to identify and assist with drug or alcohol issues.

Urgent and emergency services

- There was 24-hour access to CT scans and the department had its own x-ray department. The MRI service was open from 7.30am to 8.30pm, Monday to Friday and 7.30am to 7.30pm, Saturday and Sunday. Out of these hours, MRI scans were performed in Middlesbrough at the James Cook Hospital.

Access to information

- The trust had a real time electronic patient record system.
- We reviewed a sample of patient records which contained all the necessary information required for ongoing care.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- We observed patients being asked for verbal consent to care and treatment. Patients told us that interventions were explained in a way that they could understand before the intervention was carried out.
- Staff training on the Mental Capacity Act was offered and 74.3% of trust A&E staff had completed this. Staff we spoke with were clear about their responsibilities in relation to patient capacity, consent and the deprivations of liberty safeguards.
- We observed parents/carers being asked for verbal consent to care and treatment of their children.
- There was a room available where patients with mental health problems could be accommodated. Patients who were at risk of harm were cared for in the room where they would be closely supervised.

Are urgent and emergency services caring?

Good

Patients received a caring service in the department. We observed respectful and courteous interactions with patients that showed patients were treated well and with compassion.

At the end of 2014 between 84% patients would recommend this service at this hospital in the NHS Friends and Family Test.

Compassionate care

- The trust used the NHS Friends and Family Test to capture patient feedback. It asks people if they would recommend the services they have used and offers a range of responses. The Friends and Family Test highlights both good and poor patient experience. Low response rates are common for A&E departments.
- At the end of 2014 between 84% patients would recommend this service at this hospital in the NHS Friends and Family Test. The response rate was 19%.
- Positive themes from the Friends and Family Test for the department included good nursing care and patients were treated with dignity and respect. Negative themes include communicating with patients and relatives, waiting times and cleanliness.
- The CQC (2014) accident and emergency survey rated the trust around the national average on most of the 33 questions and better than average on one of the questions that asked patients 'before you left the department, did you get the results of your tests'?
- Throughout our inspection we witnessed patients being treated with compassion, dignity and respect. We saw patients were attended to promptly when staff were called to assist them and patients we spoke with told us "I feel safe and the staff listen", and "I understand the treatment I will receive and I feel I am being treated with respect".
- We spoke with many staff of all grades who displayed a passion for delivering good quality care and gave us an overall sense of caring about patients. This was also evident during our observations of interactions between patients and staff.
- We looked at patient records and found they were completed sensitively and detailed discussions that had taken place with patients and relatives.

Understanding and involvement of patients and those close to them

- Patients and relatives told us that their care and treatment was explained to them in a way they could understand and we observed this interaction throughout our inspection.

Emotional support

- Staff told us there were good links to sources of specialist support, such as counselling and 24-hour chaplaincy services.

Urgent and emergency services

- We spoke with the lead chaplain who confirmed there was a good chaplaincy service. He explained how staff could access leaders from different faiths.

Are urgent and emergency services responsive to people's needs?

(for example, to feedback?)

Requires improvement

Between October 2013 and October 2014, the department did not meet national targets. It did not meet the standard of admitting, transferring or discharging 95% of patients within 4 hours. The trust also had a higher than England percentage average for patients waiting 4–12 hours in the department from the decision to admit until being admitted into an inpatient bed. In addition, the standard that 95% of ambulance patients should be handed over within 15 minutes of arrival was not met. It was evident that staff understood that access and flow was a top priority and they worked well together to try to comply with national standards. Systems were in place for investigating complaints, learning the lessons of those complaints and communicating lessons to staff.

Service planning and delivery to meet the needs of local people

- The A&E department had undergone a service transformation. The transformation team had worked closely with a nurse from the department's service improvement team to review the registering and streaming of patients, to develop consultant-led rapid assessment teams to improve patient transitions through the department and to introduce the role of navigator and experienced practitioner to stream ambulatory patients before registration.
- In order to improve the service provided by A&E, the trust had plans to refurbish the department by 2016.

Meeting peoples individual needs

- Interpretation services were used for patients whose first language was not English.
- Work had begun to identify people that attended A&E frequently because of mental health issues so that management plans could be put in place.
- Staff knew about the passport document system for people with learning disabilities used at the trust. These passports set out people's specific needs.
- There was one entrance into the department, which was used by ambulances, ambulatory adult patients and children. This meant children who attended with their parent or guardian used the same entrance as adult patients. There was a separate children's waiting area situated near to the reception area but it was difficult for nursing staff to observe children when nurses were not in attendance.
- There was a paediatric resuscitation area where very ill children were treated.
- We read a number of child friendly information books and brochures. Topics included 'Monkey has a blood test' and 'Monkey has an injection'.
- Positive changes had taken place to make the department dementia friendly by making simple and low cost changes such as hanging dementia friendly clocks and painting doors in different colours. There were plans to further improve the environment by making more permanent changes during the department's planned refurbishment.
- There was a room where relatives or partners of people being resuscitated could wait, so as to be near to their loved ones. The room allowed staff to give emotional support in a private environment.
- There was a remembrance room located next to the relative's room where families could spend time with deceased relatives.

Access and flow

- Trusts within England are set a government target of admitting, transferring or discharging 95% of patients within 4 hours of their arrival in the A&E department. The department's average performance for this target ranged from 92% to 79% (October 2014 to January 19th 2015), which meant the target was not met.
- From January 2014 to September 2014, the trust had a higher than England percentage average for patients waiting 4–12 hours in the department from the decision to admit until being admitted into an inpatient bed. However, in October 2014 the trust's percentage average was better than the England average.
- The national standard for patients who arrive by ambulance states 95% should receive an initial assessment by a registered healthcare professional

within 15 minutes of arrival into the department. The department's average performance for this target ranged from 82% down to 37% (October 2014 to February 2015), which meant the target was not met.

- Managers told us the main issue with maintaining compliance with the 4-hour target was patient flow, particularly related to patients who were waiting for medical beds. We saw evidence of staff working well together to monitor patient flow and evidence of the escalation plan being implemented when necessary.
- A&E departments across England have to record the rate of people who leave the department without being seen. The quality threshold is 5%; the hospital had a rate of between 2.6% and 4.2% of people who left without being seen by a doctor or a nurse (October 2013 to October 2014). This meant the standard was met.

Learning from complaints and concerns

- We did not see information displayed around the department that explained to patients how they could make a complaint or give feedback. We raised the issue of the lack of information with senior managers and while we were at the hospital, the managers took action to display complaints information.
- Staff were aware of how to manage complaints and how to support patients who wished to complain. We talked with nursing staff who told us they knew how to put patients in touch with the Patient Advice and Liaison Service (PALS).
- Managers told us that any verbal complaints would be discussed with staff at team meetings and we read the department meeting standing agenda, which contained an item for complaints feedback. This meant that staff were informed of any complaints so that learning could take place.
- There were 33 formal complaints from April 2014 to December 2014. Themes included reception staff attitude and keeping patients informed about waiting times. Feedback from these complaints was given to staff at department meetings.

Are urgent and emergency services well-led?

Requires improvement

There was clear management structure in the department, and senior managers worked closely together to meet strategic objectives, monitor and improve care. Regular governance and information-sharing meetings were held and staff told us they felt empowered to take responsibility for issues. However, There was a lack of monitoring systems and processes and as a result of this not all resuscitation drugs, equipment and fridge temperatures were checked regularly and the environment was not clean.

Staff were focused on giving patients a positive experience.

Vision and strategy for this service

- Staff we spoke with were aware of the trust's vision and values. The departmental vision had been reviewed with consultation from all teams to help ensure a cohesive, flowing service redesign.
- By 2016, the trust aim was to offer 24 hours a day, 7 days a week service in the hospital and community, with senior staff, including consultants and senior nurses, on the frontline around the clock. The objective is to reduce avoidable emergency admissions.

Governance, risk management and quality measurement

- The department faced a number of risks and we found no evidence that they had been effectively mitigated. Further, there was a lack of monitoring systems and processes and as a result of this, the environment was not clean and resuscitation equipment and fridge temperatures were not checked regularly. Some types of medication were not stored securely.
- Quarterly governance meetings were held and the matron had a weekly meeting with consultants to discuss issues around staff rotas, performance of the department and any major incidents.

Urgent and emergency services

- A quarterly integrated governance report was presented to the trust: 'Quality and Healthcare Governance Committee', which included reports on trends, incidents, complaints, assessment compliance and sickness absence.
- Some nursing staff we spoke with told us they were aware of the new statutory duty of 'Duty of Candour'. The duty of candour was introduced for NHS bodies in England in November 2014. Certain key principles are set out including a general duty to act in an open and transparent way in relation to care provided to patients, and as soon as reasonably practicable after a notifiable patient safety incident occurs, the organisation must tell the patient (or their representative) about it in person.
- Any member of staff could identify risks but their formal inclusion on the risk register was controlled through the quarterly governance meetings and bi-monthly 'Care Group' meetings. Risks documented on the risk register had an action plan in place. Progress on risks were discussed at these meetings and overdue actions were brought to the attention of management on a monthly basis via the trust-wide quality team.

Leadership of service

- The leadership structure consisted of a consultant who offered overall leadership to the medical team. Each member of the medical team had designated areas of clinical and leadership responsibility.
- The matron and six band 7 nurses all had responsibility for a defined team and specific clinical responsibilities.
- A band 7 nurse had attended a leadership course and another member of the nursing staff had a masters degree in leadership.

Culture within the service

- We saw good team working in the department between staff of different disciplines and grades. Staff worked well together and there was respect between specialties and across disciplines.
- Staff were well engaged with the rest of the hospital, reported an open and transparent culture on their individual wards and felt they were able to raise concerns.
- Staff spoke positively about the service they provided for patients. High quality compassionate patient care was seen as a priority and staff were aware of their responsibilities under 'duty of candour'.
- Staff exhibited a drive to give a positive experience to patients.

Public and staff engagement

- Consultations had been held with staff and a young people's representative group to invite views on new build plans.
- Staff reported that there was a strong culture of learning and improvement and training and development was actively encouraged.
- NHS staff survey data (2013) showed the trust scored as expected in 19 out of 30 areas and better than expected in nine areas. There were two negative findings: the percentage of staff feeling satisfied with the quality of work and patient care they were able to deliver, and the percentage of staff receiving job-relevant training, learning or development in last 12 months.

Innovation, improvement and sustainability

- The trust was a finalist for a North East Leadership Academy Award (NELA) for service improvements to change practice.

Medical care (including older people's care)

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

Information about the service

Medical care at Darlington Memorial Hospital was provided by the care group Acute and Long-term Conditions and comprised of seven medical wards, an acute medical unit (AMU) and ambulatory care provision and also a discharge lounge. The medical directorate included a number of different specialties, such as general medicine, care of the elderly, cardiology, respiratory medicine, gastroenterology, endocrinology and haematology.

During the inspection, we looked at the care records of 20 patients. We spoke with 30 patients and relatives and over 45 members of staff, including: doctors, nursing staff, therapists, volunteers, non-clinical staff and managers. We visited all medical wards, including the AMU, ambulatory care area and the discharge lounge. We carried out observations on the areas we visited. Before the inspection, we reviewed performance information from, and about, the trust.

Summary of findings

We rated medical care at this hospital as good. However, safety required improvement. Medical staffing was made up of a higher proportion of junior doctors and was higher than the England average. The proportion of consultants, middle career and registrars were all lower than the England averages. The trust was working towards compliance with the National Institute for Health and Care Excellence (NICE) draft guidance for safe nurse staffing. Nurse staffing establishments were determined using the Safer Nursing Care Tool (SNCT), however, actual staffing numbers on duty were sometimes below the planned level. We were particularly concerned about the staff to patient ratios for patients requiring non-invasive ventilation (NIV) who were being nursed in general ward areas.

Wards were visibly clean and cleaning schedules were in place. A recent patient-led assessment of the care environment (PLACE) rated the hospital as achieving over 90% compliance in all of the four areas of: cleanliness, food, privacy/dignity and wellbeing as well as condition/appearance and maintenance.

Systems were in place to report incidents and wards monitored safety and 'harm-free' care. Results were positive, overall, and were prominently displayed at the entrance to wards for staff, patients and visitors to view. Planned and actual nurse staffing levels were also clearly displayed.

Medical care (including older people's care)

Patients were happy with the care they received and found the service to be caring and compassionate. Most patients and relatives spoke very highly of staff and told us that they, or their relatives, had been treated with dignity and respect. It was reported that patients felt safe and relatives said that their loved ones were well cared for. Nutrition, hydration and comfort needs were met. Ward 44 had recently been awarded the "Quality Mark for Elder-Friendly Hospital Wards".

The trust had consistently achieved its referral-to-treatment times (RTT) for all care groupings with the exception of gastroenterology. RTT were better than the England average. The trust had consistently achieved their performance targets for national cancer waiting times.

Clear governance structures were in place to facilitate analysis of information from incidents and complaints, identify themes and ensure communication from ward to board. Key messages from incidents and complaints were communicated across the trust via staff meetings, training and newsletters.

There had been a number of developments made and there were projects ongoing to improve services, outcomes and patient experience. Most staff were clear about the vision

Are medical care services safe?

Requires improvement

Medical staffing was made up of a higher proportion of junior doctors; this was higher than the England average. While the proportion of consultants, middle career and registrars were all lower than the England averages. The trust was working towards compliance with the National Institute for Health and Care Excellence (NICE) draft guidance for safe nurse staffing. Nurse staffing establishments were determined using the SNCT, however, actual staffing numbers on duty were sometimes below the planned level. We were particularly concerned about the staff to patient ratios for patients requiring NIV who were being nursed in general ward areas.

Systems were in place to report incidents and wards monitored safety and 'harm-free' care. Results were positive, overall, and were prominently displayed at the entrance to wards for staff, patients and visitors to view. Planned and actual staffing levels were also clearly displayed.

Wards were clean and staff were observed adhering to infection control principles regarding hand hygiene and use of personal protective equipment (PPE).

Patient records and observations were mostly recorded appropriately and concerns about deteriorating patients were escalated in accordance with the trust guidance.

Incidents

- There had been 634 incidents reported at Darlington Memorial Hospital over the previous three months on the medical wards and acute admissions unit. Seventeen of these were classified as resulting in moderate harm and two as resulting in major harm. All incidents graded as moderate or above were investigated using root cause analysis (RCA) methodology. The most common reported incidents related to patient falls and pressure ulcers.
- There were systems in place to report incidents. Incidents were reported using an electronic system called " Safeguard Risk Management". Staff told us they were aware of how to use the system to report incidents.

Medical care (including older people's care)

- Incident trends were reported and monitored through the quarterly integrated governance report that was presented to the trust's quality and healthcare governance committee and the care groups clinical governance group.
- A monthly action log of all moderate harm and above incidents is maintained and discussed at the monthly sisters, staff and clinical governance meetings.
- Relevant incidents and required actions were also discussed at ward safety huddles to ensure staff learning took place and improvement actions were put into place.
- The patient safety team produced a simple "one liner" bulletin to cascade key messages and reminders to staff across the trust. We saw that this was available in paper format on wards and online.
- An example of learning from incidents was the implementation of a handover summary document between A&E and AMU to improve the safety and effectiveness of transfer of care from one department to another. This had been introduced as a result of learning from incidents relating to poor handover of care.
- Clinical pharmacists were involved in medication reviews as part of falls RCA meetings, to ensure issues relating to medicines were highlighted and lessons learned.
- The pharmacy department produced regular medication incident reports for each care group that provided a detailed analysis of the incidents related to medications. The pharmacy team shared the learning from their findings through regular medication bulletins, key prescribing messages, 'How to ' guides and 'Did you know' posters.
- As a result of a common theme identified by the pharmacy department a checklist had been implemented on the AMU to prevent medicines stock from becoming out of date.
- Staff were aware of the Duty of Candour and their responsibility in involving patients and families when incidents resulted in moderate harm or above. Staff on the coronary care unit (CCU) were able to tell us about a recent fall resulting in a fracture and how the patient and his family had been involved.

Safety Thermometer

- The NHS Safety Thermometer is a national improvement tool for measuring, monitoring analysing patient harms and 'harm free' care. All the medical wards recorded the Safety Thermometer information monthly.
- Over the previous year, the medical directorate had maintained a consistently low rate for pressure ulcers except for one peak in May 2014. Falls and catheter-associated urinary tract infections remained low throughout the year.
- Information regarding the results of the Safety Thermometer was routinely displayed on all of the wards.

Cleanliness, infection control and hygiene

- There were four cases of MRSA across the trust between January and December 2014. One case of MRSA was attributable to the medical wards.
- Clostridium difficile (C. difficile) rates for the trust had been consistently lower than the England average from March 2013 to December 2014. Two of the 22 cases reported between January and December 2014, across the trust, were attributable to medical wards at Darlington Memorial Hospital. A post-infection review was held for each case and actions were identified, implemented and reviewed.
- Methicillin-sensitive staphylococcus aureus (MSSA) had been relatively lower than the England average, aside from a notable spike in September 2014.
- Monthly infection control audits were undertaken with regard to hand hygiene, the environment and high impact interventions, such as insertion of central venous catheters, peripheral intravenous catheters and urinary catheters. We saw actions were planned and reviewed as a result of these audits.
- AMU staff told us that they kept action plans from their audits on a shared drive and these were discussed and monitored through department meetings.
- Ward areas were visibly clean, tidy and well maintained.
- Personal protective equipment and alcohol hand sanitising gel was available at the entrance to, and throughout, the wards.
- We observed that staff wore personal protective equipment and staff applied the principles of infection control. We observed good hand hygiene practice, but noticed that some soap and hand gel dispensers needed replenishing.

- Equipment was cleaned after use and labelled as clean and we observed that sluices and storage areas were clean and mostly tidy.
- Clear signs, which could be understood by staff, patients and visitors, were present on the ward where there was an infection risk.

Environment and equipment

- Wards 41 and 51 reported that stock requirements hadn't been revisited since a recent service reconfiguration and ward moves. Stock levels of some items, such as linen, bed pads and dressings were insufficient and this was causing regular problems in locating these items from other clinical areas, particularly at weekends.
- Due to the opening of an additional ward due to bed pressures there was no decant ward available for further ward renovations.
- Staff said that equipment to meet patient needs was available. Equipment such as infusion devices and pressure-relieving equipment could be obtained at any time of day or night via a Central Equipment Loan Library. Ward 42, the oncology ward expressed a need for an increase in number infusion pumps for the outpatient clinic area.
- Resuscitation equipment was accessible on all medical wards and a prompt repair and maintenance service was provided by the Medical Engineering Department.
- Effectiveness and availability of some equipment not directly related to patient care caused frustration, due to the delays and extra work this caused. Staff reported that Ward 41 could do with another computer for ward rounds. Not all wards had labellers for medicines, which meant when boxes needed re-labelling due to change of dose and frequency they had to be returned to pharmacy and the pneumatic tube delivery system (POD) was reported to regularly break down.
- Staff also expressed a need for a dedicated podiatry treatment room on Ward 41.
- We looked at equipment and refrigeration and found they were appropriately checked, cleaned and maintained. There had been some issues regarding infrequent recording of fridge temperatures before December 2014, but this had been identified and action taken. More recent recordings were completed daily as required.
- Labels were in place on equipment showing the date of the last maintenance check.
- Maintenance contracts and service level agreements were in place with an external provider to service, maintain and repair equipment.
- Resuscitation equipment was available and mostly checked regularly. However, some of the stock of needles on the trolley for Ward 52 was found to be out of date. This was immediately rectified when pointed out to the ward staff. The grab bags in CCU taken to cardiac arrest calls elsewhere in the hospital did not appear to have a stock checklist or checking process in place.
- The facilities team carried out audits on the environment at Darlington Memorial Hospital and also reviewed environmental feedback from NHS Friends and Family Test forms. Actions were taken to address any areas of concern.
- Wards were visibly clean and cleaning schedules were in place. A recent patient-led assessment of the care environment (PLACE) rated the hospital as achieving over 90% compliance in all of the four areas of: cleanliness, food, privacy/dignity and wellbeing and condition/appearance and maintenance.

Medicines

- A ward-based pharmacy team was available Monday to Friday from 8.30am to 5pm. There was an on-call pharmacist for the trust, out of hours.
- Provision for dispensing emergency medications was available through the patient flow manager and a central record of medicines stored on each ward and department is accessible on the trust intranet.
- Pharmacists visited all wards daily to review medications prescribed, carry out an in-depth assessment and reconciliation for new admissions, coordinate prescriptions for discharge and liaise with community services regarding medications which require ongoing monitoring, such as warfarin.
- An antibiotic team conducted a twice weekly hospital round, carried out antibiotic audits and attended monthly antibiotic meetings and weekly C. difficile multidisciplinary team meetings.
- As a result of identifying dual prescribing of co-amoxiclav and Metronidazole through antibiotic audits the pharmacy team had implemented posters to remind medical staff of the necessity of not prescribing both antibiotics.

- The pharmacy team told us that attendance at multidisciplinary team board rounds allowed for effective planning and has enabled improvements to discharge prescriptions being dispensed in a timely manner.
- Summary of care records were available and facilitated continuity of care between community and hospital, allowing for effectiveness of medicine reconciliation.
- Trust-wide data from September 2014 showed that 58% of patients had their medicines reconciled with 26% seen within 24 hours. The trust target for medicine reconciliation was 90% by April 2015.
- Antibiotic audit data from September to December 2014 showed consistently good compliance with choice of antibiotic and with stop or review dates recorded, results from December 2014 showed 97% and 99% respectively for these two indicators.
- An audit of controlled drugs was undertaken weekly on all wards. We looked at the storage, recording and administration of controlled drugs on four of the wards we visited. No concerns were identified.
- We reviewed a sample of medication administration records on each of the wards we visited. Most of the medication had been administered as prescribed. We found that medicines had been administered at appropriate times. However, only two thirds of the records we reviewed gave an indication of allergy/ reaction type.

Records

- Nursing staff told us that quality of record keeping was high profile in the trust and matrons and ward managers told us they carried out weekly documentation audits on live records in all wards. The ward manager on Ward 51 told us that results were generally positive and where issues were noted they were addressed immediately on a one-to-one basis with the relevant staff. Common issues were shared with all staff at ward meetings, or via safety huddles.
- One registered nurse (RN) told us that, when the ward was short of qualified staff, she felt pressured into completing documentation for patients she hadn't personally cared for.
- We found that most patient records were completed appropriately, although there were some risk assessments such as venous thromboembolism (VTE) risk assessments which were not completed. Pain scores were reliably recorded as were food and nutrition, falls risk assessments and cannula assessment records. Some notes in medical records were illegible and grade of staff, printed name and time were not always written.
- We observed that ward at a glance boards – with patient details such as name and outstanding tests, dates for discharge and so on – were situated in the ward concourse and were highly visible to anyone who visited the ward. The board on the AMU was situated in a staff only room out of sight of patients and public.

Safeguarding

- Data for the medical care wards showed an average of 87% compliance with adult safeguarding awareness and 88% compliance with Level 1 children's safeguarding training.
- All clinical staff were expected to undertake Level 2 safeguarding training and had developed an electronic work book to facilitate compliance with this requirement.
- Staff we spoke with were aware of how to raise a safeguarding concern or alert and knew who to contact if they required advice or guidance. Guidance information was readily available.
- Staff on the AMU told us RCAs were carried out following safeguarding incidents and serious incidents and action plans were completed and monitored through the departmental meetings.
- There is a band 6 nominated to provide advice and support on safeguarding matters on the AMU.
- Where medication issues were raised via a safeguarding alert a pharmacist participates in meetings to provide support and take forward any potential required actions regarding prescribing and administration of medicines.

Mandatory training

- Mandatory training was provided in different formats, including face-to-face classroom training and e-learning (an electronic learning package on a PC).
- Staff found training easy to access and were given protected time to complete it.
- Managers were alerted when staff training was required.
- Compliance rates with mandatory training for the medical directorate were between 67% for VTE and 98% for medicines management training.

Assessing and responding to patient risk

Medical care (including older people's care)

- Every ward used the early warning score (EWS) system to identify patients whose condition was deteriorating. At the time of the inspection ward 41 was piloting the national early warning score (NEWS) system, however, the Trust has reverted to the EWS system. Patient observations were recorded appropriately and concerns were escalated in accordance with the guidance.
- Nursing staff reported good responses from medical staff when a patient's condition deteriorated.
- Risks associated with falls, pressure ulcers, VTE, catheter and urinary infections were assessed on a monthly basis using the NHS Safety Thermometer assessment tool.
- During the inspection, we reviewed the care and treatment of patients requiring non-invasive ventilation (NIV). The British Thoracic Society guidelines state that patients being initiated on NIV should be identified as requiring Level 2 care and have increased nurse staffing levels that equate to 1:2 nurse to patient ratio for the first 24 hours. The staffing rotas we viewed did not meet this requirement. We asked staff if nurse staffing levels increased when patients were initiated on NIV and they confirmed that this did not happen. Staff told us that they could request extra staff when necessary and would cohort patients, if practical, to ensure that there was a dedicated nurse for the NIV patients. However, it was not possible to meet the recommended ratio of 1:2. There was no evidence of formal escalation plans to increase staffing levels when patients were on the ward with NIV.
- The ward manager on Ward 44, the respiratory ward, told us that NIV patients were identified as requiring Level 1 care and that the ward staffing establishment allowed for a 1:4 nurse to patient ratio for eight Level 1 beds. However, due to two RN vacancies and recruitment difficulties this ratio could not always be offered. To mitigate recruitment difficulties the ward had introduced the role of an appropriately trained band 4 practitioner who could provide care to NIV patients. We were told that, when possible, NIV patients would be nursed as a cohort in a single bay to facilitate the provision of a 1:4 ratio. The ward did not have a separate area or dedicated bay for the management of these patients. We were told that, when patients escalated to Level 2, a high dependency or intensive bed was sought.
- We were informed that there was one-to-one training given to staff, by an experienced staff member, and an informal assessment of competence regarding the administration of NIV. The ward manager held her own record of staff assessed as competent and entered this onto the electronic rostering system (MAPS – Manpower Analysis and Planning system) to ensure there were always appropriately skilled members of staff on duty. Staff also received training for taking capillary blood gas samples.
- We reviewed the training programme documentation available, however, there was no evidence to support any detailed competency-based assessment for the initiation and ongoing management of patients requiring NIV.
- We reviewed the British Thoracic Society audit data 2013 for Darlington Memorial Hospital and the audit data showed that treatment failed in 6 out of a total of 20 patients (30%) this was compared to the national average of 29.8% failure rate. We reviewed the paperwork and pathway documents associated with the treatment of patients requiring NIV. There was no standardised clinical pathway across the trust. There was a clinical pathway and NIV prescription chart in place at Darlington Memorial Hospital.
- Multidisciplinary safety huddles and board rounds take place each morning on all wards. This was observed as an effective means of discussing patient safety issues and coordination of care and treatment. The huddle system involved the use of a check list to ensure all key issues were raised such as; falls risks; patients needing assisted mealtimes, patients who had a do not attempt cardio-pulmonary resuscitation (DNA CPR) order. Responsibility for daily safety checks of equipment and controlled drugs was also delegated at this time.

Nurse staffing

- The trust was working towards compliance with the National Institute for Health and Care Excellence (NICE) draft guidance for safe nurse staffing.
- During the inspection week, medical wards were, in the main, observed to have nurse to patient ratios of 1:8, in line with NICE staffing guidance.
- Ward 44, the respiratory ward, displayed RN to patient staffing ratios of between 1:9 and 1:10 patients. The night shift planned ratio was 1: 14 or 1:15. The ward manager was aware that the acuity of patients suggested a ratio of 1:8 patients and 1:4 for NIV patients but was rarely able to achieve this due to unfilled vacancies.

Medical care (including older people's care)

- In addition to registered nurses and due to difficulty recruiting band 5 Ward 44 had introduced a band 3 discharge facilitator and a band 4 practitioner who was competent to perform most nursing tasks with the exception of drug administration. The practitioner was trained to a high level of technical skill and provided training to other staff in venepuncture and cannulation.
- The ward manager told us that staff establishments had recently been reviewed using the Safer Nursing Care Tool and she felt that, when the vacancies were filled, there would be enough staff to provide safe staffing levels. Recruitment to the two current, nurse vacancies was ongoing.
- Ward 41 endocrinology, displayed ratios of 1:9 in the morning, 1:14 in the afternoon and 1:14 on the nightshift.
- Ward 42 (oncology) was able to provide ratios of 1:4 across all shifts, which was in line with the acuity of patients in this area.
- Information on planned versus actual staffing numbers was displayed at the entrance to all ward areas. These figures were reported to the trust board monthly and submitted nationally in accordance with requirements.
- Additional staffing (above funded establishment) was secured wherever possible when one-to-one care was needed.
- Shortfalls in staffing were covered by substantive staff working additional hours and bank or agency staff. The trust had its own bank of nurse staff.
- Planned and actual staffing levels observed included the ward manager in the ratio unless he/she was having protected management time.
- Ward managers and matrons told us that protected management time was sometimes given up in order to care for patients when alternative cover was not available.
- Occasionally, staff needed to be moved from one ward to another to ensure safe staffing. Decisions to move staff were made by the matrons and the senior nurse for patient flow and were based on risk and patient needs. The matrons continually reassessed risks to patient safety when staff shortfalls occurred, to ensure staff were moved appropriately.
- To maintain safe staffing levels, if ratios fell below a 1:8 nurse patient ratio the matrons and patient flow manager closed beds, where possible.
- Additional healthcare assistants were also made available when numbers of registered nurses fell below what was required and could not be filled.
- Following the latest six-monthly review of nurse staffing levels by the director of nursing using the Safer Nursing Care Tool, nursing establishment uplifts had been agreed and approved by the board of directors.
- Ward managers felt that they would have enough staff to deliver care safely and effectively when their new establishments were met and vacancies filled.
- Information on planned and actual staffing numbers were reported to the trust board monthly and submitted nationally, in accordance with requirements.
- In January 2015, only one out of the seven wards within the medical directorate filled over 90% of the required shifts for both registered nurses and support staff for day duty. Night shifts on all wards achieved above a 90% fill rate.
- Ward 44, the respiratory ward, had an average fill rate of 68.5% for registered nurses on day shifts and 100% on night shifts in January 2015. More support staff were used than planned for day and night shifts. It was reported that, in addition to extra support staff being used where RN shifts could not be filled, beds had been closed occasionally, when staffing levels fell below safe levels. Additional staff were requested on an ad hoc basis, based on individual need.
- However, we had concerns that the planned staffing levels for Ward 44 were not based on accurate dependency levels for patients requiring non-invasive ventilation (NIV). In January 2015, there were 27 patients requiring NIV. Staffing levels had not been calculated based on them requiring Level 2 care. In accordance with the Intensive Care Society (2009) definitions of levels of care, these patients required Level 2 care.
- There was no separate unit or area on the ward for patients requiring Level 2 respiratory care. There was no trust guidance or protocols in place to ensure that staffing requirements matched the number of patients requiring Level 2 care who could safely be admitted to the ward.
- Ward 51, an elderly medical ward, had an average fill rate of 62% for registered nurses and 86% for support staff on day shifts, achieving just above 90% at night.
- Wards 52, 43 and 41 had average RN fill rates of 83%, 88% and 88% respectively on day shifts and 101%, 100% and 100% at night. More support staff were used than planned for day and night shifts.

Medical care (including older people's care)

- The medical wards at Darlington Memorial Hospital had experienced difficulties in recruitment and supply of registered nurses. The care group had developed a retention strategy which made pledges to improve retention of staff and to make the care group a more positive place to work.
- Managers and staff we spoke to told us of the medical directorate's approach to supporting staff development and succession planning for talented staff. Matrons and ward managers were dedicated to protecting time for staff development and training as far as possible and felt that the trust supported this approach.
- We were also told about initiatives to consider a different skills mix of registered and non-registered staff, where recruitment of registered nurses was particularly difficult.
- Ward 44 at Darlington Memorial Hospital had introduced the role of a band 3 discharge facilitator, which had proved very successful and was being rolled out to other wards.
- Wards 44 at Darlington Memorial Hospital had also successfully introduced the role of a band 4 support worker role and this was being considered for other areas.

Medical staffing

- There was 24-hour consultant cover, seven day a week, as well as junior doctor availability. Out-of-hours cover was provided at weekend and nights. Junior doctors reported good supervision and support from senior doctors and consultants.
- Medical staff reported good communication and handover of patients. Medical staff attended daily board rounds as part of the multidisciplinary teamwork activities.
- The AMU had 24-hour medical cover of one specialist registrar, a senior staff grade doctor, a foundation year 2 and a foundation year 1 doctor. Consultant cover was provided by Advanced Care Practitioners (ACPs) 08.00-16.00 and 08.00-20.00 Monday to Friday and a Physician Of the Day (POD) who was available 08.00am -22.00 then on call till 8am the following morning. At the weekend there were POD 1 08.00-08.00, POD 2 08.00-14.00 and POD 3 08.00-17.00. Nurse practitioners, some of whom were advanced nurse practitioners (ACP), worked in ambulatory care. They covered 08.00-22.00 Monday to Friday and 08.00-20.00 Saturday and Sunday.
- Two vacant consultant posts in gastroenterology were being covered by locums who had been with the department on a long-term basis. Staff were unclear as to why substantive posts had not been filled, however, managers told us that posts had been advertised but recruitment had been unsuccessful. Medical staff told us there was no specialist nurse for gastroenterology and this put additional pressure on clinicians.

Allied Health Professions (AHP) staffing

- The pharmacy team reported staffing pressures limited the level of service they were able to deliver. Not all medical wards had a dedicated pharmacist, but all wards received daily visits from either a pharmacist or pharmacy technician. Dispensary capacity was limited to one pharmacist, which impacted on the speed of issuing discharge prescriptions and may have impacted on patient flow and time spent waiting for discharge.
- The AMU had been identified as needing a dedicated pharmacist, but it had been impossible to provide this since September 2014 due to staff absence and difficulty in securing locum cover.
- On-call cover was limited to one pharmacist across the whole of the trust.

Major incident awareness and training

- The trust had a major incident plan, which provided guidance on the actions to be taken.
- The head of service was HIMSS (HIMSS is an international health information body) trained and had acquired instructor status.
- A business continuity plan was accessible to staff on the AMU.

Are medical care services effective?

Good

Policies and guidelines were based on National Institute for Health and Care Excellence (NICE) guidance and/or Royal College guidelines were available and easily accessible to staff. The trust participated in national clinical audits. The results from the Sentinel Stroke National Audit Programme (SSNAP) showed a recent improvement.

Any relevant NICE guidance was implemented as it was issued. NICE guidance was discussed at monthly clinical

governance meetings and at sister's meetings. NICE implementation was monitored on a monthly basis by the trust-wide quality team, who alerted departments who were non-compliant.

Pain relief and nutrition and hydration needs were met. Wards 43 and 44 were taking part in a "focus on food" initiative, with a lead dietician and kitchen staff to provide fortified diets or drinks for a lowered threshold of 'at risk' patients.

Appraisal rates for the medical directorate in January 2015 averaged 73% for all staff. Consultant appraisal rates for the medical directorate in January 2015 were 67% completed or were within guidelines.

The medical directorate had widespread multidisciplinary team working and staff reported very good working relationships within the multidisciplinary teams.

Evidence-based care and treatment

- Policies and pathways were based on NICE and Royal College of Physicians guidelines and were available to staff and accessible on the trust intranet site.
- The medical directorate at Darlington Memorial Hospital had care plans and pathways for a number of presenting conditions, which included: stroke, deep vein thrombosis (DVT), cellulitis, rapid access chest pain and sepsis.
- Audits were undertaken to monitor compliance with guidance, such as those which related to infection prevention and control. Results seen showed good levels of compliance.
- There were trust-wide nursing 'Quality Matters' and 'High Impact Intervention' audit programmes for ward sisters to complete. Staff confirmed they had completed audits and we were able to see results and action plans in ward files. Action plans were updated regularly and progress could be seen.
- Staff training files also reflected training initiated and completed as a result of lessons learned from the audits.
- Medical staff undertook clinical audits and these were discussed at clinical governance meetings. There was recognition of the need to improve the number of audits that were being undertaken.
- The AMU carried out regular audits to monitor mortality, the time that it took the patient to be seen by the consultant, readmissions, falls recently and pain management. Audit results and action plans were monitored through the departmental meetings noted above.
- The acute oncology service carried out annual audits on neutropenic sepsis (door to antibiotic time) and this was discussed at network level. Included in this was an audit on metastatic spinal cord compression. Both of these audits were part of the National Cancer Peer Review standards.

Pain relief

- Pain assessments were carried out and recorded.
- Pain relief was provided as prescribed and there were systems in place to make sure that additional pain relief could be accessed via medical staff, if required.
- Patients we spoke with had no concerns about how their pain was controlled.

Nutrition and hydration

- Protected meal times were in place and we observed that these were adhered to in most cases.
- Patients were assessed regarding their nutritional needs and care plans were in place.
- Systems such as the 'red tray' system were in place to identify patients who needed additional support with eating and drinking.
- We observed patients being supported to eat and drink.
- Drinks were readily available and we saw that drinks were in easy reach of patients.
- In most cases, food and fluid intake were recorded.
- Wards 43 and 44 were taking part in a "focus on food" initiative with a lead dietician and kitchen staff to provide fortified diets or drinks for a lowered threshold of 'at risk' patients.

Patient outcomes

- Over the course of 2013 and 2014 the County Durham and Darlington NHS Foundation Trust participated in national clinical audits and national confidential enquiries as well as undertaking a programme of local clinical and quality audits.
- The County Durham and Darlington NHS Foundation Trust achieved an overall organisational score of D, on scale of A to E, with E being the worst, according to the Sentinel Stroke National Audit Programme (SSNAP),

2014. This had improved on the previous rating. An action plan to continue improving the service was in place. Further actions were due to be discussed following the recent receipt of the latest report.

- Patients at Darlington Memorial Hospital who suffered an acute stroke followed a comprehensive stroke pathway, which included immediate thrombolysis and transfer to the University Hospital of North Durham, where hyper-acute stroke services were located. Stroke rehabilitation services were based at Bishop Auckland Hospital.
- The heart failure audit Darlington Memorial Hospital exceeded all of the England and Wales averages for clinical practice in England discharge measures (according to the 2012/2013 audit). In hospital care, indicators exceeded the England average for input from consultant cardiologist and patients receiving an echocardiogram while input from specialist and cardiology inpatients scored less than the England average.
- The Darlington Memorial Hospital Myocardial Ischaemia (heart attack) National Audit Project (MINAP) for 2012/2013 showed patients with non-ST segment elevation myocardial infarctions (NSTEMIs) – a heart attack – were seen by a cardiologist or their team in 97% of cases against and England average of 94%. Patients were admitted to a cardiac unit or ward in 47% of cases against an England average of 53%. Numbers of patients that were referred for angiography was 98.6% against an England average of 73%.
- Darlington Memorial Hospital performance in the National Diabetes Inpatient Audit (NaDIA) in September 2013 showed the trust performed better than England and Wales on average in 12 out of 22 indicators. Of the ten indicators that performed below the national average, these predominantly related to staff knowledge and foot risk assessment. No data was available for whether or not patients were involved in their treatment plans or percentage renal replacement therapy.
- Emergency readmissions to Darlington Memorial Hospital within 28 days of discharge from medical wards was higher than the England average for elective admissions and lower than the England average for non-elective admissions. Raised readmission rates were mainly in the areas of haematology and general medicine with a slightly raised rate in gastroenterology.
- The British Thoracic Society audit data 2013 for Darlington Memorial Hospital and the audit data showed that treatment failed in six out of a total of 20 patients (30%) this was compared to the national average of a 29.8% failure rate.
- To monitor patient outcomes within the AMU, daily reporting of readmissions commenced in June 2014. This had shown an overall trend decrease and ongoing validation by ward staff on key wards had found that the readmissions were not being admitted inappropriately. Deaths were also reviewed as part of weekly mortality audits.

Competent staff

- Appraisal rates for the medical directorate in January 2015 averaged 73% for all staff.
- A report to the board in May 2014 showed that 95% of doctors in the medical directorate completed an appraisal in 2013/2014. Sixty-two recommendations were made by the trust to the General Medical Council (GMC) in relation to 'revalidation' between 1 April 2013 and 31 March 2014. All recommendations were completed on time. Consultant appraisal rates for the medical directorate in January 2015 were 67% completed or within guidelines.
- Senior nursing staff said they did not undertake formal clinical supervision with all staff, but clinical supervision was offered on an individual basis. Staff told us this could be with someone outside of their clinical team. Ward 52 staff participated in group supervision and had regular de-briefs.
- Medical staff reported that the training was excellent at Darlington Memorial Hospital. An example given was the training programme on endocrinology, which was given to registrars.
- All staff working within elderly medicine had received a dementia awareness pack and had undertaken e-learning.
- Allied Health Professionals (AHPs) told us that new staff were given a shadowing period as part of induction to ensure staff were competent and confident to carry out their duties before undertaking unsupervised practice. It was reported that the trust was supportive of training, but staff needed to travel out of area to access specialist training.
- Junior pharmacists and junior doctors received good support from senior members of the pharmacy team.

- Practice placement facilitators and preceptorship arrangements were in place to support newly qualified nursing staff.
- Sisters and ward managers received updates and training relevant to their role through away days.
- There were good records of training available and certificates of competence were displayed in ward areas. Medical staff contributed to ongoing training and professional development through weekly topic based sessions in the ward areas.
- Staff on Ward 42 told us they were supported in undergoing specialist training in chemotherapy. Staff worked in both outpatients and on the ward to develop knowledge and skill and across the full pathway as well as to provide continuity for patients.
- New roles such as band 4 practitioners (Ward 44) and advanced care practitioners (ambulatory care) underwent assessed competency-based training before working unsupervised in their new roles.

Multidisciplinary working

- Nursing and medical staff reported good multidisciplinary working and all medical wards participated in multidisciplinary board rounds, which were observed to be an effective means of flagging potential patient issues and updating all staff on management plans. This facilitated a holistic approach to treatment plans and decisions.
- Specialist nurses were available to review patients in some specialties, such as respiratory and diabetes. These specialists were also readily available to support staff groups with support, training and to participate in multidisciplinary meetings to discuss patient care and treatment.
- Staff on the elderly care wards confirmed that there were good links with the mental health team who attended handovers three times a week and would visit the wards daily if necessary. The team provided the ward with advice and support as well as giving direct intervention to patients.
- Allied Health Professionals confirmed that there was good multidisciplinary working and also offered training, such as dysphagia training to nursing staff where appropriate. Dieticians also undertook daily reviews of those patients highlighted for their input.
- The pharmacy department provided a 'buddy' system for all new junior doctors to give informal support around prescribing, when needed.
- The AMU had input from specialist nurses, physiotherapy, speech and language, pharmacy, child and adolescent and adult mental health liaison and the Integrated Short-term Intervention Service (ISIS), as required. There was a dedicated pharmacy post for the unit. There was a strong multidisciplinary approach to assessment and facilitated/fast-track discharge.
- Staff could also access a coordination centre for district nursing and community matron referrals from 8am to 8pm, seven days per week, as well as a single point of access (SPA) for local authority referrals from 8am to 7pm, seven days per week.

Seven-day services

- Consultants provide seven-day cover for the medical wards and acute assessment unit. On-call consultants covered weekends and nights. Other medical out-of-hours cover was provided by one registrar, two foundation year two and two foundation year one doctors. There was 24-hour access to computerised tomography (CT) scanning available seven days a week. In order to meet the demands for consultant delivered care, senior decision making and leadership.
- Consultant presence on the AMU has been extended to provide cover from 8am to 10pm. All patients were seen on a daily basis by either an acute care physician or the physician of the day.
- To improve availability of the consultant on call and ensure all patients received a senior review within 24 hours of admission, on-take consultants were completely freed from any other clinical duties or elective commitments.
- An over labelled cupboard, emergency drug cupboard and on-call pharmacist were accessible out of working hours.
- Physiotherapists covered weekends on a rota system to deliver interventions to identified patients, however, routine rehabilitation was not provided.
- The trust was planning to improve access to other services following a self-assessment using the NHS Improving Quality seven day services assessment tool.

Access to information

- Staff reported prompt response to information and test results.
- Discharge letters were sent to GPs on discharge.
- Training, guidance, policies and procedures could be easily accessed on the staff intranet.

Medical care (including older people's care)

Consent, Mental Capacity Act 2005 and Deprivation of Liberty Safeguards

- Staff demonstrated a good understanding of consent, mental capacity and 'best interest' decisions and accessed training through an e-learning platform. Compliance with Mental Capacity Act 2005 and Deprivation of Liberty Safeguards training was 87.85%.
- Staff had readily accessible guidance and information and knew who to contact for advice and support, if needed.

Are medical care services caring?

Good

Most patients and relatives told us that they or their relatives had been treated with dignity and respect and that staff were caring and compassionate.

NHS Friends and Family Test information showed a lower response rate and lower percentage of patients who would recommend the services than the national average in February 2015. The trust performed around the same as other trusts in relevant questions in the national inpatient survey 2014.

Patients we spoke with were aware of what treatment they were having, understood the reasons for this and had been involved in decision making.

Patients said they felt supported by all staff and gave positive feedback about clinical nurse specialists, ancillary staff and allied health professionals, as well nursing and medical staff.

Compassionate care

- Patients we spoke to told us that staff were welcoming and that everything was explained.
- Staff were observed to be caring and compassionate and interacted with patients in a cheerful and friendly manner. This was echoed in feedback from patients and relatives who valued that they or their loved ones had been treated with dignity and respect. They felt that patients were kept safe and were well-cared for. They also valued that staff were flexible regarding visiting times when patients were extremely unwell or suffered with dementia.
- Latest data for the national NHS Friends and Family Test showed Darlington Memorial Hospital medical wards to have an average response rate of 37.5% and 90% of patients would recommend this service to their friends or family if they needed similar care or treatment.
- NHS choices showed 10 reviews relating to the medical services at Darlington Memorial Hospital between November 2014 and February 2015. Eight out of ten reviewers indicated that they were happy with the care delivered and the compassion and attitude of staff. One reviewer stated that an individual member of staff's attitude had been poor and another did not receive adequate communication regarding her mother's condition or plans for discharge.
- The trust performed around the same as other trusts in relevant questions in the national inpatient survey for 2014.
- We spoke with 30 patients and relatives throughout the inspection. Most patients and relatives told us that they or their relatives had been treated with compassion and that staff were polite and respectful.
- Staff were observed to address their patients in a friendly, caring and professional manner. We saw patients being treated with respect and dignity and privacy was maintained.

Understanding and involvement of patients and those close to them

- Ward 52 was observed to pay particular attention to the involvement of relatives in the care of their loved ones. Staff were flexible with visiting times, provided information regarding current care and treatment and displayed lots of information regarding dementia care.
- We saw that wards displayed 'You said, we did' posters to show actions taken from NHS Friends and Family Test feedback. Wards had quiet rooms where relatives could be taken speak to staff in private or to use when distressed.
- The trust had set up a "Dragon's den" initiative, which allowed staff to submit ideas that would improve services to their patients and bid for funding to make their ideas happen. Two ward managers in the medical directorate were successful in securing £1,600 to support the development of calendars to be displayed visually in the elderly care wards in both Darlington Memorial Hospital and University Hospital of North Durham.

Medical care (including older people's care)

- Ward44 at Darlington Memorial Hospital had obtained Stage II of the "Quality Mark for Elder-Friendly Hospital Wards" and ward 52 was in the process of working towards this.
- Patients told us the staff were "brilliant", "very caring and compassionate" and "explained everything".
- Patients were aware of what treatment they were having, understood the reasons for this and had been involved in the decision making.

Emotional support

- There were rooms available where relatives could speak to staff or use if they were distressed.
- Ecumenical chaplaincy services were available and easily accessible when requested.
- Staff knew of active support groups for patients such as the "Breathe Easy Darlington" (for people affected by lung conditions) and "Bowel Buddies" that could provide emotional support as well as practical advice.
- The elderly care wards were introducing volunteers who would focus on patients' social and emotional needs.
- There was a range of clinical nurse specialists at the trust and patients and staff spoke positively about their input. For example, the diabetes and respiratory nurse specialists could provide a high level of emotional support and practical advice.
- Staff on the medical wards and acute assessment unit spoke positively about links with mental health services and liaison staff who visited the ward regularly to see patients with mental health needs and give advice to staff on issues such as managing challenging behaviour.

Are medical care services responsive?

Good

There were processes in place to ensure most patients were cared for in the right place at the right time. Reconfiguration of the services was underway to further develop these pathways.

Referral-to-treatment times (RTT) for the trust had exceeded standards for all specialty groupings, with the exception of gastroenterology, which had achieved 80.6% patients meeting the 18-week wait standard against a target of 90%. RTT has been consistently better than the England average since February 2014.

The trust was better than the England average for national cancer waiting times. Data regarding the number of medical outliers outside of the directorate was collected using bed days. Outliers at Darlington Memorial Hospital ranged from 128 days in August 2014 to 227 days in October 2014. Management arrangements were in place to provide appropriate, ongoing care and treatment to outlying patients.

Length of stay at Darlington Memorial Hospital was better than the England average for non-elective admissions in cardiology and general medicine, geriatric medicine showed a longer average length of stay of 16.2 days against an England average of 9.8. General medicine, cardiology and haematology showed a shorter length of stay than the England averages for elective admissions (HES 2013/2014).

Staff worked to meet the needs of individual patients. The elderly care wards had developed practices and the environment to meet the needs of patients living with dementia. However, patient information was not readily available in languages other than English.

Ward 44 at Darlington Memorial Hospital had recently obtained Stage II of the "Quality Mark for Elder-Friendly Hospital Wards" and ward 52 was in the process of working towards this.

Service planning and delivery to meet the needs of local people

- Darlington Memorial Hospital was ranked 75, and Durham 62 out of 326 local authorities, which means there are high deprivation levels within these areas. Deaths from smoking, early deaths from cancer and from heart disease and stroke are all higher than the England average.
- The services at County Durham and Darlington NHS Foundation Trust were predominantly commissioned by NHS North Durham, Durham Dales, Easington and Sedgefield and Darlington Clinical Commissioning Groups to meet the needs of the local people.
- Bed occupancy rates suggested that there were a sufficient number of hospital beds available for the population, but the trust had identified that reconfiguration, particularly of the acute medical beds, required further work to meet patient needs. The reconfiguration was in progress and some changes had already been implemented, such as the development and opening of an ambulatory care unit.

Medical care (including older people's care)

- The ambulatory care unit had been developed alongside the AMU and had capacity for 12 patients. The area was staffed by nurse practitioners and healthcare assistants who followed approved care pathways. The ambulatory care area treated between 13 and 18 patients a day. The ambulatory care staff worked closely with the AMU and A&E and proactively initiated the transfer of appropriate patients into their area for treatment.
- Endocrinology services had been developed to be more responsive to patient needs through the development of a clear endocrine testing protocol, which facilitated the quick turnaround of tests and test results.
- Multidisciplinary working across the specialty and into the community had provided greater access to foot clinics and the provision of antibiotics without recourse to admission.
- The trust had secured funding to develop its acute oncology service to further develop multidisciplinary team working in order to improve responsiveness for cancer patients who developed complications following chemotherapy and for patients admitted with progressive diseases. The proposed model would allow GPs, community nurses and AHPs to access timely advice, which would ensure improved quality of care for these patients, promote timely diagnostics, if required, and prevent unnecessary admissions.

Access and flow

- Bed occupancy over the previous financial year for the trust was 83% or below for general and acute beds.
- Routine/elective admissions and outpatients were admitted directly to the relevant base ward.
- Non-elective/emergency patients were predominantly admitted from the accident and emergency department (A&E) to either the AMU or the ambulatory care area. This was based on established criteria.
- The AMU operated a telephone triage system to establish whether a patient needed to attend the unit, or if patient needs could be met by diverting elsewhere, for example, to community services, or to the palliative care team.
- The AMU and ambulatory care area also took direct referrals from GPs where criteria were met or where a clinician to clinician discussion had taken place.
- AMU admitted patients 24 hours a day and the maximum length of stay was 48 to 72 hours. We saw that estimated dates of discharge were planned for most patients.
- The discharge management team and the ISIS team supported patients and staff with complex discharges from AMU.
- The matron for AMU (who was also the patient flow manager) liaised closely with the A&E department and specialist nurses were regularly on the ward to assess patients and speed up flow to the relevant specialty, or to facilitate discharge home.
- The trust was better than the England average for national cancer waiting times.
- General medicine achieved 100% against the 18-week RTT target.
- Figures for April to January 2015 showed the trust had consistently achieved their performance targets for national cancer waiting times.
- Data regarding the number of medical outliers outside of the directorate was collected using bed days. Between July and October 2014, the number of outliers at Darlington Memorial Hospital ranged between a minimum of 128 days over the month of August 2014 and 227 days during October 2014. Outliers at University Hospital of North Durham ranged between a maximum of 198 days over the month of August 2014 and a minimum of 150 days during October 2014.
- A daily list was generated of all patients boarded outside of the medical wards. All patients that were outlying on other wards were reviewed daily by a medical team. In the main, nursing staff providing the care had no concerns regarding the care of outlying patients.
- The medical wards operated a buddy system for wards where outlying patients were placed. For example, Ward 52 medical team provided care for medical patients on Ward 62, unless a patient was under the care of a specialist then they would stay under the care of that consultant/team.
- Staff on the gynaecology Ward 62 told us that they experienced some problems when caring for medical patients, which included poor access to physiotherapy, the discharge management team and pharmacy support. Also nurses did not feel skilled at taking blood for tests with which they were unfamiliar. They felt that

the discharge of patients was often delayed due these problems and a lack of discharge planning. It was also reported that if a patient's condition deteriorated it was often difficult to transfer them back to a medical ward.

- An overflow ward had been opened at Darlington Memorial Hospital to increase the number of medical beds available and reduce the total number of medical patients boarded into surgical beds.
- If oncology patients needed to stay on other wards due to a lack of beds on Ward 42 the acute oncology nurse would continue to coordinate their care. If a patient's care needs escalated beyond what the Darlington Memorial Hospital department could provide for then the nurse was able to refer directly to James Cook University Hospital. Nursing staff told us that being able to provide outpatient chemotherapy had made a big, positive difference for patients. Ward 42 was covered by a visiting oncologist twice a week and that this could, occasionally, delay a patient's discharge. The ward was well supported by the medical palliative care team and patients could be fast-tracked for discharge when palliative care was needed.
- Access to James Cook University Hospital tertiary centre for cardiac patients awaiting surgery was reported to be anything from a few days to three weeks, but averaged around 10 to 15 days.
- Data regarding inpatient moves for April to June 2014 and July to October 2014 showed that 68% of patients were not moved to another ward during their hospital stay. Thirty per cent of patients had one ward move while the remaining 12% had two or more ward moves during their stay.
- Access to radiological investigations was reported as having an impact on inpatients on the medical wards. For example, it was reported that video fluoroscopy was only available one afternoon a week and this meant patients might have to wait for over two weeks for this investigation, potentially increasing a patient's length of stay. At the time of the inspection, the slots for this investigation were fully for booked for the subsequent two weeks. There was however 24-hour access to CT scanning seven days a week.
- Medical staff also reported that, due to staffing issues in radiology, multidisciplinary team working was affected as there was limited radiologist availability for meetings and also that out-of-hours provision of radiology diagnostics was variable.
- Staff on the endocrinology ward at Darlington Memorial Hospital reported that inpatient access to a podiatry service was limited to once a week.
- Step down from the intensive therapy unit (ITU) to medical wards was reported to be problem free in the majority of cases and only took place after a senior clinician to clinician discussion.

Discharge and transfer

- Discharge and transfer from Darlington Memorial Hospital was facilitated by a discharge management team.
- Band 3 discharge facilitators had recently been appointed to some of the medical wards and initial feedback from staff was that effectiveness and timeliness of discharge had improved and workload pressures for other members of staff had also been alleviated to some extent.
- Support for complex discharges was also available from the RIACT team, community matrons and the local authority.
- The medical ward staff had good links into the community, including access to an integrated care team.
- Staff on the medical wards and AMU told us they tried to identify patients for discharge or transfer as early in the day as possible and aimed not to transfer patients later than 10pm. However, it was acknowledged that, occasionally, patients were transferred out during the night.
- It was observed that on AMU estimated dates of discharge were planned for most patients. However, on one of the wards only 12 out of 28 patients were noted as having an expected date of discharge recorded on the ward board.
- Issues that were reported as adversely affecting timely and effective discharge included the absence of prescription labellers on some medical wards. This meant that medicines had to be returned to the main dispensary for relabelling if dose or frequency of medication had changed.
- The absence of a process for medication reviews of outlying patients meant that prescriptions were reviewed when received by the dispensary and, occasionally, this resulted in prescriptions being returned to wards when errors or omissions were noted.

Medical care (including older people's care)

- Processes for delivering discharge prescriptions to the wards meant that the delivery did not take place until 5pm even if they were ready earlier.
- Staff on Ward 41 (endocrinology) told us that the discharge of some patients was difficult due to the nature of patients in this specialty. For example, patients who needed long-term intravenous (IV) antibiotics, but who were unsuitable for outpatient or community administration would have an extended length of stay, as would patients with osteomyelitis who were non-weight bearing and did not have a suitable place of discharge immediately available.
- Staff on Ward 43 told us that they could not always access step down beds at Bishop Auckland Hospital, due to patients there often waiting for rehousing.
- Ward 43 had a full-time pharmacist who was able to ensure that patients had appropriate medications reviews, reconciliations and assisted with effective, timely discharge as patients rarely had to wait for discharge medications.
- A handover summary document had been introduced between A&E and AMU to improve the safety and effectiveness of transfer of care from one department to another.
- In December 2014, all new junior medics received dedicated one-to-one support at local induction and were given a flow chart to enable them to successfully complete electronic discharge letters in a timely manner.
- Darlington Memorial Hospital had a discharge lounge where some patients were sent from wards to await for transport and or prescriptions. The nurse on the discharge lounge was notified by the wards of patients who were to be discharged that day and then she would coordinate transport and pharmacy requests to a timely and effectively coordinated discharge.
- In the discharge lounge we observed six patients. Four patients had been waiting for transport for an hour and a quarter or less, one patient was awaiting transfer to a community hospital, but had to wait for three other patients on other wards to be ready, before the transfer could happen. Another patient, who had been cleared for discharge at 10.30am, was still waiting for his discharge letter at 4pm. Staff told us that patients often waited a long time for discharge letters or prescriptions.
- A patient told us that his wife had dementia and he was able to stay for extended periods and participate in his wife's care, helping to maintain her wellbeing as far as possible. Other people told us there were always drinks available and the food was good.
- Ward 52 had a wide range of literature and resources available for people living with and caring for people with dementia.
- Recent refurbishments had included changes to make ward areas more dementia friendly. For example red door frames and toilet seats were visible on Ward 52 and in the AMU.
- Ward staff used red trays to highlight patients who needed assistance with eating and drinking.
- Staff on Ward 41 (endocrinology) had a range of educational resources and offered teaching to young adults with type 1 diabetes to aid compliance and reduce the need for readmissions.
- Staff in all areas could give examples of when reasonable adjustments had been made to improve the patient experience, such as flexible visiting hours and family members being involved in meeting patients' care and emotional needs. This was confirmed through feedback from patients and relatives spoken with during the inspection.
- AMU staff could give examples of patients with learning disabilities who had been supported by the provision of a single room to enable a carer to stay overnight.
- The trust had a dedicated learning disabilities nurse that was available across site.
- Translation services were available and staff knew how to access these.
- We noted that information leaflets were available for patients, but these were not readily available in languages other than English.
- We saw examples of additional staff being employed to provide individual care for patients.
- The elderly care wards had developed practices to meet the needs of patients living with dementia. There were recognised good practices in place, such as memory boxes and the 'forget me not scheme' was in place.
- The environment in the ward areas appeared well maintained, Wards 41 and 51 had recently been reconfigured and Ward 52 had also undergone additional works to make it "dementia friendly".

Meeting people's individual needs

- A relative reported that the ward his wife had stayed on was "dementia friendly", used good signage, and aids such as colour-coded cups and toilet seats and also played "fifties music" quietly in the corridors.
- The discharge lounge was observed to be clean, spacious and light. There were two beds available in the lounge area if needed. There were magazines available for patients, but no current newspapers. The television was positioned in the corner of a room and was not visible to many patients. There was no drinking water available for patients to access for themselves, however, staff would provide drinks and food on request. Staff used the kitchen on the nearby corridor to make hot drinks.

Learning from complaints and concerns

- The trust had a Patient Advice and Liaison Service, which was available to all patients. Information was available to patients on how to make a complaint and how to access Patient Advice and Liaison Service.
- Complaints trends were reported and monitored through the quarterly integrated governance report that was presented to the trust's quality and healthcare governance committee.
- All complaint response letters were prepared by the matron or clinical staff involved in the patients' care. Response letters were sent to a head of service for final sign off, which meant that senior managers within the care group were sighted on all complaints.
- The care group's complaints coordinator analysed complaints and identified themes. In conjunction with the corporate patient experience team, a thematic action plan was developed. This was reported as part of the integrated governance report.
- Matrons and ward managers disseminated learning from complaints monthly through sister and staff meetings. Minutes of these meetings confirmed this.
- Staff we spoke to explained how they would deal with a patient's concerns immediately and, wherever possible, as they arose, Then they would escalate to their ward sister or manager, when necessary. Staff were able to signpost patients to the Patient Advice and Liaison Service department where appropriate.
- Staff were able to give examples of complaints that had happened in their area and were aware of the findings from investigations and any actions that were needed.
- Records of complaints and action plans were held in staff information files with audit reports and action plans, which were available on the wards.

Are medical care services well-led?

Good

There had been some recent changes to the leadership of the medical directorate as part of a wider trust restructure. Staff were positive about the leadership and the recent appointments. Managers and senior clinicians had a vision for the future of their services and were aware of the risks and challenges faced by the directorate.

Staff told us they were well supported by their ward managers and clinical matrons and were encouraged to develop to improve their practice. There was a good culture of learning and staff were supported to undertake additional training, be innovative and try out new ideas. Most staff were clear about the vision and strategy for the service.

Clinical governance meetings were held at directorate and care group levels. There was generally good clinical engagement and attendance.

There were examples of innovation and improvement.

Vision and strategy for this service

- Most staff were clear about the vision and strategy for their service. This was particularly evident in AMU, where the service improvement team were working with the department. There were visual displays of the vision and strategy within the department. Discussions had been held with staff regarding proposed changes and further discussions were planned.
- The pharmacy department had a strategy document for 2012 to 2015 and was updating this. The department was a pilot site for the development of the Royal Pharmaceutical Society Professional Standards for Hospital Pharmacy Services and had assessed its services against them. There were plans in place to address any identified shortfalls.
- The trust had two major projects ongoing: implementation of chemotherapy care in haematology and also criteria-led discharge.

Medical care (including older people's care)

Governance, risk management and quality measurement

- Each care group had a governance lead, who attended two regular governance meetings; a patient safety and patient experience group attended by care group matrons and lead nurses and a quality and clinical governance meeting, which was attended by consultant leads and heads of service. Any issues were escalated from these meetings to the care group governance meetings. We reviewed notes of meetings and saw there was generally good clinical engagement and attendance.
- Information from the governance meetings was cascaded to staff through ward meetings, sister's meetings and other department governance meetings.
- A quarterly integrated governance report was produced which included a dashboard showing trends and details of incidents, claims, complaints, pressure ulcers, Healthcare Associated Infections (HCAI), venous thromboembolism (VTE) assessment compliance, falls and sickness absence.
- A risk register was in place for the medical directorate, which included some, but not all the issues, identified during the inspection. The risks associated with the care of the non-invasive ventilated patients were not identified.
- Risks could be identified by any member of staff and were taken to the care group risk management meetings. Progress on risk management was discussed at these meetings and the risk register updated accordingly.

Leadership of service

- There had been some recent changes to the leadership of the medical directorate and staff were generally positive about the leadership and the recent appointments.
- Staff reported that the senior management team and the board were visible.
- The service had a clinical director for inpatient medicine and chief of service elderly care and stroke services.
- At ward level there was clear leadership of the services.
- Ward sisters on the acute medical wards occasionally needed to give up dedicated management time, due to staff shortages. This impacted on their capacity to lead their teams effectively.
- Locally, ward staff stated they were well supported by their managers, they were visible and provided clear leadership. Sisters and ward managers appreciated that they were able to access the matrons easily if needed and that they walked around the wards on a daily basis.
- Staff felt that managers communicated well with them and kept them informed about the running of the wards and relevant service changes.
- The ward manager on Ward 42 had been nominated by staff for a leadership award.
- Staff were encouraged to undertake professional development and received annual appraisals.
- Staff told us they would be confident to raise a concern with their managers and that this would be investigated appropriately.
- Staff knew who they could contact at a senior management level if they had concerns or a lack of response from middle managers.
- Staff felt managers were interested in their work and encouraged them to express ideas for service development.
- Staff were actively encouraged to undertake professional development activities.

Culture within the service

- It was evidently a period of change across many of the services we inspected.
- Most staff acknowledged the need for change and staff reported that the culture had changed positively over the last few years.
- In the main, staff were positive and enthusiastic about the changes made to service delivery and could clearly articulate the benefits for patients.
- Staff reported that there was a strong culture of learning and improvement and training and development was actively encouraged.
- There was a good ethos of multidisciplinary working and respect and value for multi-professional skills and knowledge. There were a number of examples of training and support offered across disciplines.
- The care group had in a place a retention strategy, which made a number of pledges to improve retention of staff and to make the care group a more positive place to work.

Public and staff engagement

- The medical wards and departments engaged with patients through methods such as NHS Friends and

Family Test, a postdischarge survey and in the way they handled complaints and incidents. Some of the wards undertook fundraising in partnership with patients and members of the public. Funds were generally used to improve patient comfort in areas that had been suggested through patient feedback.

- Managers told us how they had engaged with the public regarding significant developments through public consultation events.
- The wards displayed the NHS Friends and Family Test results on 'You said, we did' boards, so patients and public could see changes made as a result of their feedback.
- Staff were involved in consultation discussions regarding any proposed changes in their area.
- Methods had been adopted to promote staff engagement, such as huddles and safety briefings.

Innovation, improvement and sustainability

- The elderly care wards, particularly Ward 52, had made improvements to the care of older people including those living with dementia. The environment had been adapted to be more "dementia-friendly" in Ward 52 and on the AMU. Memory boxes were in use and volunteers were being introduced to provide individualised social and emotional support to patients. A lead nurse for dementia had just been appointed to promote improvements to dementia care across the trust.
- Ward 44 was piloting an innovative e-observations tool using smartphone technology, which could directly alert medics of patients with deteriorating NEWS scores. Staff had found the system easy to use and effective.
- The pharmacy department had implemented a 'buddy' system for all new junior doctors where a pharmacist was assigned a junior doctor to provide informal support where necessary. This initiative was commended by the president of the Royal College of Pharmacists on a recent visit and asked for additional information, as they felt it was a scheme that could be promoted more widely through the Future Hospital programme. (The Future Hospital Programme exists to implement the recommendations of the Future Hospital Commission. These recommendations are based on the very best of our hospital services, taking examples of existing innovative and patient-centred services to develop a comprehensive model of care.)
- A tracking system had been implemented for the tracking of prescriptions.
- Projects were underway to implement electronic prescribing and medicines administration across the trust and electronic prescribing for chemotherapy.
- The medical service was working towards an integrated model for the assessment and management of the frail elderly in conjunction with Darlington GPs and "criteria-led discharge".
- The development of a nurse-led ambulatory care service.
- Skills mix initiatives to develop the role of band 3 discharge coordinators and band 4 practitioners in clinical areas to mitigate difficulties in recruiting RNs.

Surgery

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

Information about the service

Darlington Memorial Hospital provides a range of surgical services for the population of County Durham and the immediate surrounding area and is also servicing the population of the north east of England.

The hospital provided elective and non-elective treatments for ear nose and throat, colorectal surgery, oral and maxilla facial, breast surgery, trauma and orthopaedics, plastics, and ophthalmology.

During this inspection we visited the following surgical wards: ward 31 (trauma and orthopaedics), ward 32 (general), ward 33 (general) and ward 34 (trauma and orthopaedics), as well as the surgical assessment unit, the surgical pre-assessment unit and the short stay unit.

We visited all theatres and recovery areas on site and observed care being given and surgical procedures being undertaken.

We spoke with 42 patients and relatives and 28 members of staff. We observed care and treatment and looked at care records for 32 people.

Summary of findings

Overall, surgical services at this hospital were good. We saw effective arrangements in place for reporting patient and staff incidents and allegations of abuse, which was in line with national guidance. Staff were encouraged to report incidents and most received feedback on what had happened as a result.

Staffing establishments and skill mix had been reviewed to maintain optimum staffing levels during shifts. Effective handovers took place between staff to ensure continuity and safety of care.

There were arrangements in place for the prevention and control of infection and the management of medicines but we saw that not all equipment had been serviced within required timescales, and issues were identified with the kitchen on the theatre corridor.

Care records were completed accurately and clearly and in line with patients' needs.

There were processes in place for implementing and monitoring the use of evidence-based guidelines and standards to meet patients' care needs. Surgical services participated in national clinical audits and reviews to improve patient outcomes and had developed a number of local audits.

Processes were in place to identify the learning needs of staff and opportunities for professional development. There was effective communication and collaboration between multidisciplinary teams.

Surgery

There were kind and caring interactions on the wards between staff and patients. Patients spoke positively about the standard of care they had received. All of the patients we spoke with felt they understood their care options and were given enough information about their condition.

Services were available to support patients, particularly those with dementia, a learning disability or a physical disability. There were also systems in place to capture concerns and complaints raised within the division, review these and take action to improve the experience of patients. There was evidence that the service reviewed and acted on information about the quality of care that it received from complaints, and we saw effective arrangements in place for collaborative working between surgical teams.

The trust vision, values and strategy had been communicated to wards and departments and staff had a clear understanding of what these involved. Staff were aware of their roles and responsibilities and there was good ward leadership. The service recognised the importance of patient and public views and there were mechanisms in place to hear and act on patient feedback. Staff were encouraged and knew how to identify risks and make suggestions for improvement.

Are surgery services safe?

Good

There were effective arrangements in place for reporting patient and staff incidents and allegations of abuse, which was in line with national guidance. Staff were encouraged to report incidents and most received feedback on what had happened as a result.

Staffing establishments and skill mix had been reviewed to maintain optimum staffing levels during shifts. Effective handovers took place between staff shifts and included daily safety briefings to ensure continuity and safety of care.

There were arrangements in place for the prevention and control of infection and the management of medicines, but we saw not all equipment had been serviced within required timescales and issues were identified with the kitchen on the theatre corridor. Theatres were not always secure and it was possible for patients to enter the theatre areas without being challenged. Medicines and fluids used within theatres were not always stored securely in cupboards or fridges where necessary.

Care records were completely accurately and clearly and in line with patients' needs.

Incidents

- Staff were aware and familiar with the process for reporting and investigating incidents, near misses and accidents using the trust's electronic reporting system. Staff told us feedback on reported incidents was given and felt they were appropriately supported.
- There had been two 'never events' reported at this trust within the last 12 months (never events are serious, largely preventable patient safety incidents, which should not occur if the available, preventable measures have been implemented). We saw these had been fully investigated by the trust, identifying the root causes of the errors, contributory factors, lessons learnt, arrangements for sharing learning and actions needed to stop reoccurrence.

Surgery

- Within surgery, 11 serious incidents had been reported in the last 12 months. The reporting of serious incidents was in line with that expected for the size of the hospital. One of these incidents related to a grade 3 pressure ulcer.
- Mortality and morbidity meetings were held monthly in all relevant specialties. All relevant staff participated in mortality case note reviews and reflective practice.

Safety thermometer

- The trust used the NHS Safety Thermometer, which is an improvement tool for measuring, monitoring and analysing patient harms and 'harm free' care. Safety thermometer information included information about all new harms, falls with harm and new pressure ulcers. Information was displayed on boards on all wards and theatre areas visited.
- The hospital was performing within expected levels, and the numbers of falls, pressure ulcers and urinary tract infections across the division had all remained low in the 12 months to July 2014. This was reflected in information displayed within ward areas.
- Care records showed risk assessments were being appropriately completed for all patients on admission to the hospital.

Cleanliness, infection control and hygiene

- Wards and patient areas were clean and we saw staff wash their hands and use hand gel between patients. 'Bare below the elbow' policies were complied with.
- Infection control information was visible in all ward and patient areas.
- All elective patients undergoing surgery were screened for methicillin-resistant Staphylococcus aureus (MRSA) and procedures were in place to isolate patients when appropriate in accordance with infection control policies.
- There had been no incidences of MRSA or Clostridium difficile reported during 2014.
- Clinical waste bins were covered with foot opening controls and the appropriate signage was used for the disposal of clinical waste. Separate hand washing basins, hand wash and sanitiser was available on the wards, theatre and patient areas.
- Infection control audits were completed every month and monitored compliance with key trust policies such as hand hygiene. Recent audits showed compliance with hand hygiene protocols varied from 49% to 100% on surgical wards. We discussed the low compliance on one ward with the ward sister. The cause of this (staff using a shared corridor for access) had been identified and processes put in place to ensure improvement.
- Nursing staff had received training in aseptic non-touch techniques. This covered the necessary control measures to prevent infections being introduced to susceptible surgical wounds during clinical practice.
- The division participated in the ongoing surgical site infection audits run by Public Health England. Each case of surgical site infection was identified, discussed at formal meetings and actions identified to avoid a repetition.
- Swab, pack surgical instrument and sharp count audits were completed within theatre and these were discussed at divisional meetings and actions were identified if required.
- Cleanliness in theatres and recovery areas was observed to be exceptional.
- The introduction of a housekeeper role to assist the teams and maintain cleanliness standards had been seen as a success and a review was considering implementing the role in other areas within the hospital.
- Local audits relating to infection control and use of personal protective clothing in theatres and recovery showed full compliance.

Environment and equipment

- We observed checks for emergency equipment, including equipment used for resuscitation. Resuscitation equipment in all areas had been checked daily.
- All freestanding equipment in theatres was covered and had been dated when cleaned. Equipment was appropriately checked and cleaned regularly. There was adequate equipment in the wards to ensure safe care.
- Records showed that theatre ventilation systems were serviced by the trust's maintenance team under a planned preventive maintenance schedule.
- Records showed not all equipment had been serviced by the trust's maintenance team within required timescales, for example Primus machines used to deliver general anaesthesia to patients was due a service in a December 2014. This was brought to the attention of the medical device staff who responded immediately.
- We saw theatres were not always secure; it was possible for patients to enter the theatre areas without being

challenged. Information provided by the trust indicated that when the reception is closed, the room behind this area is also closed and therefore not accessible to patient.

Medicines

- Medicines and fluids used within theatres were not always stored securely in cupboards or fridges where necessary. We observed this in more than one area in the department.
- Fridge temperatures were checked.
- We observed the preparation and administration of controlled drugs was subject to a second independent check. After administration the stock balance of an individual preparation was confirmed to be correct and the balance recorded.

Records

- Care pathways were in use including enhanced recovery pathways.
- All wards completed appropriate risk assessments. These included risk assessments for falls, pressure ulcers and malnutrition. All records we looked at were completed accurately.
- Care records showed 100% compliance with completing early warning score documentation and undertaking appropriate actions in 2014.
- There was a comprehensive pre-operative health screening questionnaire and assessment pathway.
- Clinical notes were stored securely in line with Data Protection Act principles to ensure patient confidentiality was maintained.
- Nursing documentation was kept at the end of the bed and centrally within the wards and was completed appropriately.

Safeguarding

- Staff were aware of the safeguarding policies and procedures and had received training in this area. They were also aware of the trust's whistleblowing procedures and the action to take.
- Information provided by the trust showed 96% of staff requiring training in safeguarding adults and children within the clinical group had completed this.
- Staff we spoke with were able to describe action they would take if they had any safeguarding concerns for either children or adults.
- Staff were aware that the trust had safeguarding policies and a safeguarding team they could contact for advice and support if they had any concerns.

Mandatory training

- Performance reports within the care group showed staff were up to date with their mandatory training.
- For example, 95.56% of staff had attended health record keeping training, 85% had attended slips, trips and falls training and 87% had attended moving and handling training.
- Staff we spoke with confirmed they were up to date with mandatory training and this included attending annual cardiac and pulmonary resuscitation training.
- During group and individual meetings, staff confirmed they felt confident they had received the mandatory training necessary to enable them to perform their role effectively.

Assessing and responding to patient risk

- All wards used an early warning scoring system for the management of deteriorating patients. There were clear directions for escalation printed on the observation charts and staff spoken with were aware of the appropriate action to be taken if patients scored higher than expected.
- We looked at completed charts and saw that staff had escalated correctly, and repeat observations were taken within the necessary time frames.
- Theatre lists were updated in 'real time' to reflect changing priorities and timescales.
- We observed that theatre staff practiced the 'Five steps to Safer Surgery' (World Health Organization [WHO]) and audits across all specialties showed good compliance results, with the exception of liver biopsy and angioplasty.
- In July 2014 55% of liver biopsy and angioplasty procedures audited did not have the relevant checklist completed; the trust had identified the reasons for this, introduced a series of detailed actions to improve the level of compliance and committed to undertake a re-audit to confirm that the actions introduced have a positive effect.

Nursing staffing

Surgery

- Staffing levels for wards were calculated using a recognised tool. Work had been undertaken recently to ensure that staffing establishments reflected the dependency of patients.
- We reviewed the nurse staffing levels on all wards visited and within theatres and found that levels complied with the required establishment and skill mix. Overall the trust employed 6.9% more nurses at band 8 and above than establishment and 7.6 %less staff at band 7 and below than establishment (October 2014).
- There was a safe staffing and escalation protocol to follow should staffing levels per shift fall below the agreed roster and needs of patients. Staffing numbers on surgical wards had been adjusted flexibly between registered and unregistered staff to meet the needs of patients and in line with the protocol.
- Bank or agency staff were not routinely used and staff told us they were asked to cover staff shortages. The trust use of bank and agency staff was 4.4% during 2014 against an England average of 6.1%.

Surgical medical staffing

- Surgical consultants from all specialties were on call for a 24-hour period and arrangements were in place for effective handovers. The general surgical on call team comprised the general consultant surgeon and a consultant vascular surgeon.
- Patients who required unscheduled inpatient surgical care were placed under the direct daily supervision of a consultant and the hospital published a rota for the provision of general surgical emergency provision.
- Consultants were available on-call out of hours and would attend when required to see patients at weekends. Medical staffing within the division was made up of 44% at consultant level (England average 40%), 25% registrar level (England average 37%), middle career 16% (England average 11%), and 15% junior doctors (England average 13%).

Major incident awareness and training

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

Are surgery services effective?

Good

There were processes in place for implementing and monitoring the use of evidence-based guidelines and standards to meet patients' care needs. Surgical services participated in national clinical audits and reviews to improve patient outcomes and had developed a number of local audits.

Processes were in place to identify the learning needs of staff and opportunities for professional development. There was effective communication and collaboration between multidisciplinary teams.

Training for surgical trainees had been developed and 'protected time' identified for completion.

Evidence-based care and treatment

- Patients were treated based on national guidance from the National Institute of Health and Care Excellence (NICE), the Association of Anaesthetics, Great Britain and Ireland and the Royal College of Surgeons.
- Enhanced recovery pathways were used for patients where appropriate.
- Local policies were written in line with national guidelines and updated every 2 years or if national guidance changed. For example, there were local guidelines for pre-operative assessments and these were in line with best practice.
- The surgery division and departments took part in all the national clinical audits that they were eligible for. The division had a formal clinical audit programme where national guidance was audited and local priorities for audit were identified.

Pain relief

- Pre-planned pain relief was administered for patients on recovery pathways.

- Patients were regularly asked about their pain levels, particularly immediately after surgery, and this was recorded on a pain scoring tool that was used to assess patients' pain levels.
- All patients we spoke with reported their pain management needs had been met. The trust had undertaken an audit of post-operative pain relief with patients. This showed 90% of patients received information about pain relief from their anaesthetist and 84% of patients recalled a visit from the acute pain nurse on how to manage their pain.

Nutrition and hydration

- Patients were screened using the Malnutrition Universal Screening Tool (MUST). Where necessary patients at risk of malnutrition were referred to the dietician.
- Audits regarding completion of the Malnutrition Universal Screening Tool (MUST) were completed at ward level and overall demonstrated good levels of compliance.
- Food and fluid intake were recorded where appropriate.
- Records showed patients were advised as to what time they would need to fast from. Fasting times varied depending on when the surgery was planned.
- Patient-led assessments of the care environment (PLACE) scored the trust above the England average for food (93, England average 90) in 2014.

Patient outcomes

- There were no Care Quality Commission (CQC) mortality outliers relevant to surgery at this trust at the time of our inspection. This indicated that there had been no more deaths than expected for patients undergoing surgery at this hospital.
- Patient reported outcome measures (PROMs) were worse than the England average for patients in seven categories and better than the England average in six categories, including all three knee replacement measures.
- Standardised relative readmission rates for elective surgical patients ran higher than the England average (100) for general surgery (111) and ophthalmology (110). For non-elective patients standardised relative readmission rates ran higher than the England average (100) for general surgery (120) and ear nose and throat (108).
- The hospital had better than the standardised relative readmission rates England average (100) for elective surgical patients for urology (75) and for non-elective surgical patients for trauma and orthopaedics (95).
- The trust contributed to all national surgical audits for which it was eligible.
- The National Bowel Cancer Audit (2013) showed better than England average results for clinical nurse specialist involvement (100%, England average 88%), discussion with the multidisciplinary team (100%, England average 97.8%) and scans undertaken (99%, England average 89%); 69 % of patients undergoing major surgery stayed in the hospital for an average of more than 5 days (better than the England average of 69%).
- Lung cancer audit 2012 results showed the percentage of patients receiving surgery was lower than the England average (16%) at 13%. The audit showed results better than the England average for multidisciplinary team discussion (100%, England average 96%) and slightly lower results for scans undertaken before bronchoscopy (89%, England average 90%).
- The trust participated in the National Hip Fracture Audit. Findings from the 2014 report showed the hospital was better than the national average in areas such as patients being admitted to an orthopaedic ward within 4 hours (60%, national average 47%), falls assessment (98%, national average 95%), senior geriatric review within 72 hours of admission (86%, national average 82%), abbreviated mental health test performed (99%, national average 94%), bone health medication assessment (99%, national average 96%), and the mean length of total trust stay (acute and post-acute) (19.3 days, national average 19.8 days).
- The hospital was worse than the national average for surgery on the day of or day after admission (62%, national average 72%) and 30 day follow-up completion rate (36%, national average 39%).
- The division had introduced initiatives to improve adherence with national targets. Business cases and focus on additional weekend working and the introduction of additional theatre sessions had been designed to reduce backlogs.

Competent staff

- Staff told us that appraisals were undertaken annually and records for 2014 showed that staff across all wards

in surgery and theatres had received an appraisal or had an appraisal planned to be completed by end of March 2015. 47% of staff and 61% of consultants within surgery had an up-to-date appraisal (January 2015).
- Although nursing staff said they did not receive clinical supervision or formal one-to-one sessions, informal one-to-one meetings did take place.
- Monthly staff meetings took place and minutes were available to staff.
- Junior doctors we spoke with told us they attended teaching sessions and participated in clinical audits. They told us they had received ward-based teaching and were supported by the ward team and could approach their seniors if they had concerns.
- Training for surgical trainees had been developed and 'protected time' identified for completion.
- Revalidation of doctors' outcomes were assessed and monitored by the Deanery.

Multidisciplinary working

- Therapists worked closely with the nursing teams on the ward where appropriate. Ward staff told us they had good access to physiotherapists, occupational therapists and speech and language therapists when needed.
- Daily handovers were carried out with members of the multidisciplinary team.
- There was pharmacy input on the wards during weekdays and dedicated pharmacy provision for each ward was planned.
- Staff explained to us the wards worked with local authority services as part of discharge planning.

Seven-day services

- Daily ward rounds were arranged for all patients and patients were seen on admission at weekends.
- Access to diagnostic services was available 7 days a week, for example, x-rays.
- There was an on-call pharmacist available out of hours. Pharmacy staff were available on site during the week and on-call arrangements were in place.

Access to information

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

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- We looked at clinical records and observed that all patients had consented in line with the trust policy and Department of Health guidelines.
- Mental capacity assessments were undertaken by the consultant responsible for the patient's care and deprivation of liberty safeguards were referred to the trust's safeguarding team.

Are surgery services caring?

Good

There were kind and caring interactions on the wards between staff and patients.

Patients spoke positively about the standard of care they had received. All patients we spoke with felt they understood their care options and were given enough information about their condition.

At the end of 2014 between 78% and 98% of patients would recommend this service at this hospital in the NHS Friends and Family Test .

Compassionate care

- We observed patients being treated with compassion, dignity and respect throughout our inspection at this hospital. We saw that patients were spoken with promptly and listened to. Patients commented positively on the dedication and professionalism of staff and the quality of care and treatment received. Patients were complimentary about the staff in the service, and felt informed and involved in their care and treatment. We observed patients being kept informed throughout their time within the anaesthetic room and theatres.
- Patients told us staff the staff were "very nice" and they "kept me well informed, explained why tests and scans

were being asked for". One patient told us "the nurses were particularly kind and caring, especially with the elderly." Another patient said, "The staff were caring and did their best to keep me informed".

- We were also told, "despite what I've had to put up with, I feel safe and confident I get good care from nurses and doctors", "the staff attitude is great, even the cleaner is helpful and pleasant, it's all of them not just the medical staff" and "I was more worried about getting my van clamped but the staff sorted it for me!"
- Staff were attentive to the comfort needs of patients.
- Patients and relatives were positive about the care and treatment they had received.
- We saw doctors introduced themselves appropriately and curtains were drawn to maintain patient dignity.
- The group's NHS Friends and Family Test (a survey that measures patients' satisfaction with the healthcare they have received) response rate varied from 26% to 69% (averaging 34%) compared to the England average of 31% between April 2013 and July 2014.
- At the end of 2014 between 78% and 98% of patients would recommend this service at this hospital in the NHS Friends and Family Test .
- Numbers of written complaints to the trust have decreased in each of the last 2 years.

Patient understanding and involvement

- All patients said they were made fully aware of the surgery that they were going to have and this had been explained to them.
- Patients and relatives said they felt involved in their care and they had been given the opportunity to speak with the consultant looking after them.
- We saw ward managers and matrons were available on the wards so that relatives and patients could speak with them.
- Ward information boards identified who was in charge of wards for any given shift and who to contact if there were any problems.
- The CQC inpatient survey (2013) showed an increase (7.7 from 6.8) in patients' belief that they were involved as much as they wanted to be in decisions about their care and treatment over the previous year.

Emotional support

- Patients said they felt able to talk to ward staff about any concerns they had either about their care, or in general. Patients did not raise any concerns during our inspection.
- The CQC inpatient survey showed an increase (7.9 from 6.9) in patients believing they had received enough emotional support from hospital staff in 2013, from 2012.
- There was information within care plans to highlight whether people had emotional or mental health problems and what support they required for this.
- Patients were able to access counselling services, psychologists and the mental health team.
- Assessments for anxiety and depression were done at the pre-assessment stage and extra emotional support was provided by nursing staff for patients both pre- and post-operatively.

Are surgery services responsive?

Good

Systems were in place to plan and deliver services to meet the needs of local people and staff were responsive to people's individual needs.

Services were available to support patients, particularly those living with dementia, a learning disability or a physical disability. There were also systems in place to capture concerns and complaints raised within the division, review these and take action to improve the experience of patients.

There was evidence that the service reviewed and acted on information about the quality of care that it received from complaints and we saw effective arrangements in place for collaborative working between surgical teams.

Service planning and delivery to meet the needs of local people

- The hospital had an escalation and surge policy and procedure to deal with busy times.
- Capacity bed meetings were held to monitor bed availability in the hospital; managers responsible for reviewing planned discharge data and assessing future bed availability had been appointed.

- During high patient capacity and demand elective patients were reviewed in order of priority for cancellation to prevent appointments for urgent and cancer patients being cancelled.
- We saw effective arrangements were in place for collaborative working between breast and general surgeons undertaking reconstructive surgery.

Access and flow

- A pre-assessment meeting was held with the patient before the surgery date and any issues concerning discharge planning or other patient needs were discussed at this stage. Patients requiring assistance from social services upon discharge were identified at pre-assessment and plans were continuously reviewed during the discharge planning process.
- The trust was not meeting the overall referral to treatment targets (RTTs) of 90% of patients admitted for treatment from a waiting list within 18 weeks of referral (June 2014). RTTs were not met within trauma and orthopaedics (85%), urology (89%) and general surgery (86%).
- The reasons for these shortfalls had been identified and additional recruitment to consultant posts undertaken and locum cover arranged to reduce backlogs.
- Delays to discharge within the trust were caused mainly by completion of assessment (59.3%, England average 19%), patient or family choice (13%, England average 14%) and waiting for further NHS non-acute care (11%, England average 21%).
- The average length of stay for elective patients was below the England average for general surgery (3.2 days, England average 3.5 days), trauma and orthopaedics (3 days, England average 3.5 days) and ear nose and throat (1.1 days, England average 1.5 days). Average length of stay for non-elective patients was below the England average for general surgery (3.3 days, England average 4.3 days), trauma and orthopaedics (5.3 days, England average 8.4 days) and ENT (2 days, England average 2.4 days).
- Nine patients had their operation cancelled and were not treated within 28 days during 2014; this is lower than the England average.

Meeting people's individual needs

- The service was responsive to the needs of patients with dementia and learning disabilities. All wards had dementia champions as well as a learning disability liaison nurse who could provide advice and support with caring for people with these needs.
- We saw suitable information leaflets were available in pictorial and easy-read formats and described what to expect when undergoing surgery and postoperative care. We were told these were available in languages other than English but these were not displayed within ward or surgery areas.
- We saw that the care of patients following surgery was particularly effective through the provision of ongoing physiotherapy services.
- Wards had access to interpreters as required, requests for interpreter services were identified at the pre-assessment meeting.
- The trust had in place policies covering the Mental Capacity Act (2005) and deprivation of liberty safeguards. There was access to an independent mental capacity advocate for when best interest decision meetings were required. Training on these had been planned throughout 2014 and 2015 and 89% of staff had completed the training.

Learning from complaints and concerns

- Complaints were handled in line with the trust's policy.
- Patients or relatives making an informal complaint were able to speak to individual members of staff or the ward manager, and staff were able to explain this process.
- Staff were able to describe complaint escalation procedures, the role of the Patient Advice and Liaison Service (PALS) and the mechanisms for making a formal complaint.
- If patients or their relatives needed help or assistance with making a complaint the Independent Complaints Advocacy Services (ICAS) contact details were visible in the ward and throughout the hospital.
- We saw leaflets available throughout the hospital informing patients and relatives about this process.
- Five formal complaints had been received on the hospital's surgical wards during 2014. The ward managers discussed these with us and we were assured these had been handled appropriately in line with trust processes.
- We saw that complaints and concerns were discussed at monthly staff meetings where training needs and learning was identified as appropriate.

Surgery

Are surgery services well-led?

Good

The trust vision, values and strategy had been communicated to wards and departments and staff had a clear understanding of what these involved. Staff were aware of their roles and responsibilities and there was good ward leadership.

The service recognised the importance of patient and public views and there were mechanisms in place to hear and act on patient feedback.

Staff were encouraged and knew how to identify risks and make suggestions for improvement.

Vision and strategy for this service

- The trust vision and strategy was well embedded with staff. Staff were able to articulate to us the trust's values and objectives across the surgical wards and they were clearly displayed on ward areas.
- We met with senior managers who had a clear vision and strategy for the division and identified actions for addressing issues within the division. Staff spoken with were able to repeat this vision and discuss its meaning with us during individual interviews.

Governance, risk management and quality measurement

- Joint clinical governance meetings were held each month. Agendas and minutes showed that audits, learning from complaints and PALS issues, learning from clinical risk management, peer review data, patient and public information involvement, infection control issues, alert notices, good practice, national service frameworks, clinical audits and research projects were discussed and action was taken where required.
- Reports identified risks throughout the care group, and actions were taken to address risks and changes in performance. These monitored (among other indicators) MRSA and C. difficile rates, referral to treatment targets, pressure ulcer prevalence, complaints, 'never events', complaints and mortality ratios.
- We saw that action plans for 'never events' were monitored across the division and subgroups were tasked with implementing elements of action plans where appropriate. The risk register reflected identified risks and progress in addressing them.

Leadership of service

- Staff said divisional managers were available, visible within the division and approachable; leadership of the service was good, there was good staff morale and they felt supported at ward level. However, some staff told us the governance structure within the group sometimes delayed and made decisions difficult.
- Staff spoke positively about the service they provided for patients and emphasised that quality and patient experience was a priority and everyone's responsibility.
- Nursing staff stated that they were well supported by their managers, although we were told that one-to-one meetings were informal.
- Medical staff stated that they were supported by their consultants and confirmed they received feedback from governance and action planning meetings.

Culture within the service

- At ward and theatre levels we saw staff worked well together and there was respect between specialties and across disciplines. We saw examples of good team working on the wards between staff of different disciplines and grades.
- Staff were well engaged with the rest of the hospital, reported an open and transparent culture on their individual wards and felt they were able to raise concerns.
- Staff spoke positively about the service they provided for patients. High quality compassionate patient care was seen as a priority.

Public and staff engagement

- The hospital's NHS Friends and Family Test response rate varied from 26% to 68% (averaging 34%) compared to the England average of 31%, between April 2013 and July 2014.
- NHS staff survey data (2013) showed the trust scored as expected in 19 out of 30 areas and better than expected in nine areas. There were two negative findings, i.e., the

percentage of staff feeling satisfied with the quality of work and patient care they were able to deliver, and the percentage of staff receiving job-relevant training, learning or development in last 12 months.

Innovation, improvement and sustainability

- There were systems in place to enable learning and improve performance, which included the collection of national data, audit and learning from incidents, complaints and accidents.
- Evidence showed staff were encouraged to focus on improvement and learning. We saw examples of innovation such as the development of effective arrangements for collaborative working between breast and general surgeons undertaking reconstructive surgery.

Critical care

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

Information about the service

The intensive care unit (ICU) at this hospital was an 11-bed facility with five level 3 and six level 2 intensive care beds. However, there was a twelfth bed space which could be used if the demand arose.

Level 2 beds are for patients requiring more detailed observation or intervention, including support for a single failing organ system or post-operative care and those 'stepping down' from higher levels of care.

Level 3 beds are for patients requiring advanced respiratory support alone or basic respiratory support together with support of at least two organ systems. This level includes all complex patients requiring support for multi-organ failure.

The unit was split into the wards ITU 1 and ITU 2 by a public corridor. ITU 1 had eight beds with the facility for level 3 and level 2 patients and ITU2 had three/four beds caring for level 2 patients only.

Patients were admitted to the ICU from the emergency department, operating theatres (both elective and non-elective) and wards within the hospital.

As part of our inspection we spoke with 24 staff, three patients and three relatives. We spoke with a range of staff including nursing staff, junior and senior medical doctors, physiotherapists, dieticians, a pharmacist, domestic staff and managers. We sought feedback from staff and patients at our focus groups and listening events.

Summary of findings

Overall we rated the ICU as good. The environment was clean and the unit complied with the trust's infection control policy. Medical and nursing staffing levels were adequate and there was evidence of a cohesive team working approach to patient care. The senior sisters on the unit were supernumerary so staff working on a 1:1 basis with patients could rely on the sister's individual support when needed. Staff told us this made them feel safe. Staff were aware of the systems and processes in place for reporting of patient and staff incidents. Staff we spoke with told us they were encouraged to report an incident and we were given examples where staff demonstrated an open and transparent culture of doing so. Staff regularly received feedback from an incident either by email or through staff huddles.

All aspects of care delivered in the unit were audited and reviewed and could demonstrate continuous improvement. The unit had an outreach team to identify and monitor deteriorating patients, although this was not well resourced. Patients received treatment and care according to national guidelines. The unit was obtaining good-quality outcomes as evidenced by its Intensive Care National Audit and Research Centre (ICNARC) data. We found there was good multidisciplinary team working across the unit. Staff were actively engaged in reviewing patient outcomes through research and audit activities, peer review and benchmarking.

Critical care

Staff cared for patients in a compassionate manner, with dignity and respect. Relatives we spoke with told us their loved ones had all their care needs met by dedicated staff who "went the extra mile". For those patients who were on the unit for exceptionally long periods of time due to their illness, we observed some very special relationships which had developed over time. We observed individualised care and attention to detail given to patients and relatives, evidenced by their work with the end of life team, their visitor's charter, care of patients with learning disabilities, and implementation and consideration of the deprivation of liberty safeguards.

The unit was responsive to patients' needs. Staff worked across ITU1 and ITU2 to ensure the required patient-to-nurse ratio was met. There was a bed occupancy rate of 80–85%, which enabled the team to plan admissions and accept emergencies. The unit occasionally experienced a delay in discharges, often due to the lack of available beds on a ward, but also because of difficulties determining who the parent team was when patients were admitted via the emergency department.

We found there was a real commitment to working as a multidisciplinary team delivering a high quality and safe service. Feedback was valued as a way of improving. On a number of occasions the team went over and above what would be expected in order to keep patients feeling safe and at ease. There was strong medical and nursing leadership within the unit. Staff felt well supported within an open, positive culture. However, the process for governance was still to be embedded. The trust had recently identified a designated executive director to take lead responsibility for critical care services and a Critical care delivery group (CCDG) had been set up. The first meeting of the CCDG took place in January 2015.

Are critical care services safe?

Good

Overall the services within the unit were safe. Staff were aware of the systems and processes in place for reporting of patient and staff incidents. Staff we spoke with told us they were encouraged to report an incident and we were given examples where staff demonstrated an open and transparent culture of doing so. Staff regularly received feedback from incidents either by email or through staff huddles. Monthly meetings would also take place where incidents were discussed. The unit had an outreach team to identify and monitor deteriorating patients.

Medical and nursing staffing levels were adequate and there was evidence of a cohesive team-working approach to patient care. The senior sisters on the unit were supernumerary so staff working on a 1:1 basis with patients could rely on the sister's individual support when needed. Staff told us this made them feel safe.

The environment was clean and staff followed infection control procedures. The NHS Safety Thermometer was used and monitored to ensure a high level of practice was maintained.

Incidents

- There were 24 incidents reported over the 2014 period. Of these, 17 caused no harm to the patients, six caused a minor harm and one patient experienced moderate harm. There were three near misses reported.
- The unit had a 'never event' at the beginning of January 2014. (A never event is a serious, largely preventable patient safety incident that should not occur if proper preventative measures are taken.) A robust route cause analysis was done and changes were made to ensure this never event would not occur in the future. This change in practice was audited and is now being re-audited to ensure practice continues to be safe and is now included in junior doctors' inductions so all staff are aware.
- Staff we spoke with demonstrated the process for reporting incidents. A number of staff who had

experienced an incident had received feedback. All incidents were communicated through daily staff 'huddles' and these were documented in the handover sessions.
- The trust had a mortality reduction committee which met quarterly and members of the ICU team attended this. The unit had its own morbidity and mortality meetings where individual cases would be discussed.

Safety thermometer

- The NHS Safety Thermometer is a monthly snapshot audit of the prevalence of avoidable harm such as: the development of pressure ulcers, catheter related urinary tract infections, venous thromboembolism and falls.
- This information was in use and was being monitored and displayed for patients and relatives to see in the reception area.
- The data reviewed showed 100% compliance with harm free care. The unit had no pressure ulcers reported for more than 2 years. We observed one patient who had been on the unit for more than 6 months and had not experienced a pressure sore in that time.

Cleanliness, infection control and hygiene

- We found the unit had no MRSA bacteraemia for over a year and no C. difficile. The unit was meticulously clean and patients were cared for in a hygienic environment
- Hand hygiene audits were regularly carried out with the last audit showing 100% compliance.
- Cleaning logs were available which were regularly audited and complied with the schedule.
- We observed staff adhering to infection control policy and saw them use personal protective equipment such as gloves and aprons. The 'bare below the elbow' policy was adhered to.
- Equipment in the sluice area had stickers with 'I am clean' and a date attached.
- Patient bed areas had bladeless fans which can reduce the amount of dust that may accumulate near a patient's bedside.
- At the time of our inspection we observed staff from the estates and facilities department carrying out a cleaning audit and staff flushing taps.
- There were arrangements in place for the safe disposal of sharps and contaminated items. Dates when the sharps box had begun were clearly marked.
- A rapid response team was available to decontaminate cubicles when needed.
- The unit used antibacterial keyboards on the computers, which were on wheels.

Environment and equipment

- The unit purchased the same equipment as the University Hospital of North Durham so that if staff worked in either of the units they would be familiar with the equipment.
- We found equipment to be clean and fit for purpose.
- We observed cardiac arrest and airway trolleys, transfer bags and emergency drug packs were clean and checked daily.
- The unit had a 3 year capital programme which included the procurement of three new Bilevel positive airway pressure (BiPAP) ventilators. These had been purchased and there was nurse training in place prior to the ventilators being used.
- Equipment safety checks were carried out by the nursing staff at each shift handover. These were recorded on the patient's care plan.
- There were two relatives' rooms: one for relatives to sit in while waiting to see their loved ones and another classed as a quiet room which was used for breaking bad news. Both these rooms were spacious and tastefully decorated.
- In response to feedback from relatives and patients, a new 'sensory space' was being developed in ITU2 so patients and relatives could sit in a more relaxed environment while remaining in the clinical area. This included a wide screen TV for stimulation and to help prevent delirium. This was seen as innovative and supports best practice.

Medicines

- The unit did not have a dedicated clinical pharmacist as part of its multidisciplinary team, nor was there a clinical pharmacist on the daily ward rounds. This was not in line with national Core Standards for Intensive Care Units 2013 which states that there should be at least 0.1 WTE specialist clinical pharmacist for each level 3 bed and for every level two level 2 beds.
- Although the pharmacy department produced regular medication incident reports for the unit, there were very few medication errors reported. There were six medication errors reported from July 2014 to January 2015.

- The pharmacy department was reviewing how clinical pharmacists could support the unit via electronic prescribing and prioritising patients. This was not imminent and the lack of pharmacy support still poses a risk to patients.
- We were told of a drug error by a member of staff who raised the incident straight away with the patient and then to her line manager. The raising of the incident demonstrated the openness to report incidents when they happen in real time.
- Fridge temperatures were monitored daily and controlled drugs were secured safely.

Records

- Documentation was kept at the patient's bedside and observations were recorded clearly.
- There was a pressure sore screening score which included timely assessment and review dates.
- Falls risk assessments were complete and appropriate. There were action plans such as bed rails being in place, supervision if necessary and reminders that the patient's state should be reassessed once the patient returned to the ward.
- There was evidence of medical assessment taking place, the documentation was thorough and the outcome of ward rounds was documented with clear plans and evaluation.
- There was evidence of microbiology input into the notes daily.

Safeguarding

- Staff confirmed they had received safeguarding awareness training as part of their mandatory training and updates.
- Staff we spoke with told us how they would make a safeguarding referral.
- Attendance at safeguarding adults awareness and safeguarding children level 1 training was 89%

Mandatory training

- Mandatory training records showed 95% completion. Subjects included record keeping, moving and handling, hand hygiene, fire training, Mental Capacity Act assessments, medicines management, slips, trips and falls and safeguarding children training.
- For new staff mandatory training would be included in their first week of employment.

Assessing and responding to patient risk

- Staff on the unit used a points scoring system which was broken down: a level 3 patient scored 2 points, a level 2 patient scored 1 point and the maximum number of points allowable on the unit was 16. This gave the staff flexibility in terms of number of patients and dependency that could be admitted safely.
- Staff told us they had regular nursing handovers which enabled them to review patients' scores with another member of staff. As the senior sisters (band 7) were supernumerary staff told us they felt confident in reporting any deterioration in a patient's condition immediately to the senior sister on duty.
- The unit operated a limited outreach service. The outreach service had been fully staffed with eight nurses when it was established in 2000 and provided cover for 24 hours, 7 days a week. Since then the service had gradually been eroded to its level of three nurses delivering overnight outreach to five nights per week. Medical staff from the parent team would carry out their own medical emergency team response before referring to the ICU team.
- We observed staff carrying out safety checks on the position of a nasogastric tube. The tube was marked at the point of the nostril which was deemed to be correctly inserted and checked before feeding to ensure it was still in the correct place. This was documented in the notes and this was seen as best practice.

Nursing staffing

- There were 56.6 whole time equivalents (WTE) of nursing staff, 5.8 of which were healthcare assistants (HCAs). There were no vacancies for nursing staff at the time of the inspection.
- Nursing ratios to patients were in line with national guidance: 1:1 for a level 3 patient and 1:2 for level 2 patients. Staff worked on a rotational basis of days and nights and also rotated between ITU 1 and ITU 2.
- The unit met the 'Core Standards for Intensive Care Units' for nurse staffing. There were two senior nurses (band 7) who were supernumerary. This meant they were not rostered to deliver direct patient care to a specific patient and were always available for staff for support or troubleshooting. These senior nurses were visible on the unit and staff told us they valued this role and felt supported.

Critical care

- There was a very low use of bank and agency staff, but where agency staff were used these worked at the unit on a regular basis.
- There was an air of calmness about the unit even though 10 out of the 11 beds were occupied. Staff were well supported.
- The unit was considering increasing the HCA establishment to allow one HCA per four critical care beds to support the registered nurses.

Medical staffing

- There were 10 consultants, five of whom were core ICU staff. Consultants worked five week days Wednesday to Wednesday, with five anaesthetists with an interest in intensive care covering the weekends.
- Two consultants would be on duty in the morning; one for ITU 1 during the day and one for ITU 2 in the morning only. At weekends there would be one consultant working from 8am to 5pm, one consultant to cover orthopaedic trauma and another to act as the on-call anaesthetist.
- Out of hours there were two consultants on call, one of whom would be among the 10 consultants with sessional daytime commitments to the unit. All trainees we spoke with confirmed the ease of access to consultant advice.
- Junior medical staffing was provided by a combination of trainees completing basic ICU training blocks and specialty doctors. There were two trainees covering operating theatres, the ICU and obstetrics.
- This system worked well and there was an intention for consultants to cover the ICU and theatres as a separate entity. Staff told us that at present there would not be enough medical staff to resource this model although in time this may occur.
- The unit had 10 trainees including six staff grades and associate specialists. Trainees told us they like working in the unit and had more opportunities to gain practical experience.
- Ward rounds were consultant led and undertaken daily. Medical handovers were via a formalised team brief, ensuring all senior clinical staff were aware of any significant issues facing the unit daily.

Major incident awareness and training

- The trust had a major incident plan. Staff could tell us the procedure if there was a major incident. All staff well aware of the major incident procedures which could be found on the intranet.

Are critical care services effective?

Good

Patients received treatment and care according to national guidelines. The unit was obtaining good-quality outcomes as evidenced by its Intensive Care National Audit and Research Centre (ICNARC) data. We found there was good multidisciplinary team working across the unit. Staff were actively engaged in reviewing patient outcomes through research and audit activities, peer review and benchmarking.

All staff were actively engaged in monitoring and improving the quality of practice and there were examples where staff were working with patients to ensure their care was individualised.

The staff's work in understanding and delivering the complexities of working with deprivation of liberties safeguards was exceptional. Practice had changed through this process and the staff had learnt to review and monitor how individuals make decisions about their care and treatment.

Evidence-based care and treatment

- There were a number of guidelines for common intensive care conditions in place demonstrating best practise such as ventilator-associated pneumonia care bundles, central line-associated bloodstream infections guidelines ('Matching Michigan') and the use of sepsis bundles.
- Matching Michigan was a quality improvement project based on a model developed in the United States, which resulted in reducing the incidences of central venous catheter bloodstream infection.
- The unit could demonstrate auditing and improving practice. For example, the audit of central venous line insertion and documentation following the 'Matching

Michigan' guidelines demonstrated the lack of documentation. A new form has been introduced and there will be a further audit to ensure compliance with the guidance.

- The unit undertakes other audits such as the trust-wide Quality Matters Audit October 2014 which included audits on bladder and bowel care (84% compliant) , incident reporting (88% compliant), infection control (86% compliant), medicines (82% compliant), nutrition (75% compliant), privacy and respect (76% compliant), personal and oral hygiene (78% compliant), record keeping (86% compliant), safeguarding vulnerable people (82% compliant), communication and going home and transfers (95% compliant).
- The unit undertook a number of high impact interventions audits between November 2014 and January 2015, such as central venous catheter insertion and ongoing care, an intravenous cannula care bundle, urinary catheter care and a number of other areas, with a high level of compliance across all areas.

Pain relief

- The acute pain nurse informed us that both units at Durham and Darlington had recently purchased new patient controlled analgesia (PCA) pumps. **PCA** is a method of pain control that gives patients the power to control their pain.
- Patients' pain scores were assessed and documented and there were clear links between pain scores and the level of analgesia administered.
- Patients on the unit with pain issues were reviewed daily by the acute pain team; this ensured that their pain management was seamless between the unit and the wards.
- We observed a patient who had been admitted to the unit during the night ventilated, who was subsequently extubated and by 09am was administering her own PCA.

Nutrition and hydration

- Staff on the unit used the Malnutrition Universal Screening Tool (MUST) to assess the nutritional needs of patients.
- We saw that nutritional risk scores were updated and recorded appropriately, and completed nutritional assessments and scores audits confirmed this.
- All patients unable to take oral intake had appropriate nutritional support such as enteral to ensure adequate nutrition. There was appropriate guidance in place for initiating nutritional support.
- Patients who were unable to eat or drink also received nasogastric feeding within 24 hours of their admission to the unit or intravenous feeding if nasogastric feeding was inappropriate.
- The dietician visited the unit daily and kept separate notes on each patient. Although the dieticians did not always attend nursing staff huddles, they had their own staff huddles where complex patient issues were discussed.

Patient outcomes

- We reviewed the data from ICNARC for the unit for 2014.
- The unit's ICNARC standardised mortality ratio (the ratio of observed deaths in a study group compared to expected deaths in the general population) for 2013/14 was within expected range.
- For other ICNARC outcome measures (including ventilated admissions, admissions with severe sepsis, pneumonia, elective surgical and emergency surgical admissions) there were no areas of concern and figures were within expected ranges.
- There were no concerns, from the data, in relation to MRSA and C. difficile infections for the unit.
- The unit undertook regular reviews of the ICNARC data such as unexpected deaths. The last review looked at 39 patients between April 2013 and March 2014 and found there were some areas where improvements could be made. However, it did demonstrate that some unexpected deaths were not actually unexpected and may have been coded wrongly.

Competent staff

- Appraisals were undertaken regularly for nursing staff. This included departmental objectives, learning needs, the six C's and adherence to these standards. The six C's are: caring, compassion, competent, communication, courage and commitment.
- All nursing staff new to the unit had an induction and a 3 month mentorship programme during which they were supernumerary and supported by a mentor.
- All staff had clinical supervision; it was expected they would have 12 clinical supervisions per year.

- Teaching sessions were provided regularly for trainees and nursing staff to ensure that they were aware of the best evidence in intensive care medicine.
- Forty-two per cent of nursing staff were registered as a critical care nurse and other nursing staff were attending courses to prepare them for further critical care qualifications.
- There was a strong commitment to medical training for staff grade doctors who had protected study leave of 10 days per year and a protected budget of £1,100 per year. Staff grade doctors expressed very high levels of satisfaction with the way they were treated by the anaesthetic and ICU teams.
- All junior medical staff had a mentor.
- Revalidation for doctors was in progress.

Multidisciplinary working

- There was a strong multidisciplinary approach to care throughout the unit. Team ward rounds were well represented. The dietician was not formally part of multidisciplinary working but felt welcomed and involved in patients' care planning. The dietician was on the unit at least 4 days per week.
- All staff we spoke with told us there was a great team working ethos and the unit was led as a team and not just by senior managers.
- A review of physiotherapy establishment had been carried out to ensure sufficient staff to provide the respiratory management and rehabilitation components of patient care.
- We were told the speech and language therapy services had a relationship with the unit and there was a good referral pathway in place. The therapist would visit at the first available slot.
- Physiotherapists worked on the unit throughout the day and provided a weekend service. The support for each patient would be dependent upon the patient's individual needs.
- A consultant microbiologist did daily ward rounds and provided advice over the weekends.
- The unit had an outreach service but this was not well resourced. There were plans to review this service.

Seven-day services

- There was consultant cover throughout the weekdays and an-on call system out of hours.
- Pharmacy, dietetics and microbiology were all available Monday to Friday and physiotherapists were available 7 days a week.
- The unit had access to CT scanning and there was a protocol pathway in place with two local trusts for access to MRI.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- Deprivation of liberty safeguards (DoLS) were assessed daily as part of the morning handover, although staff recognised this was a complex area specifically for intensive care units therefore more education was required so staff were kept up to date with DoLS complexities.
- Wherever possible patients were asked for their consent to treatment and care; where patients were unconscious, staff were able to provide examples of how they would act in the patient's best interest.
- Staff told us they considered all patients for a DoLS if the patient has no capacity, is subject to 1:1 supervision and not free to leave the unit.
- We saw evidence of DoLS applications in the patient's notes; these were up to date and visible. The notes also explained how the nurse articulated the reason for a do not attempt resuscitation (DNAR) discussion with relatives
- Staff gave an example of where a patient had a DoLS in place which was then discontinued on the same day as the patient's condition improved. This demonstrates staff were familiar with recognising when a patient moves from needing a DoLS and gaining more capacity to make a decision for him/herself.
- We were also told of the death of a patient who had a DoLS in place being referred to the coroner which is considered best practice by law.

Are critical care services caring?

Good

Staff cared for patients in a compassionate manner with dignity and respect. Relatives we spoke with told us their loved ones had all their care needs met by dedicated staff who "went the extra mile". For those patients who were on the unit for exceptionally long periods of time due to their illness, we observed some very special relationships which

had developed over time. Relatives told us they were involved with their loved ones' care and felt supported in making decisions as a family. There were some difficult messages to give to some relatives, which were carried out in a sensitive and supportive manner.

Staff used a 'getting to know you' form for relatives to fill in so that staff could learn and get to know more about their patients, such as interests, pets and hobbies. This meant that staff could talk with their patients about things the patient had an interest in even when patients were sedated or ventilated.

Patients' individual needs were a priority, with staff going over and above expectations to meet patients' preferences, such as working with staff to fast track a ventilated patient home so they could die in the place of their choice.

We observed care which was thoughtful and patient centred such as a nurse organising the care of one of her patients who was heavily sedated; she changed the patients dressing and shaved the patient before stopping sedation so that when the patient awoke she could concentrate on providing the patient with psychological support rather than just daily personal care.

Compassionate care

- We observed staff on the unit introducing themselves to patients and relatives. They also used a 'getting to know you' form for relatives to fill in so that staff could learn and get to know more about their patients, such as interests, pets and hobbies. This meant that staff could talk with their patients about things the patient had an interest in even when patients were sedated or ventilated.
- We observed nursing and medical staff maintaining patients' privacy and dignity, for example we observed a doctor entering a bed area surrounded by curtains saying "knock knock – can I come in?" before entering though the curtain.
- We observed a doctor introduce himself to a patient, check with patient what they wanted to be called and waiting for a nurse before examining the patient.
- A patient satisfaction survey was carried out between July 2014 and November 2014. The results showed that 79% of patients felt their comfort was perceived to be a priority, 75% of patients felt their pain was actively managed, 81% felt their hygiene needs were attended to, 76% felt their privacy was maintained and 81% felt they were treated with respect. The unit undertook patient satisfaction surveys with the response being very positive such as: "Excellent patient care given under difficult circumstances at times. I appreciated the sense of humour and uplifting banter, a friendly place, dedicated staff that I have much respect for." and "I have been amazed by how kind and helpful everyone has been".
- We observed care which was thoughtful and patient centred such as a nurse organising the care of one of her patients who was heavily sedated; she changed the patients dressing and shaved the patient before stopping sedation so that when the patient awoke she could concentrate on providing the patient with psychological support rather than just daily personal care.

The unit had a 'memory box' which was used for relatives when patients died on the unit. There were items such as equipment to take hand and lip prints, flowers and tea lights which could be placed in the quiet room where relatives would sit. There was also a gift box tied with a ribbon with a message for the relative.

- The unit also had 'separation bands', which were used when couples were parted and someone would have to go home leaving their partner on the unit.
- We observed a patient who had not eaten food for over 6 months due to their illness, being fed by mouth by a nurse. The look of pleasure on both the patient's face and the nurse's face showed the intimate relationship the two had and the immense pride the nurse had to be part of this very important moment.
- The unit's nursing structure included link nurses for specific areas such as tissue viability and infection control. There was also a 'care maker' whose responsibility was to ensure the six C's were regularly reviewed and applied.
- We observed a dietician communicating with a patient who had a tracheostomy; she spent time with the patient listening and took the time to understand what the patient was saying.

Understanding and involvement of patients and those close to them

Critical care

- We heard a number of examples where staff had gone the 'extra mile' to involve relatives where the patient could not give their consent. There were some difficult messages to give to some relatives, which were carried out in a sensitive and supportive manner.
- We observed a consultant break off from his morning ward round to speak with a relative who had arrived out of hours.

Emotional support

- All relatives we spoke with gave positive feedback on being supported through some difficult times.
- We were told that all staff gave emotional support where needed and if necessary the chaplaincy service was available 24 hours a day.
- Staff also received emotional support through their open clinical supervision sessions and staff huddles.
- We were told the counselling services were used regularly, not just for bereavement purposes but also for staff's personal concerns.

Are critical care services responsive?

Good

The unit was responsive to patients' needs. Staff worked across ITU1 and ITU2 to ensure the required patient to nurse ratio was met. There was also a bed occupancy rate of 80–85% which enabled the team to plan admissions and accept emergencies.

The unit occasionally experienced a delay in discharges, often due to the lack of available beds on a ward but also because of difficulties with determining who the parent team was when patients were admitted via the emergency department.

Translation services were available to people who first language was not English. We also saw that patients with learning disabilities were well supported, for example by the use of a learning disability passport.

Although there were very few complaints, staff within the unit learnt from these.

Service planning and delivery to meet the needs of local people

- Both units at Darlington and Durham had recently formed a trust-wide critical care delivery group (CCDG) to ensure that critical care provision met the needs of the population. Both units also participated in a regional Securing Quality in Health Services (SeQIHS) project along with trusts in Tees Valley. As part of this group, they were reviewing how critical care was provided and developing a model for critical care to meet the needs of patients in the region.
- The unit had an extra bed on ITU 2 which could provide extra capacity during busy times. We were told that if necessary there were a further three ventilators which would allow them to provide care for up to 15 patients in an emergency situation such as coping with the increased demand due to bird flu.

Access and flow

- There was an outreach service which used the seven core elements of 'Comprehensive Critical Care Outreach: PREPARE'. This provided an outreach service to the wards five nights per week, but this was a limited resource and we were told this was to be reviewed. The purpose of the service was to assess critically ill or deteriorating patients on wards and to stabilise them at ward level and so avoid the need to escalate to the unit.
- When patients were admitted from a specialty team within the hospital, they did not always receive a daily review from the parent consultant/specialty team. The surgical team reviewed their patients before the morning operating lists but the medical teams did not do this in a timely manner. This approach meant some patients did not always have a seamless transfer from the unit to the ward. There was a need to establish a process to overcome this situation.
- This became more of a problem when a patient was admitted via the emergency department and did not have a parent team. This then resulted in a delay in discharge back to a general medical ward as the medical teams did not always agree to take the patient into their care.
- The unit had no delayed admissions to the unit and met its target of 4 hours from the decision to admit to actual admission to the unit. Data showed that only five elective cases were cancelled due to a lack of an intensive care beds during 2014.
- Referrals were made to the renal and neurology units at the James Cook University Hospital in South Tees and

patients with liver disorders were referred to The Freeman Hospital in Newcastle. There was also access to a respiratory weaning centre in York, where patients who required longer term ventilation could be cared for.
- The unit had a target for not discharging patients for non-clinical reasons between the hours of 10pm and 7am as this was seen as being unsafe and not to the benefit of the patient. Although staff worked hard to make sure this did not happen, there were times when the time was breached by minutes only. Senior staff made sure the message they shared with staff was that the quality of care for the patient should not be compromised by rushing to meet the target.

Meeting people's individual needs

- Critical explanations were carried out in a calming and sensitive manner. There was access to an interpreting service if needed and patients were asked whether they wanted their relatives to interpret on the patient's behalf.
- We were told of a patient with a learning disability who had no 'patient passport' prior to admission to the unit. The learning disabilities liaison nurse came to assist in obtaining the patient a passport. There was evidence of a referral being made to social services and a request for support when required when the patient left the hospital. As this patient was not registered as a person with a learning disability, the nurse and sister had to explain to the parents, which required very sensitive handling. This patient was subsequently referred to social services for assessment.
- Feedback from patients and relatives using ITU 2 found part of the unit to be more of a storage space. Staff were turning this space into a sensory area where patients can sit when out of bed in a more relaxing space.
- Feedback from a patient also resulted in a separate toilet, washroom and wet room being built for patients. This was to be funded through money being donated through charitable funds.
- We spoke with a relative who described staff as being "brilliant, we get the opportunity to talk with the doctors which they usually do when all the family are there".
- The unit had a visitors charter which was posted on the wall in the reception area where visitors sit before visiting their relatives. This included what staff were doing to keep their patients safe and at ease and what they expected relatives to do in return. For example: "We will be polite and courteous – please show respect for staff: we have a zero tolerance to violence and aggression."
- The unit had a healthcare assistant who was present at the reception throughout the week and provided a 'meet and greet' service for relatives. This reduced the amount of time staff would spend answering the door while needing to care for their patients. This person also acted as a support worker for families when needed.
- There were facilities at the reception for hot drinks and there were books for adults and children to read while waiting. Visiting times were between 11am and 3pm, and 5pm to 7pm, although relatives told us this was flexible and they could visit their relatives at other times if the need arose.
- Staff had produced a poster which was kept in the office, which included what they could do for patients at the end of their life. Nursing staff used this as a prompt as to what was appropriate to do in each case.

Learning from complaints and concerns

- The unit received very few complaints, although staff were aware of how to support patients and relatives in making a complaint. We were told following an investigation of a complaint an action plan would be developed where appropriate and would be sent to the complainant with a response. A quarterly newsletter called 'Quality Vibes' was also developed highlighting examples of lessons learned.
- There was a quarterly 'Lessons Learned' report on the trust intranet.

Are critical care services well-led?

Good

There was strong medical and nursing leadership within the unit. Staff felt well supported within an open, positive culture. However, the process for governance was still to be embedded. The trust had recently identified a designated executive director to take lead responsibility for critical care services and a critical care delivery group (CCDG) had been set up. The first meeting of the CCDG took place in January 2015.

We found there was a real commitment to work as a multidisciplinary team delivering a high quality and safe

service. Feedback was valued as a way of improving, and on a number of occasions the team went over and above what would be expected in order to keep patients feeling safe and at ease.

Vision and strategy for this service

- In July 2014, the trust requested a North of England Critical Care Network appraisal of the ICU services at Darlington Memorial Hospital and the University Hospital of North Durham. As a result a multidisciplinary CCDG had been established and there was an action plan in place to make improvements to the service. A number of actions had already been completed by staff on the unit.
- The trust had recently identified a designated executive director to take lead responsibility for critical care services and a CCDG had been set up. The first meeting of the CCDG took place in January 2015.
- There was a strategy being developed for critical care across both the University of North Durham Hospital and Darlington Memorial Hospital which included the use of outreach services and a rehabilitation after critical care (RaCI) programme. This had been passed to the surgical and diagnostics clinical group for consideration and approval.
- The unit operated its anaesthetic rotas jointly between the operating theatres and the unit. There was some discussion as to whether the rotas should be separated but at the time of the inspection medical staff considered the unit did not have sufficient staff to commit to this.

Governance, risk management and quality measurement

- Historically, intensive care was part of the anaesthetic directorate; however, the unit had moved to become its own team with its own reporting and governance processes.
- The unit had recently started holding monthly multidisciplinary team clinical governance meetings and there were medical and nursing leads for clinical governance. The unit was organising an internal audit calendar with audit key guidelines relating to intensive care such as: NICE 50 guidance, discharge information, delirium screening, nasogastric tube documentation and consultant ward rounds.
- There was a risk register for the unit, including controls and assurances to mitigate risk, which was reviewed every 2 months.
- The senior management teams had a good understanding of the risks to the service and could effectively articulate the controls and assurances in place to mitigate these risks.
- The unit continued to undertake its own mortality and morbidity meetings.

Leadership of service

- There was a strong and visible leadership from the senior medical and nursing staff.
- Staff felt valued and time was spent with junior staff developing and training them as a team.
- There was a clinical lead for the unit. Consultants had specific roles including clinical governance, college tutor for the Royal College of Anaesthetists, audit lead, trauma link, paediatric link, obstetric link, clinical lead for organ donation and ICNARC lead.

Culture within the service

- We found a multidisciplinary team that valued feedback as a way of improving and on a number of occasions went over and above what would be expected in order to keep patients feeling safe and at ease.
- Staff felt supported and spoke to us about the culture being open. Staff were passionate about working as a team in order to deliver the highest quality of care to their patients.

Public and staff engagement

- During the inspection we saw cards and thank you letters from patients and relatives for the care they had received on the unit
- The unit had recently been bequeathed a substantial amount of money from a patient who had been cared for on the unit. Some of this money was to be used to create a sensory area in ITU2 and build a toilet and shower facility requested by other patients. The money was also being used to buy iPads for patients to help with communication and patient entertainment.

Innovation, improvement and sustainability

- The unit had submitted poster presentations on the research they have carried out on the unit and had in the past been nominated for an award.

Maternity and gynaecology

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

Information about the service

Darlington Memorial Hospital is part of the County Durham and Darlington NHS Foundation Trust. Since the trust's re-organisation in November 2011, the maternity services have formed part of the care closer to home care group, situated within the families clinical specialty.

The Darlington Memorial Hospital maternity department and women's services offered a range of healthcare provision to meet the needs of the communities of Derwentside and surrounding villages of Bishop Auckland, Weardale and Teesdale. In addition to early pregnancy services including foetal medicine and antenatal care, there was provision for intrapartum and postnatal services. Facilities were available to support women in all aspects of motherhood, from early pregnancy, ultrasound scanning through breast feeding and pregnancy loss.

There was no longer an option to provide women with care in a midwife-led unit following the closure of the unit at Bishop Auckland on safety grounds.

Women's sub-specialty services include rapid access clinic for cancer services, gynaecological services including outreach services, hysteroscopy, colposcopy, urogynaecology services and infertility services. Fertility control, including medical and surgical termination of pregnancy and contraception, was provided.

We visited the gynaecology ward, fertility control service and all wards in the maternity department. We spoke with seven women, partners of two and a relative of one. Twenty members of staff spoke with us from a range of roles and grades. The care records of eight women using the service were reviewed.

Maternity and gynaecology

Summary of findings

Overall, maternity and gynaecology services at this hospital were good. However, the well led domain required improvement. Senior leaders understood their roles and responsibilities to oversee the standards of service provision. However, within the medical team there were concerns that there was a lack of a joined up approach to the service. Efficiency was compromised by the structure of the closer to home directorate, with decisions not being made or delayed. The arrangements for managing the service were further affected by issues within specific staff groups, which had not been dealt with proactively.

Nursing and midwifery staff considered their direct line leadership to be good, with respected and supportive leaders who understood and shared their aims to deliver quality care. Staff were aware of the trust's values and expectations. Staff felt the service encouraged and supported learning and development.

There were effective arrangements in place for reporting adverse events and for learning from these.

Patient access to designated gynaecology beds was sometimes limited by availability of beds as the ward was used for medical outliers. Staffing arrangements ensured sufficient numbers of skilled and knowledgeable staff were on duty to meet people's individual needs.

Consent was sought from patients prior to treatment and care delivery. Patients received consultant-led care and staff had the support of specialist staff for advice and guidance. Procedures were in place to continuously monitor patient safety and recommended guidance was followed by staff.

Maternity outcomes were monitored and information was communicated through the governance arrangements to the trust board.

The experiences of the care provided by nursing and midwifery staff and medical personnel was positive with regard to the attention received, involvement in decision making, the provision of information and caring approach.

Individual care needs of women using the services were fully considered by staff and respected as far as possible. Physical and mental health needs were addressed by staff with support from those with expertise. Nutritional, religious, cultural and medical dietary needs were met.

The views of the public and stakeholders were sought in relation to developing services. Staff were encouraged and supported to consider better ways of working and to develop the service.

Maternity and gynaecology

Are maternity and gynaecology services safe?

Good

Incidents were reported within the maternity and gynaecology services. Action was taken to understand the cause of serious incidents and learn from the experiences to improve the safety of the service.

The wards and units were clean and uncluttered. Technical equipment was readily available and had been tested for use. Medicines were stored, managed and administered appropriately.

Processes for safeguarding, assessing and responding to risks to safety were appropriate and there was a system for escalation of concerns.

Staff had access to mandatory training in addition to other safety related development opportunities. Nursing and midwifery staffing levels were appropriate and within expected levels. The midwife-to-birth ratio was above the recommended ratio of 1:29. Medical staffing arrangements were managed to ensure sufficient numbers were on duty or available at all times.

Incidents

- Clinical and medical staff were fully aware of the reporting process for incidents, near misses or 'never events'. A never event is a serious, largely preventable patient safety incident that should not occur if proper preventative measures are taken. There was a good understanding from staff who spoke with us of the reporting and investigative processes. Additionally they were able to describe how shared learning from such investigations was communicated to them. This included, for example, discussion at governance and team meetings, newsletters and emails. We reviewed a number of 'key message' notices displayed on wards, which supported what we had been told.
- Staff were aware of a reported never event. We saw that action had been addressed to reduce the risks of future incidents. This included the provision of small white boards in each labour room to enable staff to record counts of equipment used in procedures. A hook was also attached to this board, enabling staff to hang the red tie on it.
- We saw from information provided that staff had reported 86 incidents via the electronic reporting system. These incidents related to the mother or baby during the period of August to November 2014. Incidents had been graded according to impact, such as near miss or moderate harm. There were no particular themes identified in our review to suggest unsafe care.
- Staff were knowledgeable about the review process for incidents, including those that resulted in harm. They understood the need to be open and honest with people and the trust's responsibilities under the 'duty of candour'.
- We attended the multidisciplinary risk meeting, which was held on Friday morning in the maternity department. (A similar meeting also took place in the gynaecology department.) The meeting was run by clinical governance midwives and included good consultant input. During this meeting there was presentation and open discussion of all events reported during the week. Patient notes were fully reviewed and lessons learned were discussed. The duty of candour test was applied, ensuring that any harm identified would be escalated up to include sharing of information with respective individuals.
- We saw there were multidisciplinary meetings with paediatric colleagues in which discussion of unexpected admissions to the special care baby unit took place. We saw reviews relating to maternal cases were also presented as well as risk management issues relating to management of the newborns.
- Staff confirmed there were mortality and morbidity meetings and we reviewed a number of minuted meetings and the associated reports for these. We saw detailed discussion and actions had been recorded.

Safety thermometer

- Each ward area we visited in maternity and gynaecology collected information as part of its safety monitoring. This included the number of incidents related to pressure sores being acquired in hospital, falls and infections. Three falls had been reported in the most recent period and there had been no hospital acquired pressure sores or infections.

Cleanliness, infection control and hygiene

- There had been no episodes of MRSA or Clostridium difficile in the maternity and gynaecology services during 2014.

Maternity and gynaecology

- From our observations of the environment and checks of the cleaning standards we found the environment in which women were receiving treatment and care was suitably clean. Domestic staff who spoke with us confirmed they had guidance to follow in respect to routine daily and weekly cleaning standards.
- We saw domestic staff had been provided with the recommended colour coded cleaning equipment for different areas of the departments. This enabled them to minimise risks arising from cross contamination.
- Environmental checks had been carried out on a monthly basis and we saw results displayed on wards indicating a high level of standards having been achieved.
- Feedback from people using the services indicated they were satisfied with the cleanliness of the wards, bathrooms and toilet facilities. Comments made included "It's very clean, cleaners come round all the time."
- Staff were observed to be complying with the trusts dress code, which included having bare arms below the elbow to facilitate full hand washing. Staff were seen using personal protective equipment such as gloves and aprons, and these were readily available in all areas. There was good access to hand washing and drying facilities in all areas we visited. Staff were seen to follow best practice with regard to hand washing and decontamination. Training information supplied to us indicated 87% of the care closer to home staff had completed a hand wash assessment.
- We observed staff handling and disposing of clinical and household waste correctly and sharps items were disposed in safety receptacles.
- Staff told us there were members of staff working in each area who had been identified as link personnel for infection prevention and control.
- We saw staff had access to up to date guidance in the form of infection prevention and control policies. These were accessible on the hospital intranet.

Environment and equipment

- There were separate ward areas for women using the maternity services. This included the early pregnancy assessment unit, based at the end of the gynaecology ward. A separate pregnancy assessment area was also run by maternity on the antenatal/postnatal ward. Equipment was available for scanning women, by a trained midwife.
- There were six antenatal beds, and 11 delivery rooms on the labour ward, one of which had a birthing pool and one had en-suite facilities. There was one operating theatre with a two-bay recovery room immediately accessible on the labour ward itself. Bathing and toilet facilities were shared on the labour ward. The post natal ward was made up of 15 beds in separate bay areas and two single rooms.
- There was one gynaecology ward with 12 beds, two of which were used for emergency admissions.
- There were women's outpatient facilities, which included access to fertility control services, specialty clinics such as diabetes, and gynaecological consultants.
- The areas in which women were receiving their care were noted to be suitably laid out and afforded privacy. Women spoke positively about the standards of cleanliness and of having sufficient privacy.
- We checked the availability and access to resuscitation equipment and found in each area we visited that the required equipment was available. We saw too that regular safety checks had been undertaken and drugs required for resuscitation were available and in date.
- Emergency equipment used for responding to pregnancy related complications was accessible to staff. This included pre-eclampsia (a disorder of pregnancy characterised by high blood pressure and large amounts of protein in the urine) and postpartum haemorrhage kits. Equipment used in the anaesthetic and operating theatre within the labour ward had been checked to ensure safe use and records were reviewed to confirm this.
- We saw that cardiotocography equipment used for monitoring foetal wellbeing was available. A number of the monitors enabled greater range of movement of women and facilitated monitoring while in the birthing pool or bathing.
- Resuscitaires, used to support newborn babies who may need warming or resuscitation after delivery, were available in each delivery room. These were checked on a daily routine schedule, with records made to support this.
- There were suitable arrangements in place for the provision of technical equipment used for surgical procedures. This included separate clean and dirty areas for preparing instruments in theatre and handling contaminated items after use, prior to re-processing.

Maternity and gynaecology

Medicines

- We reviewed the systems and processes for managing medicines, such as ordering, storage and administration. We found there were systems for overseeing the availability of stock, with checks by the pharmacy on a weekly basis confirmed by staff. Medicines were stored safely, in locked cupboards in secure treatment rooms. Medicines trolleys used for staff to administer prescribed medicines were locked and secured to walls. Only designated staff had key access to medicines.
- We saw that controlled drugs were stored correctly and there were processes in place for undertaking routine counts of stock, with signatures to support such checks. There were a number of discrepancies in the signature section of the controlled drugs register in the anaesthetic room of the labour theatre. One episode of a lack of controlled drugs check in January was noted on the gynaecology ward.
- Medicines audits were carried out and records we reviewed showed where aspects of their management required improvement.
- Medication errors were reported as part of the incident reporting process and we saw a number of these reported within the incident schedule provided to us. Such errors were graded according to impact, such as near miss or no harm.
- Staff on ward areas undertook checks on the fridge temperatures used for storing temperature controlled medicines. However, the fridge temperature located in the anaesthetic room of the labour ward theatre had not always been checked. For example there were 12 days in January and three in February where no checks had been recorded.
- A warming unit used to warm fluids to a required temperature in the labour ward theatre had been checked.
- We saw staff had access to emergency medicines, such as those used for allergic reactions.
- Staff had access to up to date information on medicines and there was recorded information about listed medicines which could be given under a patient group directive.
- Training information provided to us indicated that 97% of required staff within the care closer to home directorate had completed medicines management training.
- In respect to the termination of pregnancy service we saw required practices were being adhered to around prescribing and administration of medicines. This included the use of original prescription for abortifacient drugs and the administration of such medicines on the hospital site. All medicines required were prescribed as part of the care pathway and signed for after administration.
- Although we did not observe a medicines administration round taking place, we saw and heard staff providing medicines, including pain relief in response to request. Such administration was conducted in accordance with safe practice and prescription documentation was signed accordingly.

Records

- The records we reviewed for women in the maternity areas provided an indication of their individual needs, including wishes with regard to the delivery. Information required to support continuity of care was in evidence and we saw updated progress notes recorded. We saw staff recorded all aspects of the delivery including post-delivery skin to skin contact of baby and mother, and women who spoke to us confirmed this had happened following the delivery.
- Records had been kept of medicines given and any post-delivery interventions required, such as suturing of perineal tears. In the case of the latter, the timing of this had been recorded.
- Women had their own maternity records, which were brought into the hospital and these were supported by hospital based records. Staff also completed an electronic record, which detailed the specifics of the delivery and registered the baby's birth. The completion of the electronic record was observed by us to be a lengthy process and some staff reported that it was difficult to find information at times.
- We noted detailed assessment of the newborn and any required care, such as phototherapy for jaundice, entered into the records.
- The discharge arrangements for women following the baby's birth included provision of the national personal child health record or 'red book'.
- Minutes from the band 7 team meeting held on 30 September 2014 indicated that discussion took place around the difficulties of meeting the 95% target for

completing electronic discharge letters for the GP. Performance was said to be affected by inclusion of women who attended the labour ward at times when the pregnancy assessment unit was closed.

- We reviewed formal audit reports for the completion of treatment and care records at each stage of the woman's journey. For example, we saw the audit for caesarean section records carried out in October 2014. This showed the trust-wide audit of documentation had achieved a minimum compliance of 90%, and none of the required criteria had scored below 50% compliance. The intrapartum documentation conducted in October 2014 showed that 29 of the 40 criteria audited achieved at least 90% compliance while only two scored below 50%. These two areas related to absence of stickers in records and stop times not having always been recorded for intravenous syntocinon.
- Medical and nursing records we reviewed for gynaecology patients were detailed and provided information related to their pathway of care. For example, we saw information recorded as to the purpose of the individual's admission and pre-operative preparation including discussion around benefits and risks related to surgery and informed consent.
- We discussed the pathway of treatment and care for individuals attending the service for a termination of pregnancy. The records reviewed indicated a clear pathway with full discussion and consideration of the persons' needs by nursing and two separate doctors.

Safeguarding

- the executive nurse director was the accountable officer for safeguarding in the trust. The director of nursing was supported by an associate director of nursing who was the corporate lead for safeguarding and managed the adult safeguarding lead.
- Other members of the safeguarding team, which is managed by the head of children and families, care closer to home care group, include: a named doctor, named midwife and specialist midwife for safeguarding children. Staff confirmed their awareness of these arrangements.
- Training information pertaining to the care closer to home directorate indicated that safeguarding adults awareness training had been completed by 90% of staff. Safeguarding children level 1 had been completed by 92% of required staff.
- Staff confirmed they had attended safeguarding training. They were able to demonstrate their knowledge by responding to our questions about safeguarding, such as signs and symptoms they may look out for and what they should do if they suspect a safeguarding matter.
- Matters that resulted in triggering a safeguard report were said to be reviewed weekly on each acute site. These were then reviewed for compliance with clinical guidelines and graded for likelihood, harm and severity.
- A monthly safeguard report was said to be generated from these reported incidents to ensure timely monitoring of themes or trends. The safeguarding report was also discussed within the quarterly obstetric and gynaecology integrated governance meetings and subsequent reports.
- Safeguard automated reminders were sent to line managers when incidents had not been actioned or were not been completed within designated time scales.
- We asked staff how they assessed and reported concerns around female genital mutilation (FGM). FGM is defined by the World Health Organization (WHO) as procedures that include the partial or total removal of the external female genital organs for cultural or other non-therapeutic reasons.
- Senior clinical staff told us there had been training in regard to FGM the previous year, which raised awareness. Staff were said to be expected to record information in patient records and to fill in an incident report form. With the exception of the lead for fertility control who advised they asked women and girls if they "had been cut", there was no formal process in place for identifying those at risk.
- Since September 2014 it has been mandatory for all acute trusts to provide a monthly report to the Department of Health on the number of patients who have had FGM or who have a family history of FGM. In addition, where FGM is identified in NHS patients, it is now mandatory to record this in the patient's health record. Since September 2014, all acute trusts are required to provide a monthly report, which is anonymous and no personal confidential data is shared as a result of the information collection.
- In our discussion with staff it was clear that a formal reporting process had not been set up and staff were

not all aware of the requirements. We were however informed that the domestic violence co-ordinator was attending formal training in the near future in respect to this.

Mandatory training

- New employees to the trust were required to attend a formal induction, during which essential training was covered so that staff understood their responsibilities and were safe. Local induction to respective areas followed, which was confirmed by staff. A junior doctor said their induction had been thorough and included a tour of the unit, and a brief on the electronic systems, including passwords. They also had the chance to meet with their supervisor.
- Staff were able to discuss the required mandatory training they had to complete. This included, for example, training related to safety such as manual handling, infection prevention and control, fire safety and falls prevention. Midwifery staff were required to complete additional mandatory training to other nursing staff, such as breast feeding, post-partum haemorrhage and potential delivery complications.
- Midwives told us they had additional training related to their role. This included infection control and sepsis, skills drills and scenarios, and cardiotocography monitoring.
- We asked to see the training figures for the maternity and gynaecology staff and saw these indicated a variable compliance rate. for example; moving and handling training (practical) had been attended by 97% of staff, learning disabilities had been attended by 46% (target 82%), slips, trips and falls (staff & others) had been attended by 89%, and slips, trips and falls (patients) had been attended by 22% of staff.
- Training was seen to have been discussed within the Quarterly Obstetric and Gynaecology Integrated Governance report for October 2014; however, we did not see any reference to compliance rates for mandatory training or any actions to be taken to increase attendance.

Assessing and responding to patient risk

- Nursing and midwifery staff undertook various risk assessments as part of routine practice. These included risk assessments concerning the individual's skin condition and risk of tissue damage over bony prominences, manual handling and falls. In addition a venous thromboembolism (blood clot) risk was carried out. Where interventions were required we saw these were acted upon. For example, prophylactic blood thinning medicines were prescribed where needed or special compression stocking were measured for and fitted.
- A specific risk assessment was used in maternity, known as an early warning score (EWS). The recording of observations and completion of the EWS was identified in the Clinical Negligence Scheme for Trusts Maternity Clinical Risk Management Standard report for January 2014 as an area that required improvement. We saw in the records reviewed that the required monitoring of women's risks had been completed.
- For individuals attending the operating theatre, including where a caesarean section was being performed, we saw safety checks had been carried out. These had taken place prior to undergoing surgery, during and post-surgery. These checks were in accordance with the WHO recommended best practice guidance.
- Surgical patient records included the use of risk assessments, which required nursing staff to undertake various observational and physical recording of the wellbeing of the person. Where deterioration was identified the staff followed an alert protocol for requesting review by medical staff or urgent attention.
- We reviewed recorded and signed cardiotocogram records, which related to the monitoring of babies during the labour.

Midwifery staffing

- Guidance in respect to staffing levels was described within the Maternity Services Staffing Guideline documentation, a copy of which we reviewed.
- Requirements around staffing levels for professionals involved in the provision of safe care to women and their babies should demonstrate that the maternity service is working towards the recommendations within 'Safer Childbirth' (Royal College of Obstetricians and Gynaecologists [RCOG], 2007). The trust reported the midwife to patient ratio was better than the England average. For example, in March and July 2014 the ratio was 1:25 for the trust, against an average of 1:29 for England. During our visit we saw information to confirm ratios similar to that of the reported period.
- Midwives and maternity support workers provided a full range of maternity care within the community setting.

The majority of care provided was antenatal and postnatal care, but intrapartum care was also provided to women who had requested a home birth. Community midwifery services were provided between 8:30am and 5pm; outside of these hours an on-call service was provided. Community midwives also provided shifts to the labour wards.

- Staffing figures were made publicly available and we reviewed data for December 2014 and January 2015. We saw, for example, the average percentage for registered midwives on days was 100.5% in December and 98.4% in January. For nights the percentage achieved was 82% for December and 89.6% in January.
- Registered nurse staffing on the gynaecology ward on day shifts in December was reported to be 89.7% and on nights 98.4%. Registered nurse staffing on this ward in January 2015 was 101.5% on days and on nights 100.3%.
- Staffing was being monitored on a daily basis by the senior midwives, ward managers and lead obstetricians. An acuity tool was used on the electronic system to plan staffing levels. We noted that staffing levels were displayed on entry to wards. Information included expected staffing per shift, actual staffing by trained nursing/midwifery staff and healthcare support workers. For example on ward 61 we saw they expected to have four trained midwives on the early shift, three on the late shift and three at night. On the day we saw there were three on each shift. The required healthcare support workers were to be two on each shift and this was arranged. On maternity wards we saw there was an identified person in charge and also the name of the midwifery supervisor available to support staff where needed. Midwives of various band levels were rostered on duty and they were supported by healthcare workers.
- On the gynaecology ward there was an identified person in charge.
- Short-term management of issues with staffing were described in the Maternity Services Staffing Guidelines as well as the escalation process to follow.
- Information was supplied to us in respect to agency and temporary (bank) staff use for the care closer to home division. This indicated low usage of 0.6% in July 2014 up to 1.5% in May 2014.
- We reviewed figures supplied to us for sickness absence rates in nursing and midwifery. These ranged from 4.1% for May 2014 to 6.6% in September 2014.
- Turnover rates for nursing and midwifery staff ranged from 2.02% between April and June 2014 and 2.6% between July and October 2014.
- We reviewed information supplied to us, which indicated low rates of nursing bank and agency use. Figures for the period of April to October 2014 indicated between 0.6% and 1.5% of gaps were filled by staff from bank or agency.

Medical staffing

- The medical staffing mix for the maternity and gynaecology service across the trust was similar to the England average, with 34% consultant grade staff as was the England average. Middle grade staff, that is doctors with at least 3 years as a senior house officer or at a higher grade, was 5% at the trust and the England average was 7%. Registrar staff formed 55% of the staff, against an England average of 52%. Junior doctors, those in foundation years one or two, made up 6% of staff, with England's average at 7%.
- The unit had implemented, with trust support, a plan to provide resident consultant cover during weekdays and to have non-resident cover at weekends. This required the consultant to be on call with a junior member of the team, and the consultant provided all the obstetric expertise. This provided a high level of on-site obstetric cover for a unit delivering just over 2,000 babies per year. This was recognised as an innovative arrangement. With four consultants participating in weekday on call, this provided flexibility for the trainees to attend training sessions during the day.
- The labour ward was effectively covered by consultant presence on all weekdays until 5pm. On 4 days a week the cover after 5pm was provided by a resident consultant with back up from another on-call consultant in case there were two simultaneous urgent events. There was one registrar and one more junior doctor also on duty. At weekends the resident cover was provided by the registrars with back up was from the non-resident consultant. The trainees we spoke with spoke very highly of this arrangement as it supported the learning of the junior trainees out of hours and the registrars indicated that consultant support was quickly available.
- Anaesthetic cover out of hours was provided by a specialist registrar who also covered the intensive care unit and the accident and emergency department. If it

became busy, a third on-call doctor (consultant grade) was called in to the hospital. No one raised any issues with us about difficulty in accessing anaesthetic support in a timely way

- Junior medical staff were satisfied with staffing, reporting there were sufficient doctors between 7am and 8pm Monday to Friday and four doctors on duty Monday to Thursday night and three Friday to Sunday nights. Two specialist registrars supported the team and consultants were said to be "always available, even at 4am." Further, they were reported to be "very helpful and approachable."
- Information was supplied by the trust in relation to medical locum usage in the care closer to home division. This indicated the percentage of time covered ranged between 10.6% in September 2014 and 14.5% in October 2014. We could not identify how much of this related to the Darlington site.
- We observed handover between medical personnel going off duty and incoming doctors. This was a multidisciplinary process involving an anaesthetic consultant as well as the incoming and departing obstetric consultants, relevant junior staff and the midwifery coordinator. It happened in a very small room (a kitchen). Handover was effective and comprehensive, covering all areas of the unit and ensuring that where patients needed review this was noted.

Major incident awareness and training

- The trust had a major incident plan in place that set out actions to be taken for major incidents and other similar events. Staff were able to describe their role in responding to a major incident.

Are maternity and gynaecology services effective?

Good

Staff had access to and were using evidence-based guidelines to support the delivery of effective treatment and care. Women reported having their pain effectively managed and that there were choices for managing pain. An anaesthetist was on duty to administer epidurals. Support was offered to women feeding babies, and food and drinks were available for mothers at all times.

Patient outcomes were being closely monitored via the maternity dashboard

Staff were competent in their roles and received performance reviews and supervision. They worked well within the multidisciplinary team to serve the interests of patients.

Evidence-based care and treatment

- Medical and clinical staff reported having access to guidance, policies and procedures on the hospital intranet. The system was said by a junior doctor to be "very helpful; easy to use and information is in the right place." We looked at a range of guidelines available and saw these were up to date. For example, guidelines for non-viable pregnancy, ectopic pregnancy, miscarriage and heavy menstrual bleeding.
- We were able to see from our observations and through discussion with staff that care was being provided in line with the National Institute for Health and Care Excellence (NICE) Quality Standard 22. This quality standard covers the antenatal care of all pregnant women up to 42 weeks of pregnancy, in all settings that provide routine antenatal care, including primary, community and hospital-based care.
- The care of women who planned for or needed a caesarean section was seen to be managed in accordance with NICE Quality Standard 32. For example we saw evidence in the notes reviewed of discussion with a consultant prior to an elective caesarean and a debrief after delivery.
- There was evidence to indicate that NICE Quality Standard 37 guidance was being adhered to in respect to postnatal care. This included the care and support that every woman, their baby and as appropriate, their partner and family should expect to receive during the postnatal period. There were arrangements in place that recognised women and babies with additional care needs and referred them to specialist services. For example, there was an on-site special care baby unit (SCBU).
- The neonatal service was provided on site from a level one SCBU. The unit had 12 cots available to support neonates who had ventilation failure or failure of lung function. This could be addressed through continuous positive airway pressure and short-term ventilation

pending retrieval by the transport service of the Northern Neonatal Network. A neonatal nursing outreach service facilitated early discharge of selected babies from both units.

- We saw evidence in records reviewed and confirmed in discussion with a new mother that there were arrangements in place to manage sepsis. **Sepsis** is a potentially life-threatening complication of an infection. Staff followed a care bundle for identifying and managing sepsis, which included provision of antibiotic therapy.
- The RCOG evidence-based guidelines related to feticide: section 6.7 were being adhered to. This sets out the premise that feticide should be performed before medical abortion after 21 weeks and 6 days of gestation to ensure that there is no risk of a live birth.
- We found from information reviewed and from discussion with staff that the fertility control service adhered with The Abortion Act 1967 and Abortion Regulations 1991. This included the completion of the necessary forms (HSA1 and HSA4).
- Diabetes care in pregnancy forms part of the National Diabetes Inpatient Audit (NADIA). We spoke with one individual who described how their diabetes had been managed during the pregnancy and their baby had been monitored subsequently.
- The risk management operation policy indicated that there was an obstetric audit lead on each site. The Clinical Governance Audit half days and the Obstetric & Gynaecology Clinical Governance forum were held together when possible.
- There was an annual audit calendar in place in line with the trust requirements, which focused on clinical priorities. The audits were delegated by the obstetric audit lead and the patient safety and quality midwives. We saw audit data related to WHO checklist compliance, which had been carried out in December 2014. We noted out of the 27 checklist records reviewed that a red compliance rating had been applied to the sign out section, with 87% completed against a target of 95% or above.
- We found that the care of women using the maternity services was generally in line with RCOG guidelines (including 'Safer childbirth: minimum standards for the organisation and delivery of care in labour'). These standards set out guidance in respect to the organisation, safe staffing levels, staff roles, and education, training and professional development.
- In conjunction with The NHS Litigation Authority Clinical Negligence Scheme for trusts, maternity clinical risk management standards were assessed in January 2014 against five standards. Each standard contained 10 criteria giving a total of 50 criteria. In order to gain compliance at level two the organisation was required to pass at least 40 of these criteria, with a minimum of seven criteria being passed in each individual standard. The organisation scored 49 out of 50 for safety standards such as high risk conditions, postnatal and newborn care, and clinical care.

Pain relief

- We saw from our review of medical records and from our discussion with individuals that options were offered for pain relief during caesarean section and other surgical procedures. One person said they had a spinal anaesthetic and monitoring of their pain had taken place throughout their stay. Pain relief was said to have been given when needed. Other women who had delivered their babies confirmed that their need for pain relief had been addressed. For example, one person said, "I have had pain relief and staff are constantly checking."
- Options for pain relief were also discussed for the management of labour. We saw this included epidural, Entonox gas and controlled drugs such as pethidine.
- There was access to the pain team for individuals who required additional interventions and management.
- We discussed the experience of pain management with patients who had undergone gynaecological surgery. One person said they had experienced "quite a lot of pain" and "as soon as I ask they give me something." This person said the staff always asked if the pain relief had worked and were constantly asking what their level of pain was. Their care records confirmed this.

Nutrition and hydration

- Feedback on the quality and choices of food provision was for the majority positive in each area we visited. Comments included, "It's quite tasty" and "good menu with enough choice from small, medium or large portions." Another person said the food was "very nice" and "we have choice." Preferences for vegetarian or dietary restrictions were catered for, such as gluten free and diabetic. Another person said the food was "really nice, lots of choice and good quality", which they were not expecting.

- We observed meal service provision and saw staff ensured each person had a meal of their choice. Good hygiene practices were adopted by staff during the handling and distribution of food items. We saw adequate provision of fluids and people confirmed they were able to have drinks as required.
- One new mother said staff had been respectful of their decision about how to feed their baby. Another mother said staff had supported her to feed her baby and as a result of low blood sugar the baby was having supplementary tube feeds.
- Another new mother told us how staff had been helping her with breast feeding, such as finding the best position. This person said they had also been given information on breast feeding in preparation for discharge home.

Patient outcomes

- The service was not identified as a risk for maternity outliers, such as maternal readmissions, puerperal sepsis and other puerperal infections. (A puerperal infection, or puerperal sepsis, is a condition that occurs when a woman experiences an infection related to giving birth).
- The National Neonatal Audit Programme (NNAP) includes two questions that would apply to the maternity area. The report for 2013 indicated that the location achieved 100% compliance with temperature taking of babies born at less than 28 weeks and 6 days. The location scored below the percentage of mothers being given a dose of antenatal steroid when they delivered a baby between 24 plus 0 and 34 plus 6 weeks gestation.
- Patterns of maternity care were monitored in accordance with the RCOG 11 quality indicators. 10 out of 11 RCOG indicators were within expected range for this trust, with the clinical indicator for third degree tears being above expected range.
- The trust had no post partum hysterectomies reported in 2014.
- There were 1,093 deliveries at the location for the period April to September 2014.

Competent staff

- There was a nominated maternity lead for coordination of education and training. This person was responsible for monitoring of the training needs analysis for the maternity services in conjunction with the Employment Services Bureau.
- We reviewed information which outlined the training programme for obstetrics covering 2014/15. We saw specific sessions were listed with duration and named speakers. Subjects covered included, for example, early recognition of seriously ill pregnant women, antenatal and newborn screening and medicines management.
- New nursing and midwifery staff had a period of 'preceptorship', where they received additional support and went through a programme of competencies. Staff reported that the level of support and training was "very good." Examples of skills covered included a period of time in operating theatres, during which midwives increased their previous knowledge acquired through midwifery training. This included scrubbing for surgery.
- Staff who spoke with us explained how they had the opportunity to achieve various competencies. This included, for example, suturing, cannulation and phlebotomy (taking blood).
- The measurable standards for level of staff training was seen to be outlined in the trust's training policy.
- In addition to the trust mandatory training, there was a separate maternity services training needs analysis. The dates for all mandatory training were agreed in advance to enable members of the team to book and maintain high compliance with the training requirements.
- We saw from the training programme there were skills drills in subjects such as cord prolapse and breech delivery, shoulder dystocia, eclampsia and obstetric haemorrhage. (Shoulder dystocia occurs when, after delivery of the foetal head, the baby's anterior shoulder gets stuck behind the mother's pubic bone. If this happens, the remainder of the baby does not follow the head easily out of the vagina as it usually does during vaginal deliveries.)
- Healthcare support workers were required to attend training to support the delivery of maternity services and information we reviewed indicated examples of subjects covered. These included the care of deteriorating patients and MEOWS, maternal observations, skills drills, breech births, eclampsia and neonatal life support.

- A team from the trust, including obstetricians, anaesthetists and midwives, had attended a simulation centre at Teeside University in November 2014. There were also funded places for simulation training at Sterling in February 2015.
- Staff working in both maternity and gynaecology confirmed they had an annual performance review or that they were expecting to have one in the immediate future. We were told the review offered a chance to discuss their performance and development needs and it was seen as a valuable and positive opportunity.
- We reviewed information which indicated that out of 26 medical personnel, six were behind on having their annual appraisal. We could not identify from this if this figure related to the whole service across both sites or just Darlington. Revalidation was part of appraisal and the medical staff spoken with reported no difficulty in getting an appraisal done.
- Separate to their appraisal, midwives said they had access to and support from a midwifery supervisor. They reported that the process was very similar to the annual performance review.
- The Local Supervising Authority has a statutory role and responsibility to deliver the standards for effective statutory supervision of midwifery set by the NMC. The LSA Midwifery Officer monitors the standards through national, regional and local quality assurance processes.
- The Formal Local Supervising Authority Audit Report 2013/14 for County Durham and Darlington Foundation NHS Trust was reviewed by us. We saw a number of recommendations were made from the audit review and an action plan was to be produced for consideration.
- The trust reported that it had a specialist midwife for safeguarding, a patient safety and quality midwife as well as a research midwife and diabetes specialist.

Multidisciplinary working

- There was cross site working within the leadership team for maternity and gynaecology. Multidisciplinary meetings took place in relation to gynaecology cancer patients.
- There were arrangements in place for the transfer of women using the maternity service between sites when required.
- Transfers of all babies in the region were done by a dedicated transfer team working out of the level three centres and this was said to be working well.
- Staff confirmed they were able to access advice and guidance from specialist nurses/midwives, as well as other allied health professionals. We saw arrangements had been put in place for a referral to physiotherapy for a gynaecology patient.
- The health visitors and the community midwife team worked together in respect to identifying and reporting potential risks to hospital staff. Any risks were notified via health visitors, and community midwives had access to pathways in respect to vulnerability or learning disabilities. Information was said by staff to be shared through a concerns form and a red flag alert was added to the booking system.
- Community midwives rotated onto the wards and this was said to have aided communication and the development of the team.
- We saw there were effective arrangements in place for communication with the community maternity team. This included the completion of information in each expectant mother's personal records, in addition to the supply of the postnatal care pathway being sent to the community at discharge. Staff confirmed these arrangements and told us community midwives were provided with information on the delivery and immediate post-delivery care.
- Communication with GPs during antennal care and around the discharge was seen within women's hand-held records.
- Staff confirmed there were systems in place to request support from other specialties such as physicians, consultant microbiologists and pharmacy.

Seven-day services

- Consultant obstetrician cover for the location equated to 98 hours, based on a resident model. Cover was said to be provided on weekdays between the hours of 9am and 5pm. Anaesthetic consultant cover was arranged between 8am and 6pm Monday to Friday, and there was on-call cover for out of hours periods.
- Where necessary there was access to out of hours services such as pathology, diagnostics and physiotherapy.

Access to information

- People who used the women's and maternity services had access to a range of informative literature. We saw examples on display, such as information on whooping cough in pregnancy, smoking cessation and local pregnancy posture groups. We saw information about local 'Birth and Babi' information groups, (BABi).
- Website information available included a publication by the trust: 'Choosing where to have your baby'.
- Maternity care assistants had a particular role in supporting the provision of information to new mothers and their partners. This included health promotion, such as breastfeeding, nutrition and exercise. In addition they addressed smoking cessation. A maternity care assistant explained their role and how they were supported by an infant feeding coordinator, which enabled information and guidance to be delivered effectively.
- Information to support the fertility control pathway included leaflets about medical and surgical pregnancy termination and being 'undecided about your decision'. A leaflet had also been developed for those supporting someone having a termination of pregnancy.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- Staff described how they provided information to women receiving pregnancy care about matters such as intimate examinations. This enabled them to obtain informed verbal consent.
- Where women were to undergo a surgical procedure, including elective or emergency caesarean section or gynaecological operative procedures, these could not proceed without the required completed formal consent records. We saw such records in the notes reviewed and saw, for example, detailed information about risks and benefits of surgery having been discussed.
- A patient who had undergone their surgery told us with respect to consent that they had discussed everything before surgery and the doctor came back to double check they were happy to proceed. They said everything had been "fully discussed, including risks."
- The fertility control pathway for medical or surgical termination of pregnancy required separate consultation between the individual and two doctors independently. We saw from information reviewed and observation that individuals attending the clinic were seen by each one of two doctors separately. This allowed full consideration and discussion of the facts before prescribing the course of action and gaining the required consent.
- Staff working in fertility control understood their responsibilities in respect to females under the age of 16. Fraser guidelines formed part of the competency assessment around advice and/or treatment without parental consent.
- Staff were able to describe how they supported individuals with learning disabilities or who lacked capacity. This included involving carers, next of kin or advocates where decisions about treatment or care were required.
- Within the gynaecology services women over the age of 65 years of age were assessed in respect to cognition, which helped to identify anyone with impairment such as dementia.
- There was additional review by the sister on the gynaecology ward of any outliers being given care on the unit to ensure that all women had appropriate assessment of their cognition in the light of sometimes quite acute illness.

Are maternity and gynaecology services caring?

Good

We spoke with seven women and three partners or their relatives. Without exception they reported positively on their experience of receiving care from staff. Staff were described as supportive, caring and compassionate. The majority of respondents reported receiving detailed information, of being involved and enabled to make informed decisions. Choices and decisions were respected by staff and explanations for alternative options where needed were discussed.

We observed calm and organised ward environments, in which women receiving treatment and care were treated respectfully and with dignity.

Arrangements were in place to ensure women received appropriate emotional support and that their partners were involved.

Compassionate care

- Individuals who spoke with us in maternity areas and on the gynaecology ward spoke very positively about the care provided. For example a person who had current and previous experience of the service said, “It’s always excellent care, nurses are great and I can’t fault anyone.” This person said there was a high regard for personal respect and privacy.
- A woman who spoke with us about the delivery of their baby said it had been “great, no problems and an enjoyable experience.” This person added that staff had been respectful about their decisions, preferences and provided sufficient privacy.
- One new mother reported a mixed experience of their first baby’s delivery with regard to her expectations. The relative accompanying this lady said, “We feel she should have had a caesarean section.” The baby’s mother said, “They talked to me about it but I wasn’t given a choice or the option.” We informed the midwife of this in order that they could discuss the matter. Despite the initial comments made to us the new mother said from the moment the baby was born, “care has been perfect, brilliant.” The midwife was said to have been excellent and the student midwife was “fantastic.”
- Another new mother told us their experience had been “really good” and gave examples of staff having been very responsive to calls and providing help and support. They said their partner had been fully involved and encouraged to stay overnight, and had been allowed into theatre during the caesarean surgery. In response to our questions around staff treating her with dignity and respect, this was confirmed. Another couple said their decisions were “fully respected” and “our midwife was first class.”
- New parents described the service as “first class, every step from the GP and appointments to delivery.” Staff were described as supportive, open to communication and that all their questions were answered. They added that “although staff were busy at the time of our arrival, we felt they made time for us and nothing was rushed.”
- We observed positive interactions of staff with women and their partners. Staff were seen to behave in a calm, compassionate and caring manner. We heard staff providing advice and encouragement, as well as dealing with urgent situations with calmness and efficiency.
- Six of the Friends and Family Test results were better than the England average. This included three elements about staff care during labour and birth and the care in hospital after birth. We saw displayed on ward information boards feedback from Friends and Family Test responses. For example on the postnatal ward 62 responses had been made in December 2014. Of these, 36 people said they were extremely likely to recommend the service and nine that were likely to. Sixteen of the remaining respondents did not know. All the people we spoke with said they would recommend the services to friends and family.
- The CQC survey of women’s experiences of maternity services for 2013 indicated that the trust performed better than others for six of the questions asked. The remaining responses indicated the trust as being about the same as other trusts.

Understanding and involvement of patients and those close to them

- Patients who had received surgery and were being cared for on the gynaecology ward reported positively on the level and range of information provided. A patient said they had been “fully informed each step of the way.” They added they had been able to ask questions and had had them answered.
- Women using the maternity services at Darlington Memorial Hospital told us they had been given detailed information throughout their pregnancy. Information was said to have been provided in a meaningful way, which they understood. The women and their partners who spoke with us after the birth of their baby said they had been fully involved in discussions and the decision making process. One person described how they had made the decision the day before to have a caesarean section and said, “It was scary but staff were lovely and made the experience good.”
- A new father told us "we could ask questions and nothing was missed.” They added, “It has been a tremendous service, all great and a very good handover at the bedside.” (referring to the sharing of information and their involvement).
- With respect to labour, women told us they had been fully informed and things were explained to them. A new mother who had not experienced the delivery as she expected told us the doctor who was there at the delivery “made a point of explaining everything and took time to update us.”

- A new mother whose baby had to go to the SCBU for intravenous antibiotics expressed her frustration at having to keep asking for an update. This person said they felt they had to pass information between respective departments.

Emotional support

- We saw from the notes reviewed that staff included information about previous or existing anxiety and depression.
- Midwifery staff confirmed they could arrange for women to access an experienced midwifery counsellor. Nursing staff leading the fertility control service also had a role to provide counselling.

There was a designated member of staff to support individuals and their families who suffered bereavement. Facilities and aids were provided to ensure the bereaved parents had time with their baby and could keep mementos such as photographs.

Are maternity and gynaecology services responsive?

Good

Patient flow through the maternity unit enabled women to access the service at each stage of their pregnancy with ease.

The provision of beds on the gynaecology ward were frequently limited by use for medical patients. This had resulted in some cancellations of surgery and postoperative care of gynaecology patients on alternative surgical wards.

The individual care needs of patients and women at each stage of pregnancy were fully considered by staff and acted on as far as possible.

The fertility control pathway provided an efficient and effective service to women and girls in response to their respective needs.

There were arrangements in place to support people with physical and learning disabilities. Translation services could be arranged as required and information in alternative languages could be provided on request.

The complaints process was understood by staff and patients were supported to raise concerns or discuss their worries. Where complaints were raised, these were investigated and responded to and lessons learned were shared with staff.

Service planning and delivery to meet the needs of local people

- As part of the teen mother pathway there were sexual health practitioners (young parent support). Within the trust there were two whole time equivalent posts dedicated to preventing second or subsequent unintended teen pregnancies. All teenage mothers were offered planned support during the antenatal period for contraception services for post-delivery. There had been 204 referrals since the start of the programme in March 2014, which was an uptake of 82%.
- Senior clinical staff reflected on the maternity services and said it was about “birth and beyond.” They reported the challenges to be about making changes happen quickly, with pressures of processes to go through and resources. In addition there were recognised capacity pressures.
- Service planning had included a review and report on the birth environment at Darlington, carried out in December 2014. The purpose of this had been to contribute to the maternity strategy, with a view to increasing the normal birth rate, and reduce interventions and caesarean section rates. The review process had involved contributions from women who had used the service. Our review of the report demonstrated that the process had identified a number of changes required.

Access and flow

- The maternity service consistently met the 90% target of maternity bookings before 12 completed weeks’ gestation.
- Overnight bed occupancy for 2013 and the first quarter of 2014 was better than the England average, ranging between 45.5% and 49.5%.
- Length of stay in maternity was calculated in terms of midwifery episodes. These ranged from 0.53 to 0.93 between May 2013 and October 2014.
- At the time of our visit the trust was not collecting data on the percentage of women during labour being seen by a midwife within 30 minutes and by a consultant within 60 minutes.

- A central booking line was in place for early pregnancy diagnosis. Referrals could come via the GP or midwife, and if there was a previous history of ectopic pregnancy or miscarriage, women could self-refer.
- The CQC's survey of women's experiences of maternity services for 2013 received information related to access and flow. With respect to the question 'If you used the call bell how long did it usually take before you got the help you needed?', the trust scored 8.6, against an England average of 8.
- The maternity unit had been closed twice to new admissions in the period 1 January to 30 November 2014. On one of these occasions elective work was delayed but no patients required transfer out. Monitoring of closures, including rationale for this, was undertaken within the management team.
- The fertility control pathway outlined the route for medical or surgical termination of pregnancies. Access to the service was available subject to best practice guidance at the Bishop Auckland location. The number of medical abortions between April 2013 and March 2014 was 915. Surgical termination of pregnancy was carried out on 98 occasions for the same period.
- There was a nurse-led hysteroscopy service along with a nurse-led laparoscopic procedural list, which took place every 2 weeks.
- We found the gynaecology ward was being used as an outlier ward for medical patients, and staff confirmed this was a regular occurrence. There was a degree of concern from staff that they sometimes cared for medical patients who had treatment needs for which they had not had recent training. They informed us that in such situations they escalated the matter so that alternative beds could be located as soon as possible.
- While we were on the gynaecology ward we were made aware that five patients were being admitted by nursing staff but they would not have a bed to use after their surgical procedures. Staff had made arrangements for the patients to go to the day surgery unit after their surgery to be looked after.
- We were told there had been 31 cancellations as a result of the bed status, particularly over Christmas, and surgical procedures were in the main reduced to day case activity while inpatient beds were not available.

Meeting people's individual needs

- There were arrangements in place to support individuals with complex needs, with access to clinical specialists and medical expertise. The trust advised they had a lead nurse for learning disabilities. Staff were aware of how to access these staff if required.
- Staff were able to explain how the translation service was accessed and used. We saw there was guidance to support staff through the 'Interpretation and Translation Policy' dated 10 April 2014. This also referred to using the services of the British Sign Language service.
- Midwives said they encouraged 'normalisation' in respect to women's experiences, providing a good environment, as relaxed as possible, "with lots of information and informed choice."
- Midwifery staff described their role in supporting individuals who had learning disabilities. The emphasis was around ensuring the individual/s concerned understood the provision of maternity care. Next of kin and carers were involved and, where necessary, social services, to ensure the best outcomes for parent/s and child.
- A teenager pregnancy clinic took place once a week with a designated lead consultant.

Learning from complaints and concerns

- The trust advised us that the chief executive officer had overall responsibility for managing complaints across the service. The director of nursing managed the complaints process together with the associate director of nursing. Individual complaints were managed by the corporate patient experience officer team, one of whom was assigned to each care group. Investigating officers provided the response to the complaint, supported by complaint leads.
- The care closer to home directorate had one patient experience officer dedicated to investigating complaints.
- Senior clinical managers told us complaints had declined in general but themes were identifiable and included attitudes and behaviour of staff. Where such complaints arose, individual conversations took place with staff. This included discussion about expectations. Insight training was said to have been used positively to improve staff communications.
- Complaints were discussed as part of the governance arrangements and included a formal review in the 'Quarterly Obstetric & Gynaecology Integrated

Governance Report' for May to July 2014. We saw information that identified six complaints as having been raised and investigated for the period April to June 2014.

- A listening service was also provided to women and their partners, which they could self-refer to. We saw from information recorded that four such discussion meetings had taken place between April and June 2014 for women who used the Darlington Memorial Hospital and Bishop Auckland General Hospital. In each case the reason for referral was recorded. This included, for example, women wanting to know the reasons for a caesarean section and understanding the cause of a traumatic birth. The outcome from the discussion was also evaluated and recorded.

Are maternity and gynaecology services well-led?

Requires improvement

Senior leaders understood their roles and responsibilities to oversee the standards of service provision. However, within the medical team there were concerns that there was a lack of a joined up approach to the service. Efficiency was compromised by the structure of the closer to home directorate, with decisions not being made or delayed. The arrangements for managing the service were further affected by issues within specific staff groups, which had not been dealt with proactively.

The directorate had a direction of focus, defined by strategic aims and an associated vision. The governance arrangements enabled monitoring and evaluation to be conducted and information was reported to the trust board and to staff.

The care closer to home directorate identified actual and potential risks at a service level and had in place mechanisms to manage them and monitor progress.

Nursing and midwifery staff reported positively on the level of engagement with their immediate line managers and medical staff. They reported their areas to be well-led, with open communication channels and a good level of support.

Medical teams worked well across sites on subject-specific projects such as high risk pregnancy, but this appeared to be largely due to personal interest and motivation rather than being part of a coherent plan for joint working.

The nursing and midwifery team encouraged innovation, learning and continuous improvement. There were opportunities for people using the service, staff and the public to contribute to service improvements.

Vision and strategy for this service

- Discussion with the clinical director for maternity indicated that he thought there was a vision for the service, which was to focus on reorganisation of the services. The strategy was to maintain two maternity units within the trust, as analysis undertaken by the trust had indicated a centralised service would disadvantage the population. However, there was an awareness of the pressures in maintaining standards, particularly as it was anticipated that there would be increasing demands from other regional areas.
- Plans were said to have been presented to the trust board in relation to restructuring and environmental development and the senior team were "pushing hard for release from the trust board."
- The directorate had been successful in identifying funding to create new consultant posts to deliver a consultant-led service out of hours. This was more advanced at this site than University of North Durham hospital .
- For obstetrics, the focus was on achieving more consultant presence on the delivery suite and establishing alongside a midwifery-led service on one or both sites.
- We reviewed the draft clinical and quality strategy for 2014–16 and saw this outlined work streams aimed at achieving centres of excellence in respect to gynaecology and pregnancy assessment. We noted there were identified measures of success and milestones, although there were no dates identified for achievement or evaluation.

Governance, risk management and quality measurement

- We found that the patient safety meeting had been given delegated authority by the care closer to home assurance group to review, discuss and make decisions about patient safety relevant to the County Durham and

Darlington NHS Foundation Trust. It also examined the evidence required to provide assurance to the care closer to home assurance group and make recommendations on the effectiveness of internal control mechanisms. Further, it was responsible for the review of safety procedures, safe systems of work, and ensuring that all risks were escalated in line with the County Durham and Darlington NHS Foundation Trust risk management strategy and incident management policy. The designated representative for maternity was the patient safety and quality midwife.

- The Obstetrics and Gynaecology Quarterly Clinical Governance Forum was a multidisciplinary group, representative of the trust-wide overarching group. The group considered patient safety, clinical governance and clinical quality. Staff confirmed the group met on a quarterly basis to review activity on the wards as well as governance matters. This included clinical obstetric and gynaecological issues along with organisational matters.
- The 'Quarterly Obstetric and Gynaecology Integrated Governance Report' for May to July 2014 was reviewed and we saw this contained information about safety, such as incident reviews and medication incidents, with investigation outcomes and actions taken. This included, for example, additional supervision and training. We saw the risk register was reviewed and updated to reflect closed matters or new additions.
- We reviewed the obstetric and gynaecology risk management operational policy in conjunction with the trust risk management strategy. Information contained therein outlined the purpose, methods and responsibilities for managing risks in the maternity services. We noted there were a number of key measurable objectives set for the period 2014/15, such as safe staffing levels, safe practices and incident review reporting processes.
- Senior managers for the clinical staff confirmed that risk meetings were held weekly in maternity and monthly in gynaecology. The lead safety and quality midwives were responsible for attending these meetings and creating the action plans and information bulletins arising from the review process. The practice development midwife addressed areas within the monthly training sessions to reinforce further the key messages.
- The obstetric and gynaecology risk management operational policy stated a core aim as "Maintain and update a dynamic maternity risk register. This will demonstrate that risks have clearly been identified and the corresponding controls and requirements are agreed and identified on the risk register or escalated and shared with the trust board'.
- The risk register for maternity services was reviewed and we noted a lack of risks identified. The one risk reported related to sickness absence. This was accompanied by an action plan, a designated responsible person and review dates. However, in our discussion with senior clinical staff they described another risk related to the pregnancy assessment clinics, linked to the ultrasound service. We asked why this was not on the risk register and it was explained to us that the Care Group evaluated the risk and considered that mitigations were in place, hence it was removed from the risk register but monitored through the issues log in accordance with the Care Group's local practice.
- The maternity service dashboard did not have much detail on it and it was not clear where the standards had come from. Maternity dashboards are generally used to provide an early alert to the maternity service and the trust board. Performance of the maternity service would be expected to be benchmarked and assessed against 'Mothers and Babies; Reducing Risk through Audits and Confidential Enquiries-UK' (MBRRACE-UK) reports, RCOG and Royal College of Midwives (RCM) guidance, National Patient Safety Awareness (NPSA) Never Events, and patient experience/complaints.
- Staff confirmed there was maternity and gynaecology representation on the trust board, ensuring a voice for the services.

Leadership of service

- Several staff commented that the Care Closer to Home Care Group structure didn't work within maternity and gynaecology services. The care group was said by a number of senior staff within this service to be made up of large divisions, with too many layers, which impacted on efficiency. Complicated decisions were said by one consultant to get lost or delayed in escalation. Another separate senior member of medical staff commented that it was difficult to be "listened to." Examples of the difficulties included the time taken to consider matters, such as agreement to expand the consultant team. The plan was said to have been put forward more than 4 years previously and a business case and funding was agreed, but this had since got 'lost in the system'. Clinical staff at a senior level said the channels of

communication needed to be reviewed but they "made it work." They added, "A flatter structure works better for us" and "staff want to be valued and this impacts at a local level."

- We reviewed the organisational structure for midwifery and gynaecology, which was overseen by the designated head person. There was a lead matron and nurse colposcopist for the gynaecology service reporting to the head of midwifery and gynaecology. Named individuals for gynaecology, colposcopy/ hysteroscopy, gynaecology outreach, fertility and infertility services reported upwards accordingly.
- The senior midwifery and gynaecology clinical staff explained how there had been divisional restructuring over the past few years in order to create a "strong and visible leadership." A senior midwife post had been created for each site and managers undertook clinical work 1 day per week. Although the units were said to be different with differing needs, the senior team worked together to ensure that themes worked across the sites.
- A number of midwifery staff indicated they had been working for a significant period of time at the location. Comments made to us by midwives included, "we work well as a team and have a good rapport." They added that they could discuss issues and problems in what was a "happy environment." Leadership was said to be good and a comment made included, "we know where we stand" and "leaders are approachable". There was no fear of reprisal from raising concerns expressed by this person.
- The clinical director reported the positive impact the new matron had brought to the department, with new ideas to support development.
- A trainee doctor commented on the variability in consultant job plans, which they felt sometimes made it difficult to work out what to do. This was particularly difficult where there was no consistent approach and suggestions differed from one consultant to another. An example was described to us to clarify what was meant by this.
- Senior midwifery meetings were said to be held monthly, where information was communicated from other organisational meetings, service developments and feedback from complaints, incidents or best practice reviewed. These were organised and led by the senior midwife on each site. We reviewed minutes that supported this information.
- A member of domestic staff said they felt part of the team and they "loved it", with reference to working on the antenatal/postnatal ward. They added that they were invited to team meetings and were encouraged to put ideas forward, as well as being included in discussions.
- A review of sickness absence, staff morale and behaviour was undertaken for the Darlington Memorial Hospital labour ward and ward 61. This review had identified matters such as bullying and harassment as a concern. We saw an action plan had been developed to respond to the findings. We were also told about the review and measures used to improve the areas of concern. This included monthly support meetings, learning lunches and identifiable coordinators, who were available to discuss problems or concerns.

Culture within the service

- Midwives reported the working relationships with consultants and doctors as good, with many staying a long time and those in training coming back to take on permanent roles. A consultant reported a good working relationship with midwives but highlighted a lack of consistency in the consultant group and that the group as not "well gelled."
- The culture of the service was one of learning from serious events, with escalation through appropriate channels. However, it was reported to us that responses to other issues, such as staffing expansion, were poor.
- There was a perception from the clinical director that despite the merger of the trust, both locations were working separately.
- We were made aware of a number of issues related to performance and working practices, which medical staff said had not been addressed early. As a result there was an impact on working relationships, demands on some medical staff and inflexibility from others. Medical staff also commented that support was not good after issues were raised.
- Despite the issues described, there was no indication from nurses or midwives on the ward areas of any awareness of these medical related issues. Staff said they were proud of the service and the focus on putting people first. Senior clinical staff said, "We know they are proud of us and we tell the staff."

Public and staff engagement

- Staff, commissioners and stakeholders had been consulted about the trust-wide clinical strategy, 'Right First Time 24x7.' This had resulted in a public discussion document being produced in January 2014.
- There was a good level of engagement with staff. For example, they reported that they received the trust newsletter 'Your Trust' directly to their homes. They found this was very positive and were able to keep up with news from around the trust.
- There had been engagement with members of the public and staff as part of a focus, in 2013, on improving service user experience and that of staff in respect to dignity. This work was conducted as part of the action plans related to complaints received. Feedback was gathered from people who had used the service and staff on their perception of dignity.
- We reviewed the Dignity Campaign Report for November 2013 and noted some of the themes raised by patients had already been addressed. For example, clear patient information leaflets, consistent handover of patient care and increased involvement in treatment plans.
- Minutes of a maternity meeting held on 8 December 2014 indicated that staff were involved and encouraged to provide ideas for improving patient and staff experience. This was with a view to addressing working practices in each area.

Innovation, improvement and sustainability

- The senior clinical team for midwifery and gynaecology described a number of measures under development or for future change, which were expected to improve services for people. This included creating an outpatient hysteroscopy and colposcopy service to the Bishop Auckland site. Trained nurse hysteroscopists/ colposcopists were available to support this service.
- We asked staff to tell us what they were proud of in relation to improving the services for people. They cited the local and national awards, which had been won in relation to smoking cessation in pregnancy.
- Other improvements included the introduction of information specifically aimed at people providing support to individuals having a pregnancy termination.
- Another area of improvement related to the holistic approach to pregnancy termination. Where a pregnancy was being terminated for medical reasons, support had been provided and the family had been involved. An area had been made suitable for the family to stay as part of the bereavement process.

Services for children and young people

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

Information about the service

The children's service at this hospital was responsible for inpatient services for babies, children and young people. Services at Darlington Memorial Hospital included one children's ward (ward 21), which had 24 inpatient beds, a six-bed day surgery unit and four assessment rooms. Adjacent to ward 21 was a dedicated children's outpatient department. Within the same building block, next to maternity services, was the special care baby unit (SCBU) which had 12 level one (special care) cots. The service was also responsible for providing community neonatal and paediatric outreach services.

Based on statistics provided by the trust, the Darlington services paediatric medicine specialty (not including sub-specialties or surgery) had a total of 3,998 non-elective admissions, 76 elective admissions and 59 day case admissions during the period January to December 2014. The SCBU had a total of 365 admissions in the same period. There were 6,182 outpatient attendances in the same period for paediatric medicine.

During our inspection we visited all clinical areas where children were either admitted or which they attended on an outpatient basis, including the SCBU, ward 21, and the children's outpatient department. We talked with six medical staff and 11 nursing and allied healthcare professionals, and examined 12 medical/nursing records. We spoke with 10 parents and children/young people.

Summary of findings

Overall, services for children and young people at this hospital were good.

The children's services actively monitored safety, risk and cleanliness. The levels of nursing staff were adequate to meet the needs of children and young people.

Children's services had made improvements to care and treatment where the need had been identified using programmes of assessment or in response to national guidelines.

Children, young people and parents told us they received compassionate care with good emotional support. Parents felt fully informed and involved in decisions about their child's treatment and care.

The service was responsive to children's and young people's needs and was well led. The service had a clear vision and strategy. The service was led by a positive management team who worked together. The service had introduced innovative improvements with the aim of improving the delivery of care for children and families.

Services for children and young people

Are services for children and young people safe?

Good

Staff demonstrated awareness of how to report incidents using the trust's reporting mechanisms and we saw these were reviewed and acted upon by the management team. We found risks were assessed and monitored, and control measures were put in place. We found all children's clinical areas were kept clean and were regularly monitored for standards of cleanliness. Medicines were stored and administered correctly. Medical records were handled safely and protected.

Members of staff of all grades confirmed that they received a range of mandatory training, although training records did not always accurately reflect training uptake. Levels of nursing staff were adequate to meet the needs of children and young people. Medical staffing had some gaps but these were being managed and addressed.

Incidents

- Staff demonstrated an awareness of how to report incidents using the trust's reporting mechanisms. The management team and ward managers in all clinical areas felt their staff were good at reporting incidents. We were told by most staff they received feedback about incidents they had reported.
- Minutes of meetings of the monthly 'SAGE day' (safety, audit, governance and education meeting) and the 'children's management team meetings' held during 2014 showed incidents were routinely discussed. The SAGE meetings were attended by consultant paediatricians who discussed incidents that had occurred during the previous month, including any actions arising out of the review. The incidents and actions arising out of the SAGE meetings were also discussed at the children's management team meetings.
- We reviewed incident data for the period 1 January 2014 to 31 December 2014. A total of 204 incidents had been reported across all children's service areas at both Durham and Darlington hospitals.
- Two serious incidents had been reported within the children's service over the previous 12 months. The children's management team explained that the incidents had been learned from after the review, using a root cause analysis approach, which was applied to inpatient areas. For example, one incident review had led to the development of a policy on what to do if a baby had reduced movement in a limb. We saw an example of a completed root cause analysis investigation that had been thoroughly completed.

Cleanliness, infection control and hygiene

- We found ward 21, the children's outpatient department and the SCBU were kept clean and tidy. Various infection-prevention measures were in place, such as multiple wall-mounted hand gel dispensers and hand-wash sinks.
- In clinical areas we observed members of medical, nursing and other staff regularly performing hand hygiene measures.
- Regular hand-hygiene audits and infection-control audits were undertaken in the clinical areas.
- The children's management team meeting included a standing agenda item for infection control. Discussion included hand hygiene audits and other updates when tabled. The management team explained that the ward and SCBU had nominated infection control link nurses who attended hospital-wide meetings and disseminated information to staff members via team meetings and notice boards.

Environment and equipment

- We saw and staff told us that all clinical areas had a wide range of clinical and other equipment to assist them in providing care for children and young people. Records showed the trust tested and serviced equipment according to its own policies. Some equipment, such as incubators in the SCBU, were maintained and serviced via external manufacturers.
- All the children's clinical areas we visited had suitable resuscitation equipment available, which had been checked regularly.

Medicines

- We reviewed a sample of paper-based treatment records on the children's ward and SCBU and observed the administration of medications. We found that medicines had been appropriately stored, checked and administered in these areas.
- The management team explained that children's services had a named pharmacist who attended the

children's clinical areas on weekdays at Durham and Darlington. The management team told us the service felt well supported by their pharmacist, who also conducted regular prescribing checks of treatment records.
- Mandatory training records supplied by the trust before the inspection showed that 100% (188 nursing staff) had completed medicines management training.

Records

- We found records were managed and handled safely during our inspection. For example, we did not identify any unattended medical notes during our inspection.
- Care records were paper based during an admission/ inpatient stay. Following discharge these records were scanned and uploaded to an electronic system which made these records accessible for medical and nursing staff at a later date. Staff appeared to have differing views about this system. Some found it very useful and easy to use whereas other staff said it was sometimes difficult to find the information they needed.
- Nursing documentation was completed via a paper-based record. On ward 21, this included an assessment of the child/young person's activities of daily living (ADL) which had been individualised where needed to reflect the child's and family's needs. We saw that a combination of core care plans (pre-written care plans) and individually written care plans were used following the assessment. In some records we reviewed, the ADL section had not been fully completed and in one record the ADL assessment was blank.
- The nursing evaluation was written at the same time as each medical review entry. It was clear what treatment and care the child had received and what care was required by the child.
- A permanent stamp was placed in the evaluation record for each formal ward round. The stamp acted as a safety check reminder to ensure the medical/nursing team checked and recorded an 'update from the nurse', the PEWS (paediatric early warning score chart) had been reviewed, the drug chart had been reviewed and feed/ fluid charts had been checked.
- On the SCBU we found detailed daily records were being maintained. We were told by SCBU staff that the 'plan of care' was recorded within the evaluation record. When we checked records there was a statement relating to 'plan of care' but this was usually a sentence highlighting the main form of treatment, for example, phototherapy or intravenous infusion of 10% dextrose. This was not a plan of nursing care but a treatment plan.
- However, dedicated nursing care plans were not used by the SCBU nursing team. This meant the care that was delivered did not follow an agreed documented plan, which may lead to inconsistency. For example, the nursing team had access to a neonatal pain assessment tool and we saw evidence that babies received pain relief when required. However, there was no neonatal pain care plan to guide staff on how often they should assess pain and how they should manage it. The records being used by the SCBU did not underpin or reflect the appropriate care actually being delivered by staff. The SCBU did use the 'kangaroo care record', which monitored all skin to skin contact between parents and their babies.

Safeguarding

- Managers and members of staff within children's services demonstrated a clear awareness of the referral processes they must follow if a safeguarding concern arose.
- Records showed 93% of children's service staff (all grades) had received level one safeguarding training. The SCBU was run as one unit between Durham and Darlington and the neonatal service manager told us that 97% of SCBU staff had completed level three training. All other relevant staff had also completed level three training.
- At a local ward and unit level staff had access to safeguarding advice from a nominated safeguarding nurse and nominated safeguarding midwife.
- The trust had the necessary named safeguarding staff in post, including the named nurse and designated doctor. There was initially some confusion over the named doctor role although we found this role was being covered by a consultant paediatrician. The children's management team told us the service felt well supported by safeguarding processes in place throughout the trust.

Mandatory training

- Members of staff we talked with, including staff from ward 21, the children's outpatient department and the

SCBU, confirmed they received mandatory training. This covered subjects such as fire safety, health record keeping, hand hygiene, moving and handling, and safeguarding.

- Training records submitted by the trust before the inspection showed good levels of training uptake by members of staff. For example, 91% (331 out of 365 staff) had completed health record keeping training, 91% (333 out of 365 staff) had completed moving and handling training and 90% (329 out of 365 staff) had completed fire safety and prevention training.
- The ward manager explained that 97% of staff were up to date with the paediatric life support course and the neonatal unit manager told us that 95% of SCBU staff across Durham and Darlington were up to date with the neonatal life support course.

Assessing and responding to patient risk

- We reviewed six care records on ward 21. We saw that an initial risk assessment was made for moving and handling, tissue viability and nutrition. The level of risk was recorded on the initial admission assessment documentation. If a child scored a rating identified as a potential risk, the nurse completed a full risk assessment tool for moving and handling, pressure sore risk or a nutritional screening tool. Other risk assessment and monitoring tools were used when required, for example, peripheral venous cannulation assessment and monitoring records.
- We reviewed five care records on the SCBU. Some risk assessment tools were in place such as the peripheral venous cannulation tool. The unit had a neonatal pain assessment tool, although it was not clear how frequently the tool was used. It had a form on the back to record pain assessments; this was blank because staff recorded the assessment in the evaluation record. One sister told us the unit did not use a neonatal skin integrity tool, although one of the SCBU nursing team was hoping to introduce one shortly. We talked with the clinical services manager about the use of individual risk assessment tools on the neonatal unit and they explained they would work with the neonatal unit manager and SCBU team to review their use and effectiveness.
- The children's ward used the paediatric early warning score (PEWS), an early warning assessment/clinical observation tool. This included a clinical observation chart, coma scale and additional information such as the pain score tools along with an assessment table to assist clinical staff in determining the action that should be taken for a poorly child. It was explained that the chart would assist with determining whether a child would require transfer to a tertiary centre for children such as at Newcastle. Our review of a sample of PEWS charts showed that staff completed them. The SCBU used its own observation chart designed for capturing observations specific to neonates.
- The children's section of the emergency department used specially trained advanced paediatric nurse practitioners (APNPs) to assess and manage a child's initial care. However, the APNPs had no protocols or standard operating procedures to guide them on processes they should follow to assess, manage, treat and discharge children.
- Ward 21 had a nominated high dependency room for stabilisation of very poorly children. We were told the children's service had only recently identified a dedicated high dependency room even though the availability of one within a district general hospital has been a requirement for a number of years. Staff with high dependency training were in the process of being recruited trained. There were no protocols or standard operating procedures available for staff members who cared for children requiring high dependency care or stabilisation on the ward prior to transfer.

Nursing staffing

- The clinical services manager, ward manager and neonatal unit manager explained that recruitment and retention were good within the children's clinical areas, so vacancy rates were low. Children's management meeting minutes included a section which discussed staffing matters within each of the clinical children's areas.
- The ward manager told us the sickness rate was averaging at 5% on ward 21 and 7% on the SCBU.
- We found ward 21 was adequately staffed to meet the needs of children and young people and families, and often reflected best practice guidance on children's ward staffing issued by the Royal College of Nursing. During daytime shifts for the inpatient areas there were seven registered nurses and one healthcare assistant, and six registered nurses and one healthcare assistant on night duty.

- We talked with staff members on ward 21 who felt there was generally sufficient members of staff to meet the needs of children.
- On the SCBU, which had 12 level one (special care) cots there was a minimum staffing of three registered nurses per span of duty. The neonatal unit manager explained that approximately 90% of shifts per month met the best practice British Association Perinatal Medicine (BAPM) qualified in specialty standards. Staffing on the SCBU met the BAPM ratio of one registered nurse per four babies. However, one of the nurses also acted as the shift coordinator. The three nurses on duty were also responsible for supporting maternity 'transitional' care arrangements (where babies stay with the mother on the postnatal ward) and also provided a neonatal outreach service (where a nurse goes to the baby's home to offer support when discharged). The SCBU staff told us this was usually manageable but sometimes they felt 'stretched'. The neonatal outreach service was also supported by the paediatric outreach service.

Medical staffing

- We found medical staffing was reasonably covered within paediatric medicine and the SCBU. At Darlington hospital we talked with six doctors of all grades.
- We were told there were some gaps at tier one and some gaps at tier two (middle grade) in the medical staffing rota. These gaps were covered by regular locum doctors or a consultant paediatrician. We were told the service had a plan in place to manage the medical staffing gaps at tier one and tier two. We were told the trust had invested in developing the role of resident consultant paediatricians with plans in place to increase the whole time equivalent numbers.
- Paediatric medical handover took place as a minimum in the morning and evening. We saw the handover was well attended by medical staff and one registered children's nurse. Handover included discussion of the child's medical plan and was followed by a ward round.
- Nursing staff did not raise any concerns over medical staffing and felt well supported. The foundation and specialist trainee doctors we talked with were complimentary about the training and support they had received from paediatric consultant staff.

Major incident awareness and training

- The trust had a major incident plan in place that set out actions to be taken for major incidents and other similar events. The clinical services manager explained there had been two local major incidents (one in Durham and one in Darlington) over the last 12 months which had involved the initiation of the major incident plans.

Are services for children and young people effective?

Good

The trust had systems and processes in place to review and implement National Institute for Health and Care Excellence (NICE) guidance and other evidenced-based best practice guidance. We reviewed information that demonstrated the children's services participated in national audits which monitored patient outcomes when these were applicable.

Children and young people had access to a range of pain relief if needed and staff used an evidence-based pain-scoring tool to assess the impact of pain. The nutritional needs of children were addressed. Consent forms were completed to an adequate standard. Staff had received an annual appraisal and received support and personal development. There was evidence of positive multidisciplinary working across various disciplines and specialties.

Evidence-based care and treatment

- The trust had systems and processes in place to review and implement NICE guidance and other evidenced-based best practice guidance. New guidance came to the children's service via the care closer to home group and was discussed via the SAGE meetings. The children's management team discussed recent examples of NICE guidance and how these had been reviewed, for example, neonatal guidance for use of antibiotics for early onset infection. An audit plan submitted showed that NICE clinical guidelines were identified to be audited during 2015. For example, the guideline on urinary tract infection in children was due to be audited by 31 March 2015.
- We reviewed SAGE meeting minutes for 2014 and these included various examples of where the service had reviewed clinical pathways to ensure they reflected clinical practice. For example, the SAGE meeting minutes for October 2014 noted the diabetes

ketoacidosis guidelines had been updated and a new pathway had been developed. The same month also included a proposed new guideline for bronchiolitis before the start of that seasonal illness.
- Discussion with clinical staff and the review of submitted documents demonstrated that the service participated in national audits such as diabetes, epilepsy and asthma. Other local audits had also been completed, for example, 'prescribing practices for buccal midazolam and its use in the community'. An action plan had been completed for this audit, which included actions to be taken to address an identified issue.

Pain relief

- Children and young people had access to a range of pain relief if needed, including oral analgesia, patient-controlled analgesics and epidurals where indicated.
- The service used evidence-based pain scoring tools to assess the impact of pain. The PEWS assessment chart included different pain scoring tools which were linked to a table that advised on the type of analgesic that should be used. We reviewed a sample of pain score ratings, which showed that members of staff regularly assessed pain when required. Parents we talked with confirmed that their child had their pain assessed.
- The children's service had its own paediatric pain nurse available, which was good practice for a children's service based in a district hospital. The paediatric pain nurse was based in Durham hospital but we were told regularly supported staff at Darlington hospital. The ward manager told us they were also able to access ready advice and support from the adult pain service located within Darlington hospital.

Nutrition and hydration

- Children's food likes and dislikes were identified and recorded as part of the nursing assessment of the child's daily activities of living. When triggered by an initial assessment the nursing team used the Malnutrition Universal Screening Tool (MUST). Observation of records and audits confirmed this.
- Children were able to choose their food from the daily menu with the support of parents and staff. Children could eat food from the adult menu or have a meal from the 2-week children's menu. Snacks and drinks were available in between meals. We were told vouchers were available for parent meals.

Patient outcomes

- We reviewed information which demonstrated that children's services participated in national audits in order to monitor patient outcomes when this was applicable to the service. For example, we reviewed data and information relating to the National Neonatal Audit Programme (NNAP). The trust did not supply any associated action plan, so it was not clear what measures had been taken to address matters.
- The children's management team talked through examples of learning from the last NNAP audit. For example, the unit aimed to improve outcomes in relation to having discussions with parents within 24 hours of admission.
- The children's service also participated in other national audits such as diabetes, asthma and epilepsy audits. The last available diabetes audit from 2013 showed results were similar to the England and Wales average. The trust continued to make progress and had a high HBA1c (a blood test used to provide an average blood sugar reading) policy in line with the regional network. The service had expanded to include young people up to the age of 19, as this age group nationally has poorer control of HbA1c. Multiple emergency readmissions for 1–17 year olds was worse than the England average for asthma and diabetes.
- The children's service also submitted ongoing data (where applicable to children), which contributed to the NHS Safety Thermometer monitoring dashboard. Data showed that all participating children's clinical areas scored 100% harm-free for the last 12 months.

Competent staff

- Formal processes were in place to ensure staff had received training and an annual performance development review (appraisal).
- We did not review any documents that captured appraisal statistics but the ward manager for ward 21 stated appraisal completion was 81% with identified dates in place before 31 March 2015.
- The neonatal unit manager explained that appraisal rates were low at 30%, although we saw the SCBU had

identified dates for appraisals for all members of staff before 31 March 2015. Staff we talked with either confirmed they'd had an appraisal or were yet to receive one.
- Members of staff in ward 21, the children's outpatient department and the SCBU gave positive feedback about the individual support they received with their personal development.
- Trainee medical staff we spoke with were positive about the regular training and support they received to develop their clinical and educational knowledge and skills. They felt well supported by consultant staff within paediatrics.

Multidisciplinary working

- Medical and nursing staff within children's services gave positive examples of multidisciplinary working. We were told the paediatricians and nursing teams worked closely together and also worked closely with other professionals such as dieticians, occupational therapists and physiotherapists.
- Staff told us children's services worked closely with surgeons and doctors in specialties such as emergency medicine, ear, nose and throat, and general surgery. We talked with one specialty trainee surgeon visiting a child post-operatively who told us how paediatricians reviewed aspects of care of a child having surgery such as fluids, antibiotics and analgesics. They felt this arrangement worked well. During our visit to the ward we observed post-ward-round discussion by the paediatric medical team about a child's post-operative fluid management and pain relief.
- The clinical services manager and ward manager explained how the children's service had developed positive working relationships with the Child and Adolescent Mental Health Services (CAMHS). We were told there was a nominated consultant paediatrician who coordinated close working with tier three CAMHS services. A consultant paediatrician we talked with told us how CAMHS services visited children promptly and were always available for advice. They gave examples of how the service would accompany children to clinics along with a social worker when required.
- Formal adolescent transition arrangements were in place for some sub-specialty medical conditions. For example, there were established transitional arrangements for adolescents transferring within the diabetes sub-specialty.

Seven-day services

- The children's inpatient services accessed diagnostic services such as the x-ray department, pharmacy and laboratory during the weekend. The children's management team and members of staff did not raise any significant concerns over accessing these services.
- Trainee doctors working out of hours and at weekends told us they felt well supported by consultant staff.

Access to information

- Staff we talked with told us they were readily able to access patient information and reports, including at weekends and out of hours. For example, trainee medical staff explained they were able to access patient notes via the EDMS electronic system straight away. Some staff felt the EDMS system was difficult to use, but recognised the information was there and available.

Consent

- We reviewed a sample of four records where consent had been obtained for surgery, and found these had been appropriately completed, dated and signed by the doctor/surgeon and parent. Consent forms included a suitable explanation of the proposed benefits and risks of surgery.
- Staff we talked with showed they understood the Gillick competency standard for consent for children. Staff explained that surgeons encouraged young people to be involved in decisions about their proposed treatment, for example, we saw two examples of consent forms for 16 and 17 year old people who had signed their own consent forms.

Are services for children and young people caring?

Good

Children, young people and parents told us they received compassionate care with good emotional support. They felt they were informed and involved in decisions about treatment and care. We spoke with 10 parents and children who gave examples of how they had been provided with supportive care centred on their personal needs.

Compassionate care

Services for children and young people

- Throughout our inspection we observed members of medical and nursing staff who provided compassionate and sensitive care, which met the needs of the child, young person and parents.
- We observed members of staff who had a positive and friendly approach towards children and parents. Staff explained what they were doing and took the time to speak with them at an appropriate level of understanding.
- The parents on ward 21 provided a number of examples of how they had received considerate and supportive care. For example, one parent explained how they were always asked if they wanted to ask any questions and staff always spent time to answer them. A number of parents described staff as being very caring and "friendly."
- On the SCBU we talked with one parent who explained how staff were very supportive. They explained how nursing and medical staff introduced themselves and explained all procedures.
- A quality assessment tool was used to gain people's views and completed bi-monthly based on a sample of up to 15 people, including children, young people and adults. Questions were split into five areas which reflected CQC domains used to assess services. The results were analysed and presented in the form of a report.
- Results were also presented in a more detailed way, which included individual feedback comments. For example, for the period of October 2014 out of nine parent feedback forms, all parents felt communication had been done well, 78% felt involved in the treatment plan with 11% (one parent) stated involvement could improve. Comments from parents were positive. For example, one parent stated "all staff were kind and friendly and kept us well informed at all times thank you."
- Twenty children responded to the October survey and gave a range of responses to the question "when I'm receiving treatment I feel…". Individual comments included "staff joke and make me happy", "you are in pain but never in it for long" and "the doctors and nurses asked me questions and made me feel important."
- We were told that the children's services do not participate in the adult-based NHS Friends and Family Test (a survey that measures patients' satisfaction with the healthcare they have received). An alternative system had been set up to gain the views of children, young people and families about their experiences. A quality assessment tool for both staff and families was completed bi-monthly, based on a sample of up to 15 people, including children, young people and adults. The results were analysed and presented in the form of a report.

Understanding and involvement of patients and those close to them

- We observed that members of staff who talked with children and young people used language appropriate to their age-related level of understanding. This was supported by the November quality assessment survey of parents' and young people's views. For example, 100% (four young people) felt they'd been listened to and understood their treatment. One young person stated they got a "quick response to any questions or help… [I] felt that I was treated with respect."
- A number of families we talked with told us they had felt involved in the planning and decisions relating to patients' care. For example, one parent explained staff were friendly and that they had felt involved in all aspects of care planning.
- Parents and children talked positively about the information they had received. Families also explained how they had been given sufficient information to make an informed choice about their children's care.
- Information leaflets about various treatments and other care were available within the hospital. Leaflets at this trust were written in English. Members of staff explained that they could get leaflets translated when required. We saw that a number of leaflets had been produced some years ago, although the guidance was still appropriate. The clinical services manager explained that the service was aware of this and was in the process of updating the information leaflets.

Emotional support

- Parents and children told us they had been well supported during their visits or stays on ward 21, the SCBU and children's outpatient areas.
- We observed members of staff who were responsive to and supportive of children's emotional needs. For example, we observed nurses, play specialists and other staff providing positive emotional care and support to children who were having an operation.

Services for children and young people

- Parents we talked with gave examples of how staff supported their children and themselves. For example, one parent outlined how supportive staff had been by making sure they knew how to use the various parent facilities on the ward and where they were.

Are services for children and young people responsive?

Good

We found the service was responsive to the needs of children and young people. The children's service actively planned and delivered services to meet the needs of local families. We saw evidence that showed complaints were reviewed and that the service learned from them.

Service planning and delivery to meet the needs of local people

- There was evidence that demonstrated how the children's service engaged with the trust, commissioners, the local authority and other providers to address the needs of the local population.
- The children's management team explained that the clinical commissioning group and its predecessor the primary care trust and others had been fully engaged with the 'poorly child pathway'. We were told there had been four or five stakeholder meetings that had contributed to the ongoing development of the pathway.
- A poster produced by the NHS North East Leadership Academy outlined the aims and intentions of the poorly child pathway. The aim of the pathway was to "safely reduce the number of children admitted to hospital through a range of approaches including education (including parents), supporting clinical practice, coordinating care across hospital and community, staffing and resources and by redesigning how and where children are treated".
- The management talked through one area relevant to the acute children's service, which was the development of the 'paediatric front of house'. The core concept was to use paediatric trained staff in partnership with emergency department staff. This involved children's nurses suitably skilled and trained as advanced paediatric nurse practitioners (APNPs), located within the emergency department, performing an initial assessment and treating children as required. Other areas of development for this part of the poorly child pathway included extended consultant hours and other measures. At the time of the inspection, the children's service was piloting the development and introduction of the paediatric front of house approach. In Darlington, APNPs were placed within the emergency department.

Access and flow

- Access and flow varied within the children's services provided throughout the trust. The emergency department had dedicated facilities for children at Darlington. These included a separate waiting, assessment and treatment area with suitable child-friendly décor and facilities.
- An APNP was allocated to the children's emergency department area 7 days per week between 10am and 10pm. The APNPs were part of the children's service team. The emergency department children's area was managed and supported by emergency department staff and open 24 hours per day. The APNPs were able to perform an assessment and admit directly to ward 21 rather than the ward assessment area, which assisted with access and patient flow.
- The ward 21 had a nominated high dependency room for stabilisation of very poorly children. The facility was in the early stages of development. Additional monitoring equipment was in place and the children's management team was in the process of recruiting and training some members of staff in the delivery of high dependency care.
- The children's service used the PEWS monitoring chart, which assisted staff in determining whether a child required stabilisation or transfer to a tertiary service such as at Newcastle. The management team and other staff told us the North East Ambulance Service was responsive and facilitated transfer where this was required.
- The ward manager explained how they used a large spacious room with play facilities as a 'discharge lounge' during periods when the ward had limited bed spaces, to assist with patient flow prior to discharge.
- We were told there was a weekly 'rapid access clinic' held within the children's outpatient department, led by one of the consultant paediatricians. This was accessed by referrals from GPs. The outpatient department also hosted a nurse-led paediatric clinic for children who needed to give a blood sample.

- The SCBU had facilities and appropriately qualified staff to stabilise babies born under 30 weeks gestation prior to transfer to a level two or three neonatal unit. We were told the neonatal network retrieval team responded promptly when its service was required.
- During our visit we followed a child having surgery from the day surgery unit through to the anaesthetic area and observed staff who ensured the child's needs were met. Generally, we found the needs of children who required surgery in a district general hospital setting were reasonably met in line with national guidance set out in the 'Standards for children's surgery' (2013). Children did not have a completely separate recovery (post-anaesthetic care) area but there were two nominated trolley spaces located together at the end of the general recovery area.

Meeting people's individual needs

- Staff told us interpreting services were available when they needed them, and that they did not normally have any issues when accessing these services.
- Ward 21 had facilities to promote family-centred care. For example, parents had access to a seated area and facilities to make hot drinks. Parents were able to sleep next to their child at night. There was a dedicated school room for children along with areas where children could play. Similarly the SCBU had facilities to support parents.
- We saw that ward 21 took account of adolescents' needs. The ward had bed spaces where adolescents were placed. There was also an adolescent rest room accessible to teenagers on the ward.
- There were formal adolescent transition arrangements in place for some sub-specialty medical conditions. For example, there were established transitional arrangements for adolescents transferring within the diabetes sub-specialty, including jointly run clinics with the adult team. Other specialties had some form of transitional arrangements in place such as for young people with complex needs. There wasn't an overarching policy for the coordinated development of adolescent transitional services and there was no formally nominated lead member of staff to develop adolescent services.
- The clinical services manager and ward manager told us there was a range of equipment such as hoists and an assisted bath area, along with other support, for children and young people with complex physical health needs. The ward manager explained how they were developing a sensory room and were able to access the complex needs nursing team for advice and support when a child with complex needs was admitted.
- Ward 21 was spacious and organised into clinical areas such as an inpatient area and a day case surgery area. There were suitable facilities for parents and young people, including a room where parents could make themselves a drink. Adolescents had a room where they could relax and play computer games and was adjacent to nominated adolescent cubicles. The ward also had a dedicated school classroom which was used by the local authority school teacher to provide lessons for children in hospital.
- The SCBU was located on a different floor, next to maternity services. The unit was spacious and included two parents' rooms which were shortly to be replaced by two new rooms. There was also a family room where parents could relax and make themselves a drink.

Learning from complaints and concerns

- The clinical services manager and ward manager explained that complaints were handled and resolved straight away where possible.
- Complaints information was available within the children's areas.
- We reviewed SAGE governance meeting minutes from 2014 and these minutes showed complaints were regularly discussed and reviewed by consultant paediatricians and other attendees. At these meetings the clinical services manager conducted a presentation of the complaints received and outlined any actions arising out of the investigation of the complaint, including identified areas for improvement. The review of complaints in the meeting minutes noted apologies had been given to the family when needed.

Are services for children and young people well-led?

Good

The service was well-led. Governance arrangements were in place and were very well attended by consultant paediatricians. The management team had a clear vision and strategy for the service and was formulating a new strategy. There was evidence of positive management at

ward and unit level, led by the clinical services manager. Management structures within the care closer to home group were complex and it was not always clear how some tiers of leadership worked together. Although there was an executive director for safeguarding children, the trust did not have a formally nominated board level director who championed children's rights. The service engaged with people who used the service.

Vision and strategy for this service

- The children's management team had a clear vision and strategy for the provision of children's services in the Durham and Darlington areas. We reviewed a draft strategy being developed entitled 'Quality improvement in the delivery of paediatric care within County Durham and Darlington 2015'. The head of child health explained how various stakeholders had been involved in the development of the strategy and that it was due to be published in the summer of 2015.
- The draft strategy noted that the service was working toward a paediatric-led assessment model. This included the full development of the 'paediatric front of house' initiative, which was being piloted with the placement of APNPs in the hospital's dedicated children's section of the emergency department.
- The draft strategy also centred on children's services delivering care close to home. It was proposed that this would be achieved by strengthening the paediatric community nursing service to enable more care to be provided in the home environment.

Governance, risk management and quality measurement

- The children's services' risks formed part of the care closer to home group risks. The children's services' risk register included two actual risks. One described the radiology department being unable to provide a sustainable, quality paediatric service due to the lack of a paediatric radiologist and the second risk related to there being no clear strategy to reduce the level of HbA1c (average blood sugar levels). In both cases the register listed actions to address the identified risk.
- The clinical services manager also explained potential risks, such as medical staffing, were discussed at team meetings and added to the risk register as appropriate. We reviewed draft meeting minutes from January 2015 which noted that medical staffing for foundation (tier one) and specialty (tier two) trainees should be elevated from a potential risk to an actual risk.
- The trust set out its governance arrangements/ structures in a document entitled 'Quality matters – governance counts'. The structure included ward/team meetings, service specialty governance meetings, and care group governance meetings which fed through to the operational governance committee at executive level.
- The children's service monthly governance meetings (SAGE days) were held each month. Meeting minutes from 2014 showed these meetings were medically led and had been attended by a number of paediatricians each month. The structure of the meetings included safeguarding peer reviews, complaints and incidents updates along with discussion of audit, clinical pathways and other governance information. Attendance by nursing staff appeared low and the clinical services manager and ward manager recognised that attendance by members of the nursing team could be improved.
- The children's service management team also held a monthly meeting chaired by the head of child health and attended by the nursing leadership. This meeting covered a more business focused agenda such as finance but all included a range of governance items such as medicines management, incidents and human resources.
- Other meetings held within the care closer to home care group included discussion and review of various matters in relation to children's services. For example, the group's patient safety meeting on 7 January 2015 included an agenda item for children's services which required approval of a number of revised policies and protocols. These were sent to attendees before the meeting.

Leadership of service

- The children's service formed part of the care closer to home group. The group included a range of other services such as maternity and children's community health, along with services such as palliative care. There was a chart provided before our inspection which set out a multi-tiered structure within the service and care group.

Services for children and young people

- We found the management structure above the level of band 8a (the clinical services manager) to be complex. Lines of accountability for all leaders were not set out within the group chart and it was not always clear how some leaders worked with other leaders. For example, the clinical lead paediatricians. We were told by the care group's associate medical director (who was also the clinical director for paediatrics) that there was one clinical lead each for Durham and Darlington hospitals. These clinical leads reported to the clinical director, paediatrics, who reported to an associate medical director. The group chart did not include these clinical leads so it was not clear how they fitted into the overall leadership structure. The associate medical director reported to the group clinical director.
- At service level, within nursing, there was a clear leadership structure. The wards at both hospitals had a band seven ward manager who reported to the clinical services manager (a registered children's nurse). The ward manager for ward 21 was supported by 4.5 band six sisters. The SCBU was managed across both hospitals by a neonatal unit manager who was supported by several band six sisters. The clinical services manager reported to the head of child health who in turn reported to the head of children and families services, which was the line management link for nursing with the care closer to home group directors.
- Staff at service level we talked with told us that they felt well supported by their band seven managers and also the clinical services manager. The band seven ward managers felt well supported by the clinical services manager who displayed good knowledge and awareness of acute children's services throughout the inspection.
- We found that children did not have adequate representation at the trust's board level. This view was shared by the management team and clinicians we talked with. There was an executive board lead for safeguarding children. However, we were told there was no formal board-level director to promote children's rights and views as required by the National Service Framework (NSF) for Children standard for hospital services.

Culture within the service

- At service level we found a culture of openness among all medical, nursing and other staff we met within the children's service. Staff spoke positively about the care they provided for children, young people and parents. We saw how staff placed the child and the family at the centre of care delivery, and how this was seen as a priority and everyone's responsibility. The clinical services manager had a clear vision about future developments within the service, which considered staff members at ward and unit level.
- We saw that staff worked well together and there were positive working relationships between the multidisciplinary teams and other services involved in the delivery of care for children.

Public and staff engagement

- We found that information about people's experiences with the service was regularly sought. A system had been set up to gain the views of children, young people and families via a 'quality assessment tool'. This was a formal survey undertaken bi-monthly in each area that asked a sample of parents/children about their views about their experiences. These surveys resulted in a monthly report made available to parents and families.
- The management team provided other examples of engagement with people who used the service. For example, during 2014 the children's asthma service was re-evaluated and awarded the 'investing in children' membership award. This award was a UK wide initiative that promoted the human rights of children and young people. To achieve the award, organisations had to demonstrate dialogue with young people that could lead to change. In the assessment the reviewer who talked with young people accessing the service found that "staff listen and take on board what patients and parents have to say".
- Staff views were regularly sought via a staff portion of the bi-monthly quality assessment tool, which asked members of staff a number of questions relating to five domains (safety, effectiveness, caring, responsiveness and professional development/leadership). The overall score for ward 21 in November 2014 was 98.73%. Detailed scores were positive across all domains. Staff we talked with felt they could express their views to colleagues and managers.

Innovation, improvement and sustainability

- The children's service management team provided examples of areas of practice it felt were innovative. The team felt the development of the APNP role and testing of the 'paediatric front of house' assessment approach

was already providing positive outcomes for children, young people and parents. The management team also felt that its paediatric community outreach service was "excellent" as it allowed and encouraged care at home, avoiding admission to hospital.

- The service was particularly proud of its 'paediatric rapid response team'. In outline, when any child dies in the community or acute setting within the County Durham and Darlington area a senior skilled nurse from the team attends the death to provide support and ensure appropriate skilled interaction from other agencies such as the police. We were provided positive examples of how the team had led to improvements in handling the death of a child delicately and sensitively by all agencies. The team was also supported by a nominated paediatrician.

End of life care

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

Information about the service

Darlington Memorial Hospital forms part of the County Durham and Darlington Foundation NHS Trust and provides end of life care services on site and in partnership with the University Hospital of North Durham, community and hospice services. The hospital did not have any wards that specifically provided end of life care. Patients requiring end of life care were identified and cared for in ward areas throughout the hospital with support from the specialist palliative care team. Specialist palliative care was provided as part of an integrated service across both hospital and community teams. At Darlington Memorial Hospital, the specialist palliative care team comprised one 0.6 whole time equivalent (WTE) palliative care consultant and two WTE specialist palliative care nurses. All patients requiring end of life care could have access to the specialist palliative care team. We saw that referrals to the integrated service from April to October 2014 totalled 1,852, 98% of whom were patients with cancer.

During our inspection we spoke with the members of the specialist palliative care team, mortuary staff, chaplaincy staff, porters, medical staff, ward managers, nursing staff and allied healthcare professionals. In total we spoke with 30 staff. We visited a number of wards and clinical areas across the hospital including general medicine, cardiology, elderly medicine, endocrinology, coronary care, gastroenterology, respiratory medicine, orthopaedic surgery, the intensive care unit and the accident and emergency department. We reviewed the records of 14 patients at the end of life and reviewed 22 do not attempt cardiopulmonary resuscitation (DNACPR) orders. We spoke with 5 patients and 7 relatives and we reviewed audits, surveys and feedback reports specific to end of life care.

End of life care

Summary of findings

End of life care services at this hospital required improvement. Monitoring of the safe use of syringe drivers for end of life medication was not being recorded consistently or in line with the trust's policy. DNACPR forms were generally being completed accurately and comprehensively, but mental capacity assessments were not being recorded when there was an indication that patients did not have capacity to be involved in decision making.

Staff were seen to be caring and compassionate and we saw that the development of pastoral and spiritual services were planned for as part of the end of life care steering group. We saw that the specialist palliative care team had addressed issues around staff attending specialist training by attending the wards on a regular basis every day and supporting staff to develop the skills needed to care for people at the end of life through a mentoring programme. Education had been identified as a priority area by the trust and recruitment to a dedicated end of life educator post had been included in service action plans. Structural development of the services had begun in terms of the identification of workforce needs and plans being developed to address these needs, but at the time of our inspection we saw that staffing difficulties had impacted on the ability of the specialist palliative care team to develop the service.

The specialist palliative care team provided support for patients at the end of life and for the ward staff caring for them. We observed specialist nurses and medical staff providing specialist support in a timely way that was aimed at developing the skills of non-specialist staff and ensuring the quality of end of life care. Staff were caring and compassionate and we saw that the service was responsive to patients' needs. There were prompt referral responses from the specialist palliative care team and a good focus on preferred place of care for patients at the end of life wishing to be at home.

Are end of life care services safe?

Requires Improvement

Syringe driver monitoring was unclear. Staff told us they carried out regular safety checks on syringe drivers during administration of medicines, but we did not see that these checks were recorded in line with the trust's policy. The policy stated that safety checks should be recorded 4 hourly on a trust-approved record sheet, which we did not see in use for any of the six patients we saw receiving medicines via this route.

DNACPR forms were completed consistently. Of the 22 forms we saw, all were appropriately signed and dated and there was a clearly documented decision, with reasoning and relevant clinical information.

There were effective procedures in place to support safe care for patients at the end of life and staff demonstrated a good understanding of reporting procedures. There was evidence of learning from incidents. Medicines were provided in line with national guidance and we saw good practice in prescribing anticipatory medicines for patients at the end of life.

Incidents

- There had been no 'never events' or serious incidents reported in the 12 months before our inspection. (Never events are serious, largely preventable patient safety incidents that should not occur if the available preventative measures have been implemented by healthcare providers.) There were no specific incidents relating to end of life care. We were told that the system for recording incidents would not necessarily pick up an incident as being relevant to end of life care, and as such, themes and trends may not be identified within the reporting system.
- Staff were aware of their responsibilities in reporting incidents. We saw one example of an incident where a patient who had a DNACPR decision in place in the community that wasn't communicated. Staff told us that this was reported via the trust's incident reporting system and was being investigated.
- Staff told us they received feedback from incident reports they had made and that incidents were discussed, where appropriate, at staff meetings.

End of life care

- Members of the specialist palliative care team told us that incidents were recorded based on the directorate they occurred in and as the palliative care team sat in the care closer to home group, if incidents occurred in that directorate relating to end of life care they would be informed. We were told of one example of an incident on a ward where a patient's family had been concerned that the patient's pain hadn't been adequately managed. The palliative care team told us they had been involved in the investigation and had delivered training to ward staff as well as working to ensure up to date guidance was available and visible on the ward. The palliative care consultant told us they would also contact doctors individually to discuss how patients had been managed at the end of life.
- We saw a letter of apology sent to the family of a patient following an incident relating to a procedure the patient had received. The letter included offering an opportunity for the family to meet with staff if they wished.

Environment and equipment

- We saw mortuary protocols and spoke with mortuary and portering staff about the transfer of the deceased. Staff told us that the equipment available for this was adequate and we viewed manual handling training records that showed staff had been appropriately trained in its use.
- An upgrade to the mortuary was planned, and staff told us there were issues with the environment being out of date and not meeting requirements in terms of the space needed. However, we saw that staff had implemented a number of measures to adapt the space they had available, including the use of temporary fridge spaces.
- Height adjustable mortuary trolleys were in use and staff told us a new hoist had been ordered to assist in safe manual handling techniques.
- We observed the use of McKinley syringe drivers on the wards and saw that 4 hourly administration safety checks were not being recorded in line with the trust's policy. We also did not see an audit of administration safety checks for the use of syringe drivers. This meant that it was unclear if safety checks were being carried out.

Medicines

- The trust used the North of England Cancer Network's 'Palliative and end of life care' guidelines for cancer and non-cancer patients. The guidance included the use of medicines in the management of symptoms including pain, nausea and vomiting, breathlessness and anxiety. Medical staff we spoke with were aware of the guidance and told us they could access it via the trust's intranet.
- We observed the specialist palliative care nurses working closely with medical staff on the wards to support the prescription of anticipatory medicines (medication that people at the end of life may need to make them more comfortable). The guidance they provided was in line with the end of life care guidelines and was delivered in a way that focused on developing practice and confidence in junior doctors around prescribing anticipatory medicines.
- We reviewed 14 medication record charts of patients who were considered to be at the end of life and in all cases we saw that anticipatory medicines were prescribed appropriately and in line with the guidance.
- Controlled drugs were stored, administered and recorded in line with controlled drug guidance, and medicines for anticipatory prescribing for key symptoms were in date, available and accessible.
- We observed the use of syringe drivers for the administration of medicines at the end of life on a number of wards. Staff told us they had been trained in the use of McKinley syringe drivers and we viewed training records that demonstrated this. We viewed 6 patients having medicines administered via syringe drivers at the end of life, however there were no records of appropriate monitoring of safety checks or audits relating to administration. Staff we spoke with told us they checked the drug, dose, rate and volume of medication to be infused via syringe drivers regularly but that they did not record this on a syringe driver monitoring chart. The trust's policy stated that safety checks should be recorded every 4 hours on a trust-approved record sheet.
- The palliative care consultant told us that a one month re-audit of 30 cases of the use of opiates in end of life care was being carried out. The aim of the audit was to identify the medicines prescribed for the five key symptoms patients experience at the end of life, as well as auditing the correct use of opiates in patients who had impaired renal function.

Records

End of life care

- An 'adult inpatient admission record' was used to record patient details, medical and nursing assessments and risk assessments, and care plans.
- Patients identified as being end of life were cared for using guidance that had been developed by the Northern England Strategic Clinical Network that was created in June 2014. The guidance stated that regular assessments and daily reviews should be documented in the medical and nursing notes.
- We viewed the records of 14 patients who were considered to be end of life. In all cases we saw that assessment and care records were completed appropriately and accurately.
- We reviewed 22 DNACPR forms. In all cases we saw that there was a clearly documented reason for the decision recorded, with clinical information included. All decisions were dated and approved by a consultant. Discussions about DNACPR decisions with patients and relatives were mostly recorded in sufficient detail within patients' notes; however, we saw 9 examples of decisions not being discussed with patients where the reason for this was not clearly recorded on the form or in the patient's notes.
- As part of the policy for the administration of subcutaneous medication via the T34 syringe pump, we saw there was a syringe pump infusion monitoring chart available, but this was not in use on the wards. Syringe driver monitoring checks were not clearly recorded so it was unclear as to the regularity of safety checks when patients were receiving continuous subcutaneous medicines at the end of life.

Safeguarding

- We viewed mandatory training records and saw that members of the palliative care team had attended training in safeguarding children at level 1 or 2 and safeguarding adults.
- Staff we spoke with demonstrated a good understanding of their responsibilities in reporting safeguarding concerns.

Mandatory training

- We viewed training records and saw that members of the palliative care team had attended training in a number of mandatory areas. Examples included fire safety, safeguarding, the Mental Capacity Act, infection control, moving and handling, and basic life support.
- End of life care awareness training was not part of the trust's mandatory training programme at the time of our inspection. Members of the specialist palliative care team told us they had participated in delivering end of life care training as part of the trust's regular mandatory training programme in the past but that this had not been consistent in recent years for end of life care. We were told that mandatory training was coordinated centrally by the learning and development service and there were multiple priorities in terms of mandatory training subjects.
- We were told that mandatory training for foundation doctors included 1 hour of end of life care training, but that due to doctors having to attend a specific percentage of the overall training programme it was possible that end of life care training would be missed.
- We saw that plans to develop an end of life education strategy, once the post of end of life educator had been filled, included aims for aspects of end of life care training to become part of induction or mandatory training.

Assessing and responding to patient risk

- We observed the use of general risk assessments on the wards, including those relating to the risk of falls, malnutrition and dehydration, the use of bed rails and the risk of pressure damage.
- Early warning tools were in use throughout the hospital, with regular assessments guiding staff in identifying patients whose condition was deteriorating. For end of life care specifically we saw that the use of the system helped to prompt discussions around care with the patients themselves or with family as appropriate.
- The trust had developed 'guidance for the care of patients who are ill enough to die' for the care of patients whose condition had deteriorated, if the clinical team believed that the patient was ill enough that they may die within hours or days. The guidance included the requirement for the senior clinician in charge of the patient's care to review the patient within 24 hours and to make a plan for symptom control.

Nursing staffing

- There were 2 whole time equivalent (WTE) band seven specialist palliative care nurses based at Darlington hospital.
- Members of the specialist palliative care team we spoke with told us that the trust had recently recruited to two

band eight lead nurse posts, two discharge facilitator posts and one nurse educator post. We were told it was expected that post holders would be in place from April 2015.
- Specialist palliative care nurses were available from 9am to 5pm, Monday to Friday. There was no on-call specialist palliative nursing cover out of hours.
- Nursing staff on the wards told us they felt they had sufficient staffing to prioritise good quality end of life care when needed and that they had processes in place to escalate staffing concerns should they arise.
- There were link nurses available on the wards who had a special interest in end of life care and would take a lead with other nursing staff in terms of ensuring end of life care was sufficiently prioritised and developed at ward level.

Medical staffing

- There were 2.7 WTE palliative care consultants employed across the trust, including one locum. This included one 0.6 WTE consultant who was based at Darlington hospital.
- Staff told us that based on the population based needs assessment for specialised palliative care for the Northern England Strategic Clinical Network, there were consultant shortages across the trust and difficulties recruiting to posts.
- Ward-based doctors were supported to deliver end of life care by the specialist palliative care team and we observed the specialist palliative care nurses discussing prescribing guidelines with doctors on the wards.
- Medical staff we spoke with told us the specialist palliative care team was available for specialist advice as needed.
- There was no out of hours specialist palliative care medical cover in place, however the consultant in palliative care told us this had been discussed at a broader regional level with a view to developing a regional out of hours telephone service.
- Ward staff told us they would refer to the written guidance out of hours and that they could access more specialist advice from local hospices.

Major incident awareness and training

- Business continuity plans within the mortuary included arrangements for times of increased mortality rates, for example in the winter months where capacity within the mortuary was increased to meet demand with the use of temporary units.
- We viewed a business continuity plan and saw that arrangements for major incidents included the use of temporary mortuary facilities, use of community funeral directors, and that transfers between hospital mortuaries was part of the trust's contingency planning.
- Major incident planning included the use of the chaplain in a support role and we saw that the on-call chaplain was included in a 'call-out cascade' when a major incident occurs.

Are end of life care services effective?

Requires Improvement

The trust had taken part in the 2013/14 NCDAH, where it had not achieved six out of seven organisational key performance indicators. The trust performed below the England average and failed to meet all of the 10 clinical key performance indicators. The trust had an action plan in place to address areas identified as part of the National Care of the Dying Audit (NCDAH), including the implementation of training and staff surveys.

Where patients were identified by staff as lacking the mental capacity to be involved in DNACPR decisions, family members were consulted. However, we did not see mental capacity assessments being completed and recorded in line with the principles of the Mental Capacity Act 2005.

Assessments of patients' pain were consistently carried out, with a variety of appropriate measures and tools in place for staff to use. Symptoms were generally addressed in a timely manner. Nutrition and hydration assessments were carried out and staff we spoke with were consistent in their awareness of quality of life issues relating to nutrition and hydration at the end of life.

The trust had taken action to plan and develop services in line with national guidance, with the implementation of an end of life care guidance document on the identification, assessment, care planning, coordination and symptom management of patients at the end of life. Members of the specialist palliative care team were appropriately qualified

and experienced to give specialist advice and we saw evidence of good multidisciplinary team working as part of the approach to supporting ward based staff and patients in delivering good quality end of life care. We saw that the Liverpool Care Pathway (LCP) was no longer in use since the national phase out date of July 2014.

Evidence-based care and treatment

- We viewed a guideline document for end of life care that had been ratified in January 2015. The guidance included identifying patients at the end of life, holistic assessment, advanced care planning, coordinated care and the management of pain and other symptoms.
- The end of life care documentation had included national guidance from sources such as the Leadership Alliance for the Care of Dying People, the Department of Health End of Life Care Strategy, the National Institute of Health and Care Excellence (NICE) and the Gold Standards Framework (GSF).
- The LCP had been phased out nationally by July 2014 and staff we spoke with at Darlington hospital told us it had not been used since this time.
- We saw a document titled 'Guidance for care of patients who are ill enough to die', which staff told us had replaced the LCP. We saw laminated copies of the guidance displayed in ward areas and in the files of patients who had been identified as being ill enough to die.

Pain relief

- Staff told us there were adequate stocks of appropriate medicines for end of life care and that these were available as needed both during the day and out of hours.
- The wards we visited had adequate stocks of medicines in line with anticipatory prescribing guidance on the five key symptoms most commonly experienced at the end of life.
- Pain assessment charts were available on the wards and these included a universal pain assessment tool, the Abbey pain scale for patients who are cognitively impaired and the Wong-Baker FACES Pain Rating Scale. We saw that the different scales were used based on patients' ability to express, score or rate their pain.
- We viewed pain scales being used appropriately on the wards to assess patients' pain and to evaluate the effectiveness of medication administered.
- Patients and relatives we spoke with told us that the nursing staff supported them well in managing their pain.

Nutrition and hydration

- The Malnutrition Universal Screening Tool (MUST) was incorporated into the inpatient admission record to assess patients on admission, then weekly as appropriate after this.
- The assessment included identifying a risk score. If a patient had a score of 1 they were considered to be at moderate risk and if they had a score of 2 they were considered to be at high risk. When a patient was at moderate risk there were prompts to direct nursing staff to take specific action in line with a nutrition care plan. When a patient was identified as being at high risk nursing staff were prompted to carry out a dietician referral.
- We observed staff on the wards offering patients food and drinks and encouraging relatives to be involved in that part of a patient's care as appropriate, including the administration of mouth care when a patient was no longer able to eat and drink.
- Staff we spoke with told us they were led by patients' wishes at the end of life with regard to nutrition and hydration. We saw one patient who had problems with nausea and vomiting and we observed staff offering them food and drink outside of normal eating times, as well as offering them snacks that they may find palatable.

Patient outcomes

- The trust had taken part in the 2013/14 National Care of the Dying Audit (NCDAH) where it had not achieved 6 out of 7 organisational key performance indicators. The trust performed well in the use of clinical protocols for the prescription of medications for the five key symptoms at the end of life. The trust performed below the England average and failed to meet all of the 10 clinical key performance indicators.
- We viewed a draft action plan that aimed to address issues raised following the audit, including the recruitment to an end of life care educator post, the appointment of a non-executive director to take the lead on end of life care, and the implementation of regional 'guidance for care of patients who are ill enough to die'.

End of life care

- At the time of our inspection the 'guidance for care of patients who are ill enough to die' had been implemented (in July 2014) but other actions had been delayed. Members of the specialist palliative care team told us that delays had been due to structural and staffing issues as well as the end of life steering group being newly established.

Competent staff

- There were two WTE specialist palliative care nurses based at Darlington hospital.
- Specialist palliative care nurses visited the wards on a daily basis to review patients at the end of life and to support ward based medical and nursing staff in planning and delivering care to patients.
- There were end of life resource folders kept on the wards and in clinical areas, offering staff information on where they could obtain additional support or advice and details of aspects of symptom management and care at the end of life.
- There were end of life link nurses based on the wards; these were staff that had attended end of life care training and acted as a link between ward staff and the specialist nurses in terms of sharing learning and knowledge.
- Ward staff and the specialist palliative care nurses told us that training was often delivered on the wards as there had been some difficulties releasing ward staff for formal class-based learning. We observed the specialist nurses spending time on the wards and working with nursing and medical staff in a way that focused on the development of consistent end of life care.
- Ward based nurses were able to shadow the specialist palliative care nurses so that they could develop more specialist knowledge, and there was a programme in place for specialist nurses to mentor staff who were undertaking end of life care training courses with external training providers.
- We viewed an action plan that included the development of a nurse educator role and end of life care training that included the use of staff surveys to measure the effectiveness of training delivered.

Multidisciplinary working

- Members of the specialist palliative care team participated in both lung and gastrointestinal multidisciplinary meetings, working with other specialists to support good quality end of life care in these clinical specialties.
- The specialist palliative care team told us it met daily to discuss patient care and workloads and that wider team meetings across both hospital sites were held every few weeks.
- Staff also told us they had the opportunity to meet with the wider multidisciplinary team as part of the end of life steering group meetings. We viewed minutes of these meetings that demonstrated multidisciplinary action planning in a number of areas. One example was the development of spiritual services for patients at the end of life.

Seven-day services

- The specialist palliative care team provided a 5 day, 9am to 5pm face to face service, with no out of hours input.
- The specialist palliative care team told us there were plans to join the Tees out of hours consultant on-call rota and we saw plans in place to progress this as part of action in response to the results of the 2013/14 NCDAH.
- Out of hours support at the time of our inspection was available from local hospices, and the specialist palliative care team had developed resource folders for each ward/clinical area that included information and advice for staff.
- The chaplaincy service provided multi-faith pastoral and spiritual support, including out of hours cover.

Access to information

- Risk assessments and care plans were in place for patients at the end of life. Patients were cared for using relevant plans of care to meet their individual needs.
- Once a patient had been identified as being ill enough to die, staff would use the regional guidance for care of patients who are ill enough to die. The guidance incorporated prompts for staff to assess patient symptoms, identify advance decisions, discuss values and spiritual needs and agree options for hydration and feeding.
- We viewed records that included detailed information about the management of symptoms, discussions and

interventions. We also saw the when patients were seen by the specialist palliative care team a sticker was put into the patient record so that staff could easily access the guidance given.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- The trust's 'resuscitation and do not attempt cardiopulmonary resuscitation policy' provided guidance for completing a DNACPR form for an individual who does not have capacity, stating that when a specific care decision was to be made the 'best interests' process under the Mental Capacity Act (2005) must be followed.
- We saw that where a patient appeared to lack mental capacity, discussions with family members and relevant staff involved were recorded in the patient's notes in line with best interest guidance.
- Of the 22 DNACPR forms we viewed across a variety of wards in the hospital, seven were for patients who staff identified as lacking mental capacity to make resuscitation decisions. In all cases we saw that the decision was discussed with the patient's family, but we did not see mental capacity assessments recorded as part of the decision making process. This meant that the process of identifying patients who lacked mental capacity was unclear.
- The trust was implementing guidance from the 'Deciding right' Northeast NHS document 'An integrated approach to making care decisions in advance'. We saw that this was incorporated into the DNACPR decision making form in terms of recognising when a patient has made an advanced decision. Emergency healthcare plans (care plans covering the management of an anticipated emergency) had been piloted and we were told that arrangements were in place to deliver training for ward and community based staff in the use of the plans. We did not see emergency healthcare plans in use during our visit.

Are end of life care services caring?

Good

End of life care services were seen to be caring. Patients and relatives told us they were happy with the quality of care they received and that staff were kind, caring and compassionate in their approach. We saw evidence of plans to proactively develop the chaplaincy service in terms of pastoral and spiritual care, which involved providing spiritual, pastoral and emotional support to patients and families from a number of faiths and for those who don't follow a faith.

There were elements of outstanding practice relating to the level of care and compassion found within end of life care services, in particular, the use of memory boxes in the intensive care unit (ICU) and the use of comfort packs for relatives of patients at the end of life.

Compassionate care

- During our inspection we saw that patients were treated with compassion, dignity and respect.
- We observed staff caring for patients in a way that respected their individual choices and beliefs. An example we saw included nursing staff asking family members what was important to the patients in terms of their wishes at the end of life.
- Patients and relatives we spoke with told us they were happy with the quality of care they received. One relative told us, "they couldn't have done more". Another told us, "I think they must hand pick the nurses, everyone is fantastic and the care couldn't be better".
- Responses from a bereaved relative survey were mostly positive in relation to the care patients and family members received at the end of life. Trust analysis of the results highlighted issues around communication, documentation and meeting people's spiritual support needs. We saw that these areas had been discussed at end of life care steering group meetings, and actions had been incorporated into the plan following the NCDAH.
- We saw that care after death honoured people's spiritual and cultural wishes. Members of the chaplaincy team told us they were able to source expertise from the local community around different cultures and faiths and that there were staff within the trust that had specific knowledge in this area.
- We spoke with mortuary staff who told us they worked closely with family members regarding care after death, and all mortuary staff had attended bereavement training.

Understanding and involvement of patients and those close to them

End of life care

- Patients and family members we spoke with told us they felt involved in the care delivered.
- We observed staff talking with relatives when a patient's condition had deteriorated. We saw that relatives were asked if they had questions, wanted to be involved in aspects of the person's care and whether they felt the person was being cared for in the right place.
- Staff discussed care issues with patients and relatives where possible and these were mostly clearly documented in patients' notes.
- The end of life care guidance used by the trust included prompts for discussing issues of care with patients and relatives.
- Systems were being implemented to support patients in advanced care planning in the form of emergency health plans. We saw that training was planned in the 'deciding right' approach to decision making and we saw minutes of the end of life steering group that included a pilot to develop this approach across the trust.

Emotional support

- Members of the specialist palliative care team participated in the delivery of trust wide Sage and Thyme training for clinical staff. The Sage and Thyme model is focused on supporting staff to listen and respond to patients/carers who are distressed or concerned.
- Visiting times were flexible for family and friends when patients were at the end of life and we saw that reclining chairs were available for relatives who wished to stay with a patient. There were quiet rooms available on the wards that relatives could use and we were told there were showering facilities available for those staying overnight.
- Comfort packs were given to relatives who were staying with patients at the end of life. These packs included toiletries, snacks and other items to improve the comfort of relatives.
- Where possible, patients at the end of life were given the option to move to a side room to ensure privacy and dignity.
- There was a multi-faith chapel available that held information relevant to people from different faiths. The chaplaincy services within the trust were geared towards providing support for patients and their relatives irrespective of their individual faith or if they did not follow a faith.
- We saw plans in place and evidence of discussion at end of life steering group meetings to develop the chaplaincy service in response to a decline in the number of patients and relatives referred to the service.
- A proposal had been developed that included a proactive approach to engaging with patients and family on the wards and offering pastoral and spiritual support directly. The development of this approach was based on an 'opt out' model of chaplaincy support in the last days of life based on that used by other trusts in the region.

Are end of life care services responsive?

Good

All patients requiring end of life care could have access to the specialist palliative care team. Referrals to the integrated service from 1 April to 1 October 2014 totalled 1,852, but specific data relating to the activity of the specialist palliative care team based at Darlington hospital was not available. Specialist palliative care referrals were mostly for support with pain and symptom management, with additional support provided for patients and family members for people with complex end of life care needs.

Staff, patients and relatives told us that end of life care services were responsive and we saw evidence of this during our inspection. However, there was a lack of audit data available to show patient preferences or the response times and activity of the specialist palliative care team. There was evidence of service development to meet patients' needs in terms of the facilitation of discharge to a preferred place of care at the end of life, including the development of dedicated discharge facilitator posts. Specialist palliative care staff were not always made aware of complaints relevant to end of life care, as complaints were not recorded in a way that categorised end of life care, meaning that learning from complaints may not always have had specialist input.

Service planning and delivery to meet the needs of local people

- The preferred place of care at the end of life was recorded by the specialist palliative care team but not as part of routine admission data collected on the

wards. This meant that patients who were referred to the specialist palliative care team would have had their preferences recorded but those who weren't referred may not have done.

- We viewed a bereaved relative survey in which 76% of respondents stated that they felt their relative died in the right place; however ,the trust did not have data available for patients dying in their preferred location at the time of our inspection. Staff told us this was due to a lack of administrative support to the specialist palliative care team at the time.
- The trust used a strategic commissioning plan that had been developed by local clinical commissioning groups (CCGs) with input from key staff within the trust, patients and external professionals. From this plan, we were told that the trust had recently recruited to two discharge facilitator posts.
- The aim of the strategic commissioning plan was to provide a framework for the provision of end of life care. It identified priorities such as multidisciplinary working, advanced care planning, meeting the needs of people living longer with diseases, consultant led care, 7 day services and patients choosing where they want to be cared for at the end of life.

Meeting people's individual needs

- Staff on the wards told us that patients with complex needs would be referred to the specialist palliative care team for additional support, particularly when there were issues around managing their symptoms effectively.
- We saw from training records that some staff had undertaken training in dementia and learning disability awareness via the trust's e-learning package, and we saw that the trust had plans to develop this training and improve uptake.
- Patients and family members we spoke with told us that their care was individualised, and we observed discussions around care and treatment decisions that demonstrated this.
- Mortuary, chaplaincy and ward staff told us they had access to information about different cultural, religious and spiritual needs and beliefs and that they were able to respond to the individual needs of patients and their relatives.
- Chaplaincy services were described as 'a place of worship, reflection and quietness for people of all faiths and none' and that plans were in place to develop chaplaincy services to meet the needs of people from different and no faiths.
- Assessment documentation by the specialist palliative care team included recording patients' preferred location of care at the end of life.

Access and flow

- All patients we saw had gone through a process of assessment and risk assessment from both medical and nursing perspectives on admission.
- Ward staff we spoke with told us they knew how to access the specialist palliative care team and that the team were responsive to the needs of patients. We saw referrals being made in timely and appropriate ways.
- Members of the specialist palliative care team and ward staff alike told us that, generally, patients would be seen within hours of a referral to the specialist team. We accompanied specialist palliative care nurses on visits to the wards and observed them assessing patients on the same day as the referral was made.
- Resource folders on the wards included information for ward staff on how to access specialist advice outside of normal working hours when the specialist palliative care team was not available.
- Advice given by the specialist care team was recorded in patient notes with a sticker accompanying entries so that staff could quickly access the advice given.
- The chaplaincy service was accessible 7 days a week via an on-call system. We saw that the chaplaincy service was being developed as an open ended support for patients when identified as dying. There were plans in place to raise awareness among staff about the ability of the service to provide comfort and support outside of religious or faith beliefs.
- Staff across the trust told us they felt they were able to discharge patients quickly at the end of life if they chose to be cared for at home. We were told that arrangements with the pharmacy included the prioritisation of end of life medicines in this situation and that these could be available within an hour. The trust did not collect specific data regarding rapid discharge for patients requiring end of life care.

End of life care

- Staff told us they worked with the Marie Curie rapid response team and hospice at home services to ensure patients got home as quickly as possible if this is what they wished.

Learning from complaints and concerns

- Members of the specialist palliative care team told us they were not always made aware of complaints relating to end of life care. We were told that the system for recording complaints would not necessarily pick up an complaint as being relevant to end of life care, and as such, themes and trends may not be identified within the reporting system.
- We were told that the system in place relied upon summaries of complaints being given to the head of each directorate. This meant that complaints made relating to patients being cared for in the care closer to home directorate, where the specialist palliative care team sits, would be passed on appropriately. However, if complaints were made from other directorates, the team may not always be aware of them.
- Staff we spoke with told us they felt that the complaints management system needed to be more joined up in a way that enabled them to pick up themes.
- We were given an example of a complaint on one of the wards at Darlington hospital where the specialist palliative care team had been part of the review and that this resulted in additional training and information being given to staff.

Are end of life care services well-led?

Requires Improvement

There was no trust wide end of life strategy in place and there was not a non-executive director nominated as the lead for end of life care within the trust. We saw a number of plans and tools in place aimed at improving the quality of end of life care services within the hospital. The trust had been involved in the development of a regional end of life care commissioning strategy and progress had been made in terms of recruitment to some posts developed in line with this strategy. There had been some development in relation to end of life care being prioritised within the trust; however, staff we spoke with told us these developments were hampered by structural issues relating to staffing within the teams and leadership changes. In particular, while an action plan had been devised following the National Care of the Dying Audit (NCDAH), action had yet to be taken in many areas. For example, 9 months after receiving the audit report, six out of eight objectives remained unchanged. There were also limited data available to support the effectiveness of the service, and staff told us this was due to a lack of administrative support to update the database and ensure up to date data were available and utilised effectively.

We saw plans in place to develop the service, and staff we spoke with were motivated, committed and enthusiastic in taking this forward. There were plans to address staffing issues within the specialist palliative care team and some progress had been made in terms of recruitment, but this needs to be further developed, particularly in terms of adequate consultant cover and administrative support.

Vision and strategy for this service

- There is no non-executive director nominated as the lead for end of life care within the trust.
- The director of nursing had agreed to chair the end of life steering group that had been developed in the past year; however, it had been identified that a more permanent chair was needed to ensure continuity of service development. We were told that the regular steering group meetings had been on temporary hiatus due to structural changes in the directorate, but that there was a commitment to ensure these continued regularly.
- Staff felt there had been an improvement in understanding and commitment at board level for the need for good quality end of life care, with a genuine intention to improve. However, they felt that the level of engagement between the board and the services could be further improved.
- There was a strategic commissioning plan that had been developed by local clinical commissioning groups (CCGs) with input from key staff within the trust, patients and external professionals.
- There was no trust wide end of life strategy in place, although we saw evidence of action plans being drawn up to address issues identified from external audit and local reviews. Members of the specialist palliative care team had a good understanding of the priorities that had been identified across the trust in the development of end of life care services.

End of life care

- As part of the trust's 'Quality matters' 2015–17 strategy, end of life care had been identified as one of the priority areas. The aim of this was stated as 'We want people approaching the end of their life to have confidence that the care we provide will be consistent with their preferences. We want patients and their families to be supported and informed of all options available to them'.
- Ward staff provided end of life care and we saw that with support from the specialist palliative care team they had a good understanding of what constituted good quality end of life care.
- There was an action plan relating to the results of the NCDAH that outlined the priorities for developing end of life care within the trust, and we saw that this included the development of and recruitment to new senior posts within the specialist palliative care team.
- Staff we spoke with told us they believed it had been difficult historically for end of life care to be seen as a trust priority, but that action taken in the past year, with the development of the end of life care steering group, would lead to better ownership and prioritisation.

Governance, risk management and quality measurement

- The lead nurse/head of clinical governance had been identified as the end of life lead from April 2015.
- We viewed minutes from the end of life care steering group meetings and saw that these were attended by representatives from a number of clinical areas. Attendees included the head of clinical governance, a palliative care consultant, specialist palliative care nurses, a cancer nurse specialist, a chief pharmacist, a sister from the cardiac arrest prevention team, a chaplain and a district nurse team manager. Therefore a wide range of services was represented.
- The results of the NCDAH audit had been used to develop an action plan that was led by the end of life steering group. Action points highlighted were geared towards improving end of life care. However, action had not been taken in a number of areas. For example the trust had not appointed a non-executive lead for end of life care, and the target action date (June 2015) was 13 months from the date the action had been identified (May 2014). Another example was that an audit of end of life care guidance implemented in July 2014 was not scheduled to begin until quarter 4 of the 2014/15 financial year. This did not happen due to lack of capacity within the SPC team, although it has since been undertaken, in quarter 1 of the 2015/16 financial year.
- Staff we spoke with told us the report from the NCDAH had been received in May 2014 and that work had started on the action plan from this, but that it had taken time to agree the action plan due to the end of life care steering group being in its infancy as well as staffing and recruitment issues.
- Members of the specialist palliative care team told us that problems with staffing the service had impacted on the development of the service and their ability to take action in a timely and effective way. The care closer to home risk register included the identification of risk in relation to the specialist palliative care service. Specific examples included the lack of a lead nurse, vacant consultant hours and poor administrative support due to a pause in the management restructure within the care closer to home directorate.
- Action planned as a result of the risks identified had included addressing consultant recruitment issues with the CCG, and the identification of interim clinical leadership roles.
- There were limited data available to demonstrate the effectiveness and quality of the service. Staff we spoke with told us this was due to a lack of administrative support to the specialist palliative care team and the database not being kept up to date.
- The trust started using the End of Life Care Quality Assessment Tool (ELCQuA) in 2013/14. The ELCQuA is a tool that tracks progress in delivering end of life care services. We viewed a draft report dated March 2014 where priorities had been identified, but we did not see a further report illustrating progress in relation to this.
- We were told that mortality reviews took place and were reviewed at board level, and that a member of the specialist palliative care team had been involved in these reviews. We saw from steering group meeting minutes that meetings of the mortality review group focused on the reduction of avoidable deaths and that mechanisms to review palliative care at the end of life were being developed.

Leadership of service

End of life care

- We saw evidence of good local leadership at ward level, with end of life care being seen by ward managers and staff as a priority in terms of quality and meeting patient needs and wishes.
- The director of nursing had stepped in to provide executive leadership in end of life care, but there was no non-executive lead appointed at board level. The target date for this was 13 months after the date of the audit. Staff we spoke with told us they felt more needed to be done to prioritise end of life care within the trust.
- We saw a good level of commitment within the specialist palliative care team to the development of good quality end of life care within Darlington hospital.
- The specialist palliative care team had been without a lead nurse for a period of several months leading up to our inspection and staff told us the limited structure had impacted on their ability to take forward initiatives they believed to be important to the development of the service. One particular example was that the action plan resulting from the NCDAH report (received by the trust in May 2014) had had limited action taken to date. In six out of eight objectives, the position of the trust had remained unchanged since the audit.
- The recruitment of two band eight nursing posts to the specialist palliative care team had been successful and we were told these staff members were expected to start by April 2015.

Culture within the service

- Staff we spoke with demonstrated a commitment to the delivery of good quality end of life care. There was evidence that ward staff felt proud of the care they were able to give and there was positive feedback from nursing and care staff about the level of support they received from the specialist palliative care team.
- There was evidence that the culture of end of life care was centred on the needs and experience of patients and their relatives. Staff told us they felt able to prioritise the needs of people at the end of life in terms of the delivery of care.
- Members of the specialist palliative care team told us they were proud of the care they were able to deliver, but that they would like to have a greater capacity to influence the care of patients they don't see through the delivery of education and service development across the trust.

Public and staff engagement

- Although there was no non-executive director with lead responsibility for end of life care at the time of our inspection, we saw there were plans in place to appoint a lay member at board level and to the end of life steering group.
- The results of a bereaved relative survey had been collated and compiled into a report that included action points relating to improving communication and access to spiritual support.

Innovation, improvement and sustainability

- The specialist palliative care team was focused on continually improving the quality of care, and we observed a commitment to this at ward level as well.
- We saw elements of lessons learned to improve end of life care. However, because of the way incidents, complaints and patient experience issues were recorded depending on where they received their care, it was unclear how the trust ensured relevant specialist palliative care input in the review of learning relating to end of life care.
- Plans were in place to develop an end of life education strategy in line with the appointment to an end of life educator post.
- The palliative care team staff told us they had successfully recruited to two discharge facilitator posts and we saw plans in place to develop the chaplaincy service.

Outpatients and diagnostic imaging

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

Information about the service

Darlington Memorial Hospital outpatient and imaging departments are situated on the main hospital site on the outskirts of Darlington. There were a total of 212,073 outpatient appointments between April 2013 and March 2014. The ratio of new appointments to review appointments was approximately 1:2.

Outpatient clinics were held in three different locations on the site: medical outpatients, surgical outpatients and ophthalmology outpatients. The outpatient departments ran a wide range of clinics, some nurse led, some allied health professional led and some led by doctors across a large number of specialties such as urology, gynaecology, orthopaedics, general surgery, breast surgery, orthodontics, ophthalmology, ear nose and throat, and respiratory medicine.

Radiology was part of the trust's surgery and diagnostics care group directorate. Radiology provided a trust wide diagnostic imaging service. The acute work of the trust was concentrated at the University Hospital of North Durham and Darlington Memorial Hospital, which offered a full comprehensive range of diagnostic imaging and interventional procedures, as well as a substantial plain film reporting and ultrasound service.

Radiology services were managed by a clinical lead radiologist, head of service for imaging and radiology manager. We visited the x-ray departments located at the University Hospital North Durham and Darlington Memorial Hospital.

During the inspection we spoke with 17 patients and eight relatives, one matron, eight nurses, three healthcare assistants, two administrative staff, one member of a technical team and three doctors in outpatients. Within radiology we spoke with approximately 22 staff including, the head of service, a radiology manager, a consultant radiologist clinical lead, a consultant physician, a consultant surgeon, radiographers, department nurses and appointments/reception staff.

We observed the radiology and outpatient environments, checked equipment and looked at patient information.

Outpatients and diagnostic imaging

Summary of findings

Overall the care and treatment received by patients in the Darlington Memorial Hospital outpatient and imaging departments was safe, effective, caring, responsive and well led. Patients were very happy with the care they received and found it to be caring and compassionate. Staff were supported and worked within nationally agreed guidance to ensure that patients received the most appropriate care and treatment for their conditions. Patients were protected from the risk of harm because there were policies in place to make sure that any additional support needs were met. Staff were aware of these policies and how to follow them.

There were some areas that needed improvement, such as the systems in place for checking in storage cupboards for expired equipment. A number of patient information leaflets across the departments were past their review date.

The departments took part in the NHS Friends and Family Test and another satisfaction scheme called 'I want great care'. There were comment boxes in waiting areas.

On the whole, the services offered were delivered in an innovative way to respond to patient needs and ensure that the departments work effectively and efficiently.

Are outpatient and diagnostic imaging services safe?

Good

The level of care and treatment delivered by the outpatient and diagnostic imaging services was good overall. Incidents were reported using an electronic reporting system and all the staff we spoke with were able to report incidents using the system if they needed to. Incidents were investigated and lessons learned were shared with all of the staff.

Cleanliness and hygiene in the departments was within acceptable standards. There was sufficient personal protective equipment in all of the areas we inspected and staff were aware of how to dispose of it safely and within guidelines. There was sufficient clean and well maintained equipment to ensure that patients received the treatment they needed in a safe way. We found some equipment in store cupboards that was out of date.

Staff were aware of the various policies in place to protect vulnerable adults or those with additional support needs and patients were asked for their consent before care and treatment was given. Staff were clear about who could make decisions on behalf of patients when they lacked or had fluctuating capacity.

Medical records were electronic and therefore there were few problems with information not being available for clinics.

Staff in all departments were aware of the actions they should take in the case of a major incident.

Incidents

- There had been 24 incidents within the outpatient department during 2014. Twenty of these caused no harm, three caused minor harm and one was classified as a near miss. There were no serious or moderate harm incidents at the Darlington Memorial Hospital.
- There were 50 radiation incidents (plus 4 near misses) affecting 50 patients. Nineteen of the 50 incidents required the Care Quality Commission (CQC) to be

notified under IR(M)ER and three of these required dual reporting to the HSE under IRR99. The trust was not an outlier in terms of IR(M)ER notification requirements. The underlying causes of the radiation incidents were:

- Imaging department error (wrong side, image transfer to the wrong patient folder, cassette double exposure): 25out of 55 (45.5%)
- Referrer error (wrong patient or wrong clinical history): 17out of 55 (31%)
- Equipment error: 4 out of 55 (7%)
- Other: 9 out of 55 (16.5%)

- Of the 21 required notifications to an enforcing authority, 13 out of 21 (62%) were due to referrer error. The wrong patient undergoing a medical exposure is the most common reason for notification.
- The trust used an electronic system to record incidents and near misses. All staff who worked in the departments were able to access the system to record incidents.
- We spoke with staff about their knowledge of the incident reporting system. All staff said they could access the system and knew how to report incidents.
- Staff were able to give examples of reported incidents and changes in practice that had resulted from the subsequent investigations.
- The departments had robust systems in place to report and learn from incidents, to reduce the risk of harm to patients.
- All of the staff we spoke with were able to describe how they reported incidents and how they used the electronic incident reporting system.
- The manager told us they encouraged a culture of open incident reporting across all of the diagnostic modalities and staff we spoke with confirmed this.
- There were no 'never events' reported in 2013/14 (never events are serious, largely preventable patient safety incidents that should not occur if the available, preventable measures have been implemented).
- In 2014, the department reported three serious incidents to the Strategic Executive Information System (STEIS).
- We looked at one of the serious incidents reported and saw the incident had been categorised, described and investigated. The outcomes from the investigation were recorded and these had been discussed with the patient and an apology given.
- We saw evidence through our review of departmental communication processes of post-incident feedback, learning reviewed and changes in practice implemented.
- The managers told us that they continued to report radiation incidents to the CQC under IR(M)ER.

Cleanliness, infection control and hygiene

- We saw, and patients reported, that staff washed their hands regularly before attending to each patient.
- Personal protective equipment such as rubber gloves, protective eye glasses and aprons were available to staff.
- Once used, personal protective equipment was disposed of safely and appropriately.
- The outpatient areas and clinic rooms were clean and tidy and we saw staff maintaining the hygiene of the areas using appropriate wipes to clean equipment between patient use, thus reducing the risk of cross infection.
- The imaging and outpatient department staff took part in regular hand washing and environment audits. We saw the latest reports which showed that these were part of an ongoing process.
- An infection control audit had been carried out in the outpatient department in February 2014. The department was 93% compliant. An action plan had been written to ensure that areas of non-compliance were addressed. This included replacing damaged chairs, removing boxes stored on floors, improving dusting routines and having a rota in place for cleaning of curtains in treatment and consultation rooms. We observed that there were no damaged chairs, no boxes stored inappropriately and no problems with residual dust in the outpatient departments. Curtains in the treatment and consultation rooms we inspected were clean.
- The radiology department overall appeared clean, tidy and uncluttered. However, we did see a layer of dust had been trailed out into the main x-ray corridor from the refurbishing work in one of the fluoroscopy rooms. This issue was brought to the immediate attention of the departmental managers and the area was cleaned during our visit.
- Patient waiting and private changing areas were clean and tidy. Single sex and disabled toilet facilities were available and these areas were also generally clean.

- Hand washing posters were displayed throughout the department and sufficient hand wash facilities were available.
- Staff were responsible for maintaining the cleanliness of equipment in accordance with infection prevention and control standards. Departmental cleaning schedules were not available.
- We saw staff wearing protective clothing such as disposable gloves, aprons and using hand wash gel appropriately and the 'bare below the elbow' policy was adhered to. The appropriate containers for disposing of clinical waste were available and in use across the department.
- The August 2014 Infection Control Audit overall showed positive compliance results with infection prevention and control practices.
- The manager told us that for patients with infections, infection prevention and control principles were applied. Two radiographers would be involved in the patient's care, one to solely manage the equipment the second to manage and support the patient during their diagnostic screening.

Environment and equipment

- The environments of the outpatient departments were well lit, spacious and pleasantly decorated.
- During our inspection we saw that the waiting rooms got busy and staff told us that sometimes there was not sufficient seating for patients, particularly if clinics were running late. There were rare occasions when patients had to stand.
- Overall, the outpatient departments were big enough to meet the needs of all patients and relatives.
- We saw and staff confirmed that there was sufficient equipment to meet the needs of patients within the outpatient and imaging departments.
- Emergency resuscitation equipment for adults and children was checked in the radiology departments and readily available for use. We saw daily checks of this equipment had been completed.
- We looked at the resuscitation equipment in the outpatient departments. The equipment had mostly been checked regularly as required.
- We looked in the store cupboards in four outpatient departments. In one cupboard, we found a box with more than 15 pairs of scissors that expired in March 2011. There was no clear marking to show that staff were aware that the items had expired. In the oral surgery outpatient department store cupboard, we found four boxes of Swann Morton blades which had an expiry date of December 2013. According to the trust policy, expired items should be returned to the stores department for disposal. We brought the expired items to the attention of the nurses in charge in the two departments. They assured us they would take immediate action to remove the items from the cupboards.
- Equipment was cleaned regularly and serviced in line with manufacturer guidance. Staff showed us how they cleaned equipment. The equipment we looked at was clean.
- The departments were able to replace broken equipment in a timely manner and able to order new equipment if needed. Staff we spoke with confirmed this. We also saw condemned notices were available for staff to place on broken equipment to make sure it wasn't used by mistake.
- Within training files, we saw evidence that staff who used equipment had their competencies checked at induction and then regularly to make sure that they had the skills and knowledge to use the equipment safely.
- We requested a copy of the latest radiation protection adviser report from the trust. This was written in 2013. It contained a summary of key issues faced by the trust such as ageing x-ray equipment and gamma camera, increased radiation incidents, theatre staff failure to wear dosimeters and lack of radiologist support, particularly at Bishop Auckland Hospital.
- The trust was aware of the issues and had a programme of improvements in place.
- During our observations we saw that there was clear and appropriate signage about hazards in the imaging department and the dermatology department.
- The flooring in one of the corridors at Darlington Memorial Hospital was damaged and warning cones were in place to indicate the hazards.
- The manager told us that all modalities had appointed and trained radiation protection supervisors whose role it was to ensure that equipment safety and quality checks and ionising radiation procedures were carried out in accordance with national and local guidance.
- The manager also confirmed that the radiation protection adviser worked within the trust but was not a direct employee of the trust. The manager confirmed that regular contact was maintained between the

radiation protection adviser and the departmental radiation protection supervisors throughout the year. The manager told us that the local rules for diagnostic x-ray were being updated at the time of our visit.
- The trust had policies and procedures in place in relation to principle radiation and protection regulations. We looked at the written 'Employers procedures'. We saw included the principle radiation legislation, local rules and description of the duties to be undertaken by staff in accordance with the legislation.
- The department had radiological protection/hazard signage displayed throughout the department. Illuminated treatment room no entry signs were clearly visible and in use throughout the department at the time of the inspection.
- We observed that specialised personal protective equipment was available for use within radiation areas.
- The manager told us that there were systems and processes in place to ensure the maintenance and servicing of imaging equipment.

Medicines

- The outpatient departments kept a limited supply of medication.
- Medication that needed to be refrigerated was stored in locked fridges. We looked at the temperature record charts for the fridges. All but one of these showed that temperature checks were carried out daily.
- Some staff used patient group directives to dispense drugs to patients. We checked these and found that they had been reviewed appropriately.
- There was no outpatient pharmacy on site, so patients were prescribed medication using 'FP10' prescriptions, which could be dispensed by any pharmacy. The FP10s were stored securely.
- Patients who needed medication such as insulin were asked to bring their own supply when they visited the outpatient departments.
- Within radiology, medicines were stored correctly in locked cupboards or fridges. Fridge temperatures were checked and recorded correctly.
- We were told medicine stocks were checked weekly by the nursing and pharmacy staff. We looked at a random sample of the medicines stored, including contrast medium, and found these items to be in date.
- We also looked at the controlled drugs register and saw stock counts were recorded correctly.

Records

- Records in the outpatient department were electronic. The electronic record keeping was introduced in November 2014. All staff had been trained to use the system. Staff were able to access patients' current and previous medical records using the system. This meant that problems of missing records at outpatient clinics has been all but eradicated. Additionally, the use of electronic records had made it easier to run clinics at different locations.
- Within the imaging department, records were digitised and available to be viewed across the trust.
- Some services also used an electronic records system called Systm0ne, which staff in the community and in GP practices could access. This meant that information could be shared between healthcare professionals more easily.
- Records contained patient specific information about previous medical history, presenting conditions, demographic information and medical, nursing and allied healthcare professional interventions.
- The use of electronic records and the introduction of an electronic dictation system meant that clinic letters were routinely sent to other clinicians and the patient within 2 working days of their appointment.
- Nursing assessments of blood pressure, weight, height and pulse were routinely completed when patients attended the outpatient departments. We observed people being weighed and measured during our inspection.
- We saw patient personal information and medical records were managed safely and securely.
- Patient records were held electronically on the Computerised Reporting Information System (CRIS). We looked at three records and saw these records to be up to date and completed correctly. We also saw as part of the electronic records imaging request cards were also scanned into the patient records.
- The Picture Archiving and Communications System (PACS) is a nationally recognised system used to report and store patient images. This system was available for use by radiologists from across the trust and external reporting providers under contract with the trust.
- Records were audited monthly and the outcomes from the audits were reported and discussed with the staff at departmental governance meetings.

Safeguarding

Outpatients and diagnostic imaging

- Information provided by the trust indicated that 84% of staff had completed safeguarding children level one training. There was no information provided about how many staff had undergone safeguarding children level two or three available for the outpatient department.
- Safeguarding adults awareness training had been completed by 84% of staff.
- Staff we spoke with were able to describe to us the action they would take if they had any safeguarding concerns for either children or adults.
- Staff were aware that the trust had safeguarding policies and a safeguarding team they could contact for advice and support if they had any concerns.
- We saw evidence of information available to staff and patients about who to contact should they have any concerns about the safety of children or vulnerable adults. This was displayed in some staff rooms and on the noticeboards of some outpatient departments.
- Within radiology, we observed patients reporting to the main reception and staff undertook a number of checks to verify the patient's identity for example name, date of birth and GP.
- All of the staff we spoke with were aware of their responsibilities to safeguard adults and children and were aware of the safeguarding leads within the trust. One of the radiographers we spoke with had recently accepted to become the nominated safeguarding lead for the department.

Mandatory training

- The departments had systems and processes in place to ensure staff training was monitored.
- We looked at staff mandatory training levels provided to us. They were for the University Hospital of North Durham and Darlington Memorial Hospital combined. There were good levels of compliance with mandatory training, ranging between 93% for fire safety to 100% for medicine management training.
- Staff did some mandatory training online using e-learning, and some training was carried out in classrooms.
- All of the staff we spoke with in radiology told us they received ongoing mandatory training and that they were responsible for ensuring they kept up to date.

Assessing and responding to patient risk

- There was a process in place for managing patients who were deteriorating. This included transferring patients to the accident and emergency (A&E) department when required, which was on site.
- There were policies and procedures in the imaging department to ensure that the risks to patients from exposure to harmful substances was managed and minimised.
- We were told that requests for CT and MRI were vetted by consultant radiologists before proceeding to arrange an appointment.
- The radiology service used a modified version of the World Health Organization (WHO) surgical safety checklist when carrying out non-surgical interventional radiology. An audit of the checklist had been completed in July 2014 and actions to address shortfalls on the level of compliance were agreed, implemented and compliance levels had increased.
- The manager told us that a spot check had been completed in December 2014, which demonstrated improved compliance. No formal evidence from this spot check was provided and a full re-audit of the checklist was planned for February 2015.
- A series of MRI safety checklists were developed and in use for patients, staff or family escorts and for next of kin to complete if the patient was unable to provide information for themselves.
- Imaging request cards included pregnancy checks for staff to complete to ensure women who may be pregnant informed them before exposure to radiation. These checks were scanned onto the patient's electronic records and were monitored as part of the monthly records audits.
- Nurses employed in the department recorded patients' observations before and during non-surgical interventional radiology procedures. Early warning scores were also recorded to detect any deterioration in the patient's condition during their procedure.

Nursing and diagnostic imaging staffing

- The outpatient departments are staffed by a mixture of registered nurses and healthcare assistants. At the time of our inspection, there were vacancies within the various outpatient departments. These totalled approximately 1.5 whole time equivalent (WTE) band five nurses, 1.5 WTE band two healthcare assistants and two WTE band four staff.

Outpatients and diagnostic imaging

- In the main, vacancies were being covered by current staff, or occasionally staff who worked for the trust bank agency. Where possible, staff worked flexibly to cover shifts. There had been no visible impact on patient care, such as the need to cancel clinics.
- We asked the matron whether they were able to access agency or bank staff to fill any gaps, or if staff went on long term sick leave or maternity leave. They told us they could use bank or agency staff if there was no other alternative and could advertise for replacement staff if a business case for the replacement was approved.
- All of the staff we spoke with told us that they worked hard but that they enjoyed their jobs. They said that staff pulled together and worked as a team to maintain good morale.
- There was no formal system, such as an acuity tool, being used to decide the staffing levels needed in the outpatient departments to cover clinics. This was because each clinic needed different numbers of staff and skill mixes according to the levels of support patients and doctors needed as well as the type of clinic. The matron explained that it was down to the knowledge and experience of the manager to judge how many staff were needed and to be flexible.
- All of the staff we spoke with felt overall there were sufficient staff.
- Out of hours CT services at Darlington Memorial Hospital were provided by the staff on an on-call rota.
- The manager told us that in order to improve the staffing availability and cover for this service, a proposal to increase the number of radiographers by 4.5 WTE had been submitted to the board. At the time of the inspection this proposal was being revised in readiness to resubmit to the board for consideration and approval. This proposal would also provide an opportunity for the service to explore and develop 24 hours, 7 days a week MRI services.
- The manager also told us that agency staff were rarely used within the department.

Medical staffing

- Medical staffing was provided to the outpatient department by the various specialties that ran clinics. Medical staff undertaking clinics were of all grades, but we saw that there were always consultants available to support lower grade staff when clinics were running.
- Staff told us that locums were used within the outpatient clinics depending upon the staffing levels of the specialty.
- The Royal College of Radiographers visited the trust in September 2013, and produced a report for the trust of its findings.
- In response to the report the trust had developed an action plan. One of the key actions was for the trust to maintain activity to appoint appropriately skilled consultant radiologists. The recruitment of appropriately skilled consultant radiologists had been identified as a risk and this was included on the corporate risk register for action.
- The department was funded for 16 radiologist positions. The clinical lead radiologist and the management team told us they had recently appointed a number of appropriately skilled consultant radiologists. Vacancies continued to be covered by long-term locums.
- At the time of our visit we were told there were 11 permanent radiologists employed either in full or part time positions, with five locum radiologists covering outstanding vacancies. Two further permanent appointments were made, one starting in April 2015 and the second in May 2015. Two other radiologists had been interviewed and plans were in place to secure these appointments at the time of inspection.

Major incident awareness and training

- There was a major incident policy and staff were aware of their roles in the case of an incident.
- There were business continuity plans in place to make sure that specific departments were able to continue to provide the best possible safest service in the case of a major incident.
- Managers told us that mock exercises took place to make sure that business continuity plans were fit for purpose.

Outpatients and diagnostic imaging

Are outpatient and diagnostic imaging services effective?

Not sufficient evidence to rate

Care and treatment was evidence based and patient outcomes were within acceptable limits. The staff in the outpatient and diagnostic imaging departments were competent and there was evidence of multidisciplinary working.

Evidence-based care and treatment

- We saw that National Institute for Health and Care Excellence (NICE) guidance was disseminated to departments with a lead clinician taking responsibility for ensuring implementation. This was monitored using the 'Safeguard' system to provide assurance that action had been taken when necessary. Staff we spoke with were aware of NICE and other guidance that affected their practice and could talk to us in detail about patient treatment pathways.
- We saw that the departments were, on the whole, adhering to local policies and procedures. Staff we spoke with were aware of how they impacted on patient care.
- Diagnostic reference levels were detailed in the 'Employers procedures'. Radiography dosage levels were monitored and audited. The 2013 radiography dose audit report showed positive compliance and dosage levels. The manager told us that the diagnostic reference report showed positive compliance with national comparative diagnostic reference level data from other similar sized trusts.
- The trust had a standard operating procedure in place for Ionising Radiation (Medical Exposure) Regulations (IR[M]ER).
- The imaging department carried out quality control checks on images to ensure that imaging met expected standards.

Pain relief

- Staff told us that the departments did not keep pain relief medication but that the doctors in clinics could prescribe medication for any patient needing pain relief during their attendance.
- Patients we spoke with had not needed pain relief during their attendance at the outpatient departments.

Patient outcomes

- In the 12 months before our inspection, the outpatient departments saw 212,073 patients.
- Of these, 69,984 were new appointments and 123,002 were review appointments.
- All images were quality checked by radiographers before patients left the department. National audits and quality standards were followed in relation to radiology activity.
- The outpatient departments took part in trust wide audits such as record keeping but there was little clinical audit being carried out that was initiated within the department.
- The radiology department had taken part in a number of clinical audits such as the use of the WHO checklist within radiology, a re-audit of x-ray and an audit of medical physics. There were action plans in place where improvements were needed and re-audit was planned to monitor improvements.

Competent staff

- Staff we spoke with confirmed that they had received appraisals in the last year. From the information sent to us, 100% of staff had received an appraisal within the 12 months before our inspection.
- Staff and managers told us that there was no mechanism for formal clinical supervision as per the trust policy. Staff did, however, tell us that they felt supported and that the department managers were accessible.
- In both the outpatient and imaging departments, there were formal arrangements in place for induction of new staff. All staff completed full local induction and training before starting their role.
- In both the outpatient and imaging departments, performance and practice was continually monitored through appraisals and competency assessments.
- All qualified radiographers completed equipment competency checks. Continual professional development was planned by the manager on an annual basis to ensure all statutory and topical subjects were covered.
- Medical revalidation was carried out by the trust. There was a process in place to ensure all consultants were up to date with the revalidation process.

- Staff we spoke with in the radiology department told us they had received appraisals and they were up to date with their mandatory training.
- Due to a national shortage of sonographers the trust had developed a 3 year scheme with a relevant training college to support radiographers to become sonographers. The scheme was in its second year at the time of our inspection, and staff reported that the scheme was working well.
- The manager told us of formal arrangements in place for mentoring students and new staff and for continually assessing staff performance through supervision and appraisal.
- Training alert updates for all staff were flagged to managers for action.

Multidisciplinary working

- There was evidence of multidisciplinary working in the outpatient and imaging departments. For example, nurses and medical staff ran joint clinics, and staff communicated with other departments such as radiology and community staff when this was in the interest of patients.
- Radiologists were part of the multidisciplinary internal teams working between specialties, for example, gastrointestinal and breast multidisciplinary teams.
- Specialist nurses ran clinics alongside consultant led clinics.
- We saw an example of a one stop heart failure clinic where patients could see specialist nurses, consultants, have tests and receive a diagnosis and treatment all at one attendance. Patients could also have a cardiac MRI if needed. The trust worked closely with other trusts in the region.
- We saw that the department had links with other departments and organisations involved in patient journeys such as GPs and support services.
- A range of clinical and non-clinical staff worked within the outpatient departments and they told us they all worked well together as a team. Staff were observed working in partnership with a range of staff from other teams and disciplines including radiographers, physiotherapists, audiologists, nurses, booking staff and consultants.
- Staff were seen to be working towards common goals, asked questions and supported each other to provide the best care and experience for the patient.

Seven-day services

- The orthopaedic department ran clinics 7 days per week. Other outpatient departments ran clinics on a weekend and later on an evening to ease waiting lists, but most activity in the outpatient departments happened between Monday and Friday.
- The radiology services across all of the trust's locations provided a range of services; some covered 7 days a week and out of hours services, while some locations provided services within normal working hours, 5 days a week.
- For example at Darlington Memorial Hospital, CT services were provided 24 hours a day, 7 days a week.
- MRI services were run by Alliance Medical Unit and operated 8am to 8pm on weekdays and 8am to 5pm on weekends. Limited urgent-only MRI scans were also provided out of hours by Alliance Medical. The manager told us the referral pathways for out of hours MRI services were with Newcastle from Durham and Middlesbrough from Darlington. There were clear protocols in place to direct staff to the most appropriate hospital that could provide these, either in Newcastle or Middlesbrough.
- Ultrasound services operated from 8.45am to 5pm, 5 days per week, and from 9am to 1pm on Saturdays and Sundays.

Access to information

- All staff had access to the trust intranet to access information on policies, procedures, NICE guidance and e-learning.
- Staff were able to access patient information such as imaging records and reports, medical records and physiotherapy records appropriately through electronic records.
- Radiology reports were part outsourced with an external provider under contract. The managers told us that reliance on outsourcing reports was reducing.
- The managers told us of the systems and processes in place for monitoring the quality and tracking of radiology outsourced reports.
- Information leaflets for diagnostic imaging, for example CT and MRI scans, were sent out in the post with patients' appointment times. These leaflets were also available on the trust's website.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

Outpatients and diagnostic imaging

- Staff we spoke with were aware of how to obtain consent from patients and were able to describe to us the various ways they could do so. Staff told us that in the outpatient departments, consent was obtained verbally. This was the case for the majority of imaging procedures, although consent for any interventional radiology was obtained in writing on the ward before the patient attended the imaging department.
- Approximately 94% of staff were up to date with Mental Capacity Act training.
- Patients told us that staff were very good at explaining what was happening to them before asking for consent to carry out procedures or examinations.
- Staff we spoke with in the radiology department told us they were aware of and had received training in relation to the Mental Capacity Act and deprivation of liberty safeguards.
- The trust had policies and procedures in place for staff to follow for obtaining consent from patients having diagnostic procedures.

Are outpatient and diagnostic imaging services caring?

Good

During the inspection we saw and were told by patients that the staff working in the outpatient and imaging departments were caring and compassionate at every stage of their journey. People were treated respectfully and their privacy was maintained. There were services in place to emotionally support patients and their families and patients were kept up to date and involved with discussing and planning their treatment. Patients were able to make informed decisions about the treatment they received.

Compassionate care

- All of the patients we spoke with spoke highly of the care and treatment they received. There were no negative aspects about care highlighted to us.
- During our inspection we saw patients being treated respectfully by all staff.
- People's privacy and dignity were respected. Some of the areas where patients were weighed were in the open waiting room, but staff had made sure that the scales were in the corner, as much out of public eyesight as possible.
- Staff made sure that patients were kept up to date with waiting times in clinics, and patients told us that this meant they were able to take comfort breaks if they needed to.
- We saw that patients and staff had a very good rapport, especially as many patients had been attending clinics for a number of years. Some patients told us that they knew staff very well and some staff told us some patients felt like family.
- Staff were observed to knock on doors before entering and curtains were drawn and doors closed when patients were in treatment areas.
- We spoke with 10 patients using radiology services and five relatives, and they told us they were very happy with the services provided. Staff presented as skilled, caring and helpful.
- Staff were courteous when caring for patients and were seen responding to patients' individual needs in a timely manner.
- There was one issue relating to patient privacy and dignity that was brought to the manager's attention. The entrance to the cardiac day care unit was via the main x-ray reception waiting area. One patient in bed was held waiting in this area while a space had to be cleared to access the main door of the cardiac day unit.

Understanding and involvement of patients and those close to them

- We spoke with 23 patients and eight relatives in the outpatient and imaging departments. All those we spoke with told us that they knew why they were attending an appointment and had been kept up to date with their care and plans for future treatment.
- Patients felt that they were given clear information and given time to think about any decisions they had to make about different treatment options available to them. They also told us that the treatment options had been explained to them clearly with enough information about side effects and outcomes for them to make informed decisions.
- Staff told us that they encouraged patients to involve their families and loved ones in their care, but that they respected the decision if patients chose not to involve their loved ones.
- We saw patients and people close to them being consulted before radiology procedures, and staff were attentive to the needs of the patients.

Outpatients and diagnostic imaging

- There were no delays evident to patients' care and treatment during the course of our visit to the radiology department.

Emotional support

- Patients told us that they felt supported by the staff in the departments. They reported that if they had any concerns, they were give the time to ask questions. Staff made sure that people understood any information given to them before they left the departments.
- Formal and informal networks had been created by staff to link patients with people with similar conditions who were further along their patient journey. There were posters on the walls advertising these groups, for example for patients who had cancer, hearing loss, or who were losing their sight.
- There was formal counselling support available for patients who needed it.

Are outpatient and diagnostic imaging services responsive?

Good

We found that outpatient and diagnostic services were responsive to the needs of patients who used the services. Waiting times were within acceptable timescales with outpatient clinics only occasionally being cancelled at short notice. Patients were able to be seen quickly for urgent appointments if required.

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

Service planning and delivery to meet the needs of local people

- Staff were supported by colleagues within the wider department at busy times, or when there were absences. This made sure that clinics were only cancelled as a last resort.
- Additional outpatient clinics were run to meet extra demand to ensure that waiting time targets were met.
- The imaging department was able to provide a comprehensive service across the community, in local community hospitals as well as at Darlington Memorial Hospital.
- Referrals for imaging, particularly CT, MRI and ultrasound, were triaged and vetted by each modality and booked according to clinical need.
- Darlington Memorial Hospital provided a CT service 24 hours a day, 7 days a week.
- MRI services were run by Alliance Medical Unit and operated from 8am to 8pm on weekdays and from 8am to 5pm on weekends. Limited urgent-only MRI scans were also provided out of hours by Alliance Medical. Referral pathways for out of hours MRI services were with Newcastle from Durham and Middlesbrough from Darlington. Ultrasound services operated from 8.45am to 5pm five days per week and from 9am to 1pm on Saturdays and Sundays. The imaging department had the capacity to deal with urgent referrals.

Access and flow

- Referral to treatment times were better than the England averages for non-admitted patients (98.5% against the 95% England average) and incomplete pathway patients (95% against the England average of 92%).
- The trust was better than the England average for the 2 week cancer wait target (97% against an England average of 95%), 31 day wait from diagnosis to first definitive treatment (99% against the England average of 97%) and 62 day urgent GP referral to first definitive treatment (90% against the England average of 84%).
- All but one of the hospitals (Sedgefield) had a non-attendance rate worse than the England average of around 7%. The trust had recently introduced a text message reminder service in an attempt to reduce the levels of non-attendance across the trust. The rate for Darlington Memorial Hospital between July 2013 and June 2014 was approximately 9%.
- The trust provided us with information which showed that between 1 May 2014 and 31 August 2014, 390 paediatric outpatient clinics were cancelled and 1699 general outpatient clinics were cancelled across the trust. This equates to less than10% of clinics being cancelled over this time period and is in line with similar trusts. This information was not split between the different sites that held outpatient clinics.

Outpatients and diagnostic imaging

- Within the general outpatient departments, the most common reason (51%) for clinics being cancelled during this time was annual leave. The second most common reason (24%) was because staff were on call. Other reasons included clinical support, meetings, study leave, and 'other'.
- The specialty that cancelled the most clinics across the trust was ophthalmology (185). We did not have enough information to show the number of ophthalmology clinics cancelled as a percentage of the total number of ophthalmology clinics due to run during that time period.
- The trust was better than the England average for diagnostic waiting times, but this sharply increased to worse than the England average in May 2014.
- The trust did not routinely collect information about the average waiting time for patients once they arrived at outpatient clinics and before being called in to their appointment.
- Staff told us that there was always capacity in clinics to see patients who were referred urgently and that double booking two patients in to one clinic slot happened occasionally to make sure that waiting time targets were met. Information about how often this happened was not routinely collected by the trust and therefore is not quantifiable.
- On the day of our visit patients with appointment times in the radiology department were not left waiting for long periods of time.
- Patients arriving from outpatient clinics and inpatients were booked into time slots within the departments on an as-required basis and according to the clinical need of the referral.

Meeting people's individual needs

- Staff told us that they were able to access interpreting services if they needed to.
- Staff told us there was a limited supply of patient information available in different languages. They told us that if necessary, they would make sure any information patients needed about, for example, after care, was explained to them by the interpreter and that the patient understood.
- We saw that the outpatient and imaging departments had leaflets for patients, but we noted that some of these leaflets were past their review date, some by a number of years.
- Staff were aware of the support that was available within the trust for people with learning disabilities, should it be needed. Staff told us they would allow a patient's carer stay with them if that was what the patient wished.
- Staff told us they were aware of how to support people with dementia. They told us that most patients with dementia were accompanied by carers or relatives and provisions were made to ensure that patients were seated in quiet areas and seen quickly. Staff were keen to point out that they would be careful not to make people feel awkward or different if this would cause them distress.
- The medical outpatient department had recently undergone extensive refurbishment and had been developed into a dementia friendly environment.
- There was a canteen available for patients and a small shop for patients to buy refreshments near the medical outpatient department. There were water coolers available in some of the other outpatient departments. The departments had access to food and drinks for vulnerable patients or those who had conditions such as diabetes. There was a system in place to make sure that patients who had attended by wheelchair and were waiting to return home were also able to access food and drinks.
- The departments were able to accommodate patients in wheelchairs or who needed specialist equipment, as they were spacious.
- There was clear signage throughout the departments.

Learning from complaints and concerns

- There were 119 complaints about the outpatient and radiology departments between November 2013 and October 2014. Thirty-two were about the radiology department and 87 were about outpatient departments.
- For outpatient departments:
  - 22 were about appointments
  - 3 were about staff attitudes
  - 10 were about communication
  - 7 were about delay in diagnosis/treatment
  - 13 were about missed diagnosis
  - 3 were about medication
  - 29 were about various other aspects of care and treatment.
- For the radiology department:
  - 5 were about appointments

- 1 was about the attitude of staff
- 3 were about communication
- 9 were about delays in diagnosis or treatment
- 14 were about various other aspects of care and treatment.

- Staff we spoke with were aware of the local complaints procedure and were confident in dealing with complaints as they arose.
- Information about how to access the patient advice and liaison service (PALS) or make a complaint was available within waiting areas.
- Managers and staff all told us that complaints and concerns were discussed at local team meetings and any learning was shared. We looked at two sets of team meeting minutes which confirmed this.
- The radiology manager kept local records of all complaints received. We looked at one recent complaint and saw the outcomes from the investigation were recorded and these had been discussed with the patient and an apology given.
- We also saw evidence through our review of the departmental communication processes of post complaint feedback and learning points reviewed.
- None of the patients we spoke with had ever wanted to or needed to make a formal complaint. On the whole they were happy with the experience they received from the departments.

Are outpatient and diagnostic imaging services well-led?

Good

Within the outpatient and imaging departments of this hospital, staff and managers had a vision for the futures of the departments and were aware of the risks and challenges faced. Staff felt supported by their line managers and were able to develop to improve their practice.

There was an open and supportive culture where incidents and complaints were discussed, lessons learned and practice changed. The departments were supportive of staff who wanted to work more efficiently, be innovative and try new services and treatments.

Vision and strategy for this service

- The department managers, matron and senior managers we spoke with demonstrated vision for the future of the two services, outpatients and imaging. They were aware of the challenges faced by the departments and the trust as a whole.
- Staff within the services were aware of the challenges faced by the organisation, for example the financial challenges. Most told us they were aware that there was a strategy for the trust.
- Throughout the departments, we saw information about the vision and strategy of the trust as well as information promoting the 'six C's' (a national initiative to improve the care and treatment patients receive).

Governance, risk management and quality measurement

- There were governance arrangements in place which staff were aware of and participated in. The departments had staff meetings where clinical governance topics were discussed.
- Staff were given feedback about incidents and lessons learned and the trust regularly produced lessons learned information that staff could access.
- The organisation had systems in place to appraise NICE guidance and ensure that any relevant guidance was implemented.
- The imaging department held meetings twice a month to discuss and review perception error incidents.
- Radiology reports were part outsourced with an external provider under contract. The managers told us that reliance on outsourcing reports was reducing.
- One of the medical staff we spoke with raised some concerns about the timeliness and quality of outsourced reports, and the department's reliance on locum radiologists.
- We spoke with the managers and they told us of the systems and processes in place for monitoring the quality and tracking of radiology outsourced reports.
- Both the outpatient and diagnostic imaging departments had risk registers. These were reviewed and updated regularly. We saw that action was being taken to manage, minimise or eliminate risks.

Leadership of service

Outpatients and diagnostic imaging

- Staff told us that they found the managers of the service to be approachable and supportive. All the staff we spoke with told us they were content in their role. Many staff we spoke with told us that they had worked at the hospital for many years.
- The managers of the departments were seen as fair and flexible with staff.
- Radiology staff we spoke with reported that the leadership at local level was positive. All of the staff were aware of the trust leadership and could access the relevant information from the intranet.
- Staff felt that managers communicated well with them and kept them informed about the running of the departments.
- Staff told us that they had annual appraisals and were encouraged to manage their own personal development.
- Staff were able to access some training and development provided by the trust, although this was not as easy as in the past due to staffing levels and financial pressures. Some staff, such as in dermatology, were encouraged to develop their role and undergo additional training to enable them to perform more skilled tasks.

Culture within the service

- Staff told us that the chief executive was approachable and accessible if they had any concerns. Some told us that the chief executive occasionally visited the outpatient departments.
- Some staff were unsure about who the non-clinical managers and senior managers of the outpatient department were although all were aware of the matrons who oversaw the departments.
- Staff were encouraged to report incidents and complaints and felt that these would be investigated fairly.
- Staff were aware of their responsibilities in relation to 'duty of candour'; to be open and honest with patients when incidents or accidents occurred and where appropriate to involve them in discussions and investigations.
- Managers told us that they felt well supported by the organisation.
- The radiology department had a positive 'can-do' attitude and the staff had confidence in the local leadership of the service.

Public and staff engagement

- We saw that governance arrangements were in place, and complaints and comments were discussed at team meetings.
- A complaints, litigation, incidents and PALS (CLIP) report was produced every 3 months and presented to the board and senior staff. Any themes and trends were reported back so the department could prepare action plans for improvement.
- The outpatient departments had started to take part in the NHS Friends and Family Test (a survey that measures patients' satisfaction with the healthcare they have received).
- A cardiac rehabilitation patient questionnaire was undertaken between 2 December 2012 and 20 December 2013. Patients were asked for their experience of accessing the community CHD/HF service to enable service evaluation, which can help shape and improve the services. The overall feedback was positive.
- There was no specific information from the staff survey relating to the outpatient and imaging departments, but the trust as a whole performed within expectations or better than expectations in all but two elements: percentage of staff feeling satisfied with the quality of work and patient care they are able to deliver (which had fallen since the last survey in 2012), and percentage of staff receiving job-relevant training, learning or development in last 12 months (which had improved since the last survey in 2012).

Innovation, improvement and sustainability

- Staff all told us that they were being encouraged to look at ways the trust could work more efficiently, make savings and improve quality of care for patients. They told us about how they were encouraged to try changes and then evaluate them to make sure quality of care did not fall when money was saved.
- Staff and managers reported that they were able to influence the way the outpatient and imaging departments were organised and run. We were given examples of changes that had been made that had improved the patient experience and made the clinics run more efficiently. For example, a coloured card scheme had been introduced to one of the outpatient clinics so that patients could easily tell which clinic they

were attending and whether that particular clinic was running late. This had improved patient experience and made sure that patients were aware of specific waiting times.

- The trust had developed a regional radiology training centre, the only dedicated radiology training centre in the country.
- Seventy per cent of all staff within the trust who responded to the NHS staff survey felt they were able to contribute towards improvements at work. This was higher than the England average of 68%. There was no specific information for the outpatient or radiology departments.

Outstanding practice and areas for improvement

Outstanding practice

- Ward 44 had recently been awarded Stage II of the "Quality Mark for Elder-Friendly Hospital Wards" from the Royal College of Psychiatrists and ward 52 was in the process of working towards this award.

Areas for improvement

Action the hospital MUST take to improve

- Review the achievements and actions taken to address the targets set nationally within the accident and emergency (A&E) department.
- Review consultant levels against CEM guidance.
- Ensure the A&E department meets cleanliness, infection control and hygiene standards, particularly relating to high and low level dust, blood stains, equipment and floors.
- Ensure the area outside the A&E decontamination facility is free from dirt, litter and debris.
- Be able to demonstrate that all toys are cleaned properly to reduce the risk of infection within the A&E department.
- Ensure that staff regularly check all resuscitation drugs and equipment within the A&E department .
- Ensure medicine fridges are locked and temperatures are checked regularly within the A&E department; this will include the recording of maximum and minimum fridge temperatures.
- Ensure that medical gases are stored in a secure facility within the A&E department.
- Ensure that there are sufficient numbers of suitably skilled, qualified and experienced staff on medical wards, in line with best practice and national guidance; taking into account patients' dependency levels, particularly where patients are receiving non-invasive ventilation (NIV) and require Level 2 intervention and that actual staffing levels meet planned staffing levels.
- Ensure that patients are placed on the most appropriate ward to meet their needs, including a review of the care of patients requiring NIV to ensure that they are admitted to a suitable ward with appropriately skilled and experienced staff, in line with best practice guidance.
- Ensure that patient records are maintained and up to date, are patient centred and contain the relevant information about their treatment and care, including patients awaiting discharge to eliminate unnecessary delays.
- Ensure that staff are conversant with the syringe driver policy and carrying out/recording syringe driver checks in line with this policy.
- Add audits of syringe driver administration safety checks to the annual end of life audit programme.
- Ensure medical staff record mental capacity assessments for patients who are unable to participate in decisions about do not attempt cardiopulmonary resuscitation (DNACPR) forms.
- Ensure audits of mental capacity assessments are incorporated into audits of DNACPR forms.
- Ensure robust implementation of structural changes to the specialist palliative care team to support the development of the end of life care services.
- Ensure data is available to identify and demonstrate the effectiveness of the end of life service.

Action the hospital SHOULD take to improve

- Continue to review College of Emergency Medicine (CEM) audit data to ensure patient outcome targets are met.
- Direct medical staff to check resuscitation equipment and drugs before the start of their shift even when nursing staff have completed the checks within the A&E department.
- Extend its safeguarding assessment processes and consider adding processes to identify child sexual exploitation for all age appropriate children.
- Ensure patients have their medicines reconciled in accordance with trust targets.

Outstanding practice and areas for improvement

- Review access to patient information in languages other than English.
- Review dedicated management time allocated to ward managers.
- Review the patient flow of higher dependency patients through the hospital to ensure care is given in the most appropriate setting.
- Review the servicing of all equipment within the theatre and recovery areas to ensure maintenance and service arrangements are within required timescales.
- Consider ways of improving engagement between staff and managers within the care closer to home directorate with a view to achieving a joined up approach within maternity and gynaecology services. Also, consider ways of improving responsiveness and efficiency in respect to service level decisions within this service.
- Consider ways in which it can identify the required standards within the maternity service dashboard.
- Consider within the maternity and gynaecology services clinical and quality strategy for 2014–16 timelines for review and achievement.
- Consider ways of developing a coherent plan for joint working on improvements in maternity and gynaecology services.
- Consider ways for improving timely and responsive human resource management processes, including personnel issues that impact on service delivery, in maternity and gynaecology services.
- Ensure the paediatric high dependency room has specific standard operating procedures or protocols available to guide the suitably trained staff required to deliver high dependency care.
- Ensure advanced paediatric nurse practitioners have a set of standard operating procedures available to guide their practice and care.
- Formally nominate an executive or non-executive director to represent children at board level which is separate from the safeguarding children executive lead role.
- Review access and security arrangements to theatres and recovery areas.
- Review waiting areas within theatres and recovery areas to ensure privacy and dignity for patients.
- Improve the systems in place to remove out of date stock or stock no longer used from store cupboards in the outpatient departments.
- Ensure actions in response to the National Care of the Dying Audit and other identified actions to develop the service are carried out in a planned and timely way with continued evaluation.
- Ensure systems support ways of identifying when incidents and complaints relate to end of life care so that specialist input can be provided and recorded in terms of investigation and learning.

This section is primarily information for the provider

Requirement notices

Action we have told the provider to take

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

Regulated activity	Regulation
Treatment of disease, disorder or injury	Regulation 17 HSCA (RA) Regulations 2014 Good governance Review the achievements and take actions to address taken to address performance against the targets set nationally in A&E. Review consultant levels against CEM guidance. Ensure that staff regularly check all resuscitation drugs and equipment within the A&E department . Ensure medicine fridges are locked and temperatures are checked regularly within the A&E department; this will include the recording of maximum and minimum fridge temperatures. Ensure audits of mental capacity assessments are incorporated into audits of DNACPR forms. Ensure robust implementation of structural changes to the specialist palliative care team to support the development of the end of life care services. Ensure data is available to identify and demonstrate the effectiveness of the end of life service. Review the servicing of all equipment within the theatre and recovery areas to ensure maintenance and service arrangements are within required timescales. Ensure that staff are conversant with the syringe driver policy and carrying out/recording syringe driver checks in line with this policy. Add audits of syringe driver administration safety checks to the annual end of life audit programme.

Regulated activity	Regulation

This section is primarily information for the provider

Requirement notices

Treatment of disease, disorder or injury	Regulation 18 HSCA (RA) Regulations 2014 Staffing Ensure that there are sufficient numbers of suitably skilled, qualified and experienced staff on medical wards, in line with best practice and national guidance; taking into account patients' dependency levels, particularly where patients are receiving non-invasive ventilation (NIV) and require Level 2 intervention and that actual staffing levels meet planned staffing levels.

Regulated activity	Regulation
Treatment of disease, disorder or injury	Regulation 9 HSCA (RA) Regulations 2014 Person-centred care Ensure that patients are placed on the most appropriate ward to meet their needs, including a review of the care of patients requiring NIV to ensure that they are admitted to a suitable ward with appropriately skilled and experienced staff, in line with best practice guidance. Ensure that patient records are maintained and up to date, are patient centred and contain the relevant information about their treatment and care, including patients awaiting discharge to eliminate unnecessary delays.

Regulated activity	Regulation
Treatment of disease, disorder or injury	Regulation 12 HSCA 2008 (Regulated Activities) Regulations 2010 Cleanliness and infection control Ensure the A&E department meets cleanliness, infection control and hygiene standards, particularly relating to high and low level dust, blood stains, equipment and floors. Ensure the area outside the A&E decontamination facility is free from dirt, litter and debris.

This section is primarily information for the provider

Requirement notices

Be able to demonstrate that all toys are cleaned properly to reduce the risk of infection within the A&E department.