Care Quality Commission

Gateshead Health NHS Foundation Trust

Queen Elizabeth 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	Good
Urgent and emergency services	Good
Medical care	Good
Surgery	Good
Critical care	Good
Maternity and gynaecology	Outstanding
Services for children and young people	Good
End of life care	Good
Outpatients and diagnostic imaging	Good

Summary of findings

Letter from the Chief Inspector of Hospitals

Queen Elizabeth Hospital is the acute hospital forming part of Gateshead Health NHS Foundation Trust. It provides a range of services including medical, surgical, maternity and gynaecology and services for children and young people, end of life and critical care. It has approximately 580 beds. The hospital also provides emergency and urgent care, outpatients and diagnostic imaging.

We inspected Queen Elizabeth Hospital as part of the comprehensive inspection of the Foundation Trust from 29 September to 2 October 2015 and undertook an unannounced inspection on 23 October 2015.

Overall, we rated Queen Elizabeth Hospital as good. We rated it good for being safe, effective, responsive and well-led and outstanding for caring.

Our key findings were as follows:

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and care pathways held electronically on the trust systems were in-date some paper copies held in ECC and SCBU were out of date or had no review date.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

Summary of findings

- Following an external review of governance processes, the trust was reviewing its service strategies to ensure that they remained achievable and relevant. The Board had the experience, capacity and capability to ensure that the strategy was delivered.

We saw several areas of outstanding practice including:

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

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

Importantly, the trust must:

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

In addition the trust should:

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

Summary of findings

- Ensure where required, staff are up to date with Paediatric Immediate Life Support (PILS) and Advanced Paediatric Life Support (APLS) training.
- Review processes to reduce the number of clinic appointments cancelled.
- Continue to implement and strengthen governance processes in response to recommendations following an external independent review including strengthening the board assurance framework, clinical engagement and management of performance and risk.
- Review version control arrangements for the updating of paper copies of polices and care pathways held in clinical areas to ensure staff are using policies which are in date and reflect the latest best practice guidelines.
- Ensure cause for concern-safeguarding forms identify if a child is, or is not, subject to a child protection plan to enable swift and appropriate action.

Professor Sir Mike Richards
Chief Inspector of Hospitals

Summary of findings

Our judgements about each of the main services

Service	Rating	Why have we given this rating?
Urgent and emergency services	Good 	Overall, we rated the Emergency Care Centre as good because: Serious incidents were investigated and lessons learnt and shared with staff. The service had challenges in recruiting medical staff due to national shortages and was actively recruiting to fill vacancies. One consultant had been appointed and five emergency nurse practitioners were in post to support doctors in the department. The service did not use an acuity tool to ensure the department had the required registered nurses on duty but there were processes to escalate staffing concerns when staffing dropped below recommended levels. Staff used good infection prevention and control practices. Equipment was clean and maintained. Staff managed medicines effectively. Patient Group Directives were all within review although some paper copies held in clinical areas were older versions. The department had systems to respond to emergencies and deterioration in patients' health or concerns for their safety. Staff based their care on clinical guidelines and pathways. Electronic copies of these were in-date however some paper copies of pathway documents were not in-date or showed when practice should be reviewed. The emergency care centre took part in national and local audits, to assess the outcomes of patients. Patients and relatives were treated with dignity, respect and compassion. There were systems to facilitate the flow of patients through the department. The department was achieving the national target of 95% of patients being seen within four hours. The service ensured that patient's individual needs were met. It responded to complaints but this had not always been within the trust target of 25 days. There was evidence of learning from complaints. There was strong leadership and management across the service. Staff reported an open and supportive culture, with good relationships across the teams.

Summary of findings

Medical care

Good

We rated medical care (including older people's care) as good because:
Although the service faced challenges to maintain suitably qualified, skilled and experienced staffing levels at all times it was actively recruiting to fill vacant posts and there were processes to ensure wards were adequately staffed.
The level of staff completing mandatory training had improved, but remained below trust targets of 90%.
Staff managed medicines appropriately but did not always check that fridges used for storing medicine were cold enough or that resuscitation equipment was ready for use.
Staff assessed, monitored and managed risks to patients. Patient clinical outcomes were similar or better than national expectations in most areas.
Staff followed systems to report incidents of harm or risk of harm. Managers analysed incidents and provided feedback to staff to help prevent similar incidents.
Wards were visibly clean and staff followed infection control principles. Staff worked together to understand and meet the range and complexity of patient's needs.
The majority of patients and relatives said that staff were polite, caring and respectful. Patients were aware of what treatment they were having, understood the reasons for it and, in many cases, had been involved in the decisions.
Staff were generally positive about the leadership and the levels of engagement with their line management through to executive level. There was a positive open culture within teams. Staff were encouraged to put forward ideas for improvement and had been finalists in national awards.

Surgery

Good

We rated surgical services as good because:
Staff reported incidents and felt supported by managers when considering lessons learned.
There were processes for the management of deteriorating patients. Infection prevention and control was managed. Patient nutrition, hydration and pain relief needs were met.
Staff treated patients with compassion, dignity, and respect.
All wards and theatres had appropriate staffing levels. An escalation policy and procedure dealt with busy times and bed meetings monitored bed availability on a daily basis.

Summary of findings

There was effective multi-disciplinary working to ensure patients received appropriate care and treatment. Patients were treated based on national guidance and enhanced recovery (fast track) pathways were used. Surgical services were well-led with a vision and strategy for the service. There were systems to monitor governance, risk and quality performance.

Critical care

Good

We rated the critical care department as good and outstanding for being caring because:
Details of incidents or harm or risk of harm and the lessons learned from investigating them were shared among staff and action was taken to prevent or minimise the occurrence of similar incidents.
The department was clean but there were gaps in daily recording to show if sinks and showers were flushed to avoid a build-up of waterborne bacteria; a known infection hazard. The department managed medicines.
Staff attended induction training to learn about the organisation and mandatory training to ensure they had the skills needed for their jobs.
The Core Standards for Intensive Care Units 2013 were followed to determine the number of nursing staff needed for each patient. The consultant-to-patient ratio was in accordance with national recommendations.
The critical care department provided rehabilitation after a critical illness (RaCI), which demonstrated an effective pathway for patients' transition from the critical care department to ward-based care and support following discharge.
Data from the Intensive Care National Research Centre (ICNARC) between January 2015 and March 2015 showed that the unit was within statistically acceptable limits for hospital mortality and within the limits for unplanned re-admission within 48 hours when compared to national and peer average.
Staff respected patients' privacy and dignity and treated them with understanding and compassion. Patients and relatives spoke highly about the care they had received.
Services were planned and delivered in a way that met the needs of the local population. The importance of flexibility, choice and continuity of care was reflected in the services.
Critical care services were well led. A critical care strategy document outlined the services vision. Staff spoke positively about the culture and the service they

Summary of findings

provided for patients. Quality and good patient experience and care were seen as a priority and everyone's responsibility. There was a strong cohesive team approach and a low number of complaints.

Maternity and gynaecology	**Outstanding**	☆	We rated maternity and gynaecology services as outstanding because: The service provided safe and effective care in accordance with national guidance. Staff continually monitored outcomes for women and took action where improvements were necessary. Resources, including equipment and staffing, were sufficient to meet women's needs. Staff had the correct skills, knowledge and experience to do their job. Overwhelmingly we received feedback that care was excellent and compassionate. Women reported being treated with respect and dignity and having their privacy respected at all times. Women told us that nothing was too much trouble for staff. Staff demonstrated a strong, visible person centred culture throughout the service. Staff were highly motivated and passionate about giving exceptionally high standards of care. The service took account of complaints and concerns and took action to improve the quality of care. A highly committed, enthusiastic team, each sharing a passion and responsibility for delivering a high-quality service, led the maternity and gynaecology services. Governance arrangements at all levels, enabled managers to identify and monitor risks effectively, and review progress on action plans. Engagement with patients and staff was strong. There was evidence of innovation and a proactive approach to managing performance improvement.
Services for children and young people	**Good**	●	Overall, services for children and young people were good because: Children's services monitored safety, risk and cleanliness. The levels of nursing and medical staff were adequate to meet the needs of children and young people. Not all medical and nursing staff had undertaken Paediatric Immediate Life Support and Advanced Paediatric Life Support training although there was an action plan in place to address this. 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.

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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. There was a strong person-centred culture and staff worked in partnership with patients and their families.
The service looked after children and young people's needs and was well led. The service had a clear vision and was in the process of developing a strategy to support this.
A positive and proactive management team who worked together led the service. The service had introduced innovative improvements with the aim of improving the delivery of care for children and families.

End of life care

Good 

Overall we rated end of life care as good because:
The hospital specialist palliative care team provided face-to-face support five days a week, with the hospice providing out-of-hours cover. There was visible clinical leadership resulting in a well-developed, strong, motivated team. The teams worked well together to ensure that end of life policies were based on individual need and that patients were fully involved in every part of the end of life pathway.
Palliative care link nurses championed good end of life care on the wards. Ward staff spoke about the importance of making sure they understood the preference of patients and relatives in the last stage of life.
Staff throughout the hospital knew how to make appropriate referrals. The specialist palliative care team assessed patients in a timely manner, meeting individual needs.
Medicines and equipment was provided in line with guidelines for end of life care. There were infection, prevention and control measures.
Staff cared for patients with dignity, respect and compassion. There were facilities to support different patient cultures and religions. The chaplaincy and bereavement service supported families' emotional needs when people were at the end of life, and continued to provide support afterwards.

Outpatients and diagnostic imaging

Good 

Overall outpatient and diagnostic imaging were rated as good with responsive requiring improvement because:
Overall, the trust delivered services to respond to patient needs and ensure that departments worked efficiently. However, some areas that required

Summary of findings

improvement included meeting national targets for urgent appointment waiting times, the percentage of clinics cancelled by the service and recording of actions taken following discussions.
Patients were happy with the care they received and found it to be caring and compassionate. Staff worked within nationally agreed guidance to ensure that patients received the most appropriate care and treatment. Trust policies protected patients from the risk of harm by making sure they met any individual support needs.
Communication was effective between senior management and staff, and there was good overall leadership of staff to provide good patient outcomes. The outpatients department had well organised systems for managing clinics. The department was well led, proactive and all staff worked as a team towards continuous improvement for good patient care.

Queen Elizabeth 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

Detailed findings

Contents

Background to Queen Elizabeth Hospital

Gateshead Health NHS Foundation Trust was granted foundation trust status in January 2005. The trust provided the full range of acute hospital services at Queen Elizabeth Hospital. In addition, urgent and emergency services, medical care and outpatient services and diagnostics (where relevant) were provided at specific sites, including Dunston Hill Day Hospital, Bensham Hospital, QE Metro Riverside, Blaydon Primary Care Centre and Houghton Primary Care Centre. The trust was a tertiary centre for gynaecological oncology and a provider of specialist screening services, for breast, bowel and aortic aneurism. The screening services were offered to a wider range of populations including South of Tyne, Northumberland and Humberside, Cumbria and Lancashire.

The trust had 580 beds (538 general and acute, 30 maternity and 12 critical care). It served a population of around 200,000.

Our inspection team

Our inspection team was led by:

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

Head of Hospital Inspections: Amanda Stanford, Care Quality Commission

The team included CQC inspectors and a variety of specialists: including medical and surgical consultants, junior doctors, paediatric doctor, senior managers, paediatric nurse, nurses, midwives, a palliative care nurse specialist, a health visitor, and experts by experience who had experience of using services.

How we carried out this inspection

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

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

Prior to the announced inspection, we reviewed a range of information that we held and asked other organisations to share what they knew about the hospital. These included the clinical commissioning

Detailed findings

group (CCG), Monitor, NHS England, Health Education England (HEE), the General Medical Council (GMC), the Nursing and Midwifery Council (NMC), Royal Colleges, Overview and Scrutiny Committees and the local Healthwatch.

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

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

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

Facts and data about Queen Elizabeth Hospital

- During 2014/2015, the trust saw 30,047 inpatient admissions, 391,406 outpatient attendances, 106,617 accident and emergency attendances, 5,512 ambulatory care attendances and delivered 1,887 babies.
- Deprivation in the local area was significantly worse than the England average. The district was ranked 42nd out of 326 districts for deprivation.
- Life expectancy for males and females was two years lower than the England average. Mortality rates for those under 75 due to cancer or cardiovascular disease was lower than the national average. The number of hospital stays due to alcohol related harm, and the number of smoking related deaths was significantly higher than the national average.
- The CQC intelligence monitoring report placed the trust at Band 6 since 2013, the lowest risk summary band.
- The trust employed 3,033 staff, of which 230 were medical, 880 nursing and had a revenue of £263.697 million (June 2015).

Our ratings for this hospital

Our ratings for this hospital are:

Detailed findings

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

Notes

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

Urgent and emergency services

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

Information about the service

Gateshead Health NHS Foundation Trust provided urgent and emergency services on two sites. The main service was at Queen Elizabeth Hospital where a purpose-built emergency care centre was opened in February 2015. The centre provided an emergency department, paediatric emergency assessment, ambulatory care and an emergency assessment unit. Patients attended through a single point of access and were streamed to the most appropriate service through triage by a qualified nurse. The department also had x-ray facilities and an ambulance receiving area.

The emergency provision in the department consisted of three cubicles for resuscitation of adults and one for paediatric cases (babies and children). If there was a major incident the number of resuscitation beds could be doubled. There were eight cubicles for treating major illness and injuries and eight complex minor illness and injuries cubicles. A further eight minor injuries cubicles were led by GP and nurse practitioner staff. The emergency assessment unit had 24 assessment cubicles: two of which had ensuite facilities for isolation and infection control purposes. The paediatric area consisted of eight assessment cubicles which also acted as a 24-hour short stay unit. The department operated 24 hours a day, seven days a week. The ambulatory care service was based in a different part of the hospital and had three treatment cubicles. This service operated from 8am to 9pm, seven days a week.

Blaydon Walk In Centre was the trusts second urgent and emergency service and provided care for minor injuries and minor illnesses. The service provided care led by GP's and nurse practitioner's in three treatment rooms, with access to on-site x-ray facilities and a plaster room. The service operated from 8am to 10pm, seven days a week.

The emergency department saw an average of 1,600 patients a week over the year, with a total attendance of 79,848 patients. The figures provided for walk in centre attendances were for both the Blaydon centre and patients who attended Queen Elizabeth Hospital that were streamed to the GP/nurse led service. The average weekly attendance was 550 per week over the year with a total attendance of 28,869 patients: 22.6% of which were 16 years old or under.

The trust projected a 5% increase in attendances over the next three years.

During our inspection we visited all of the clinical areas where patients attended for urgent and emergency care. These included a walkthrough of the patient's journey in the different parts of the emergency care centre and a visit to Blaydon walk in centre. We also visited during the evening.

During our inspection, we spoke with 34 members of staff of all disciplines, spoke with 18 patients and their relatives and examined 29 records from across the service.

Urgent and emergency services

Summary of findings

Overall, we rated the Emergency Care Centre as good. We rated the service as good for being safe, effective, caring, responsive and well led.

The department was divided into several areas and patients were effectively streamed to the areas best equipped to meet their needs by a nurse qualified in triage. However, there was a lack of senior medical cover for the emergency department. This had been on the trust risk register for over 18 months and there was high use of locum medical staff to cover the shortfalls in middle grade doctor cover. To overcome this, the service had recruited one consultant and five emergency nurse practitioners to support doctors in the emergency department. Senior management did not use an acuity tool to ensure the department had the required registered nurses on duty but there were processes to escalate staffing concerns when staffing dropped below recommended levels.

The service had a system for reporting incidents of harm or risk of harm. Serious incidents were investigated and there was evidence of lessons learnt and shared.

Staff used good infection prevention and control practices and had effective procedures to keep equipment clean and well maintained. Staff managed medicines effectively although some nurse prescribing directives were out of date. The department had systems to respond to emergencies and deterioration in patients' health or concerns for their safety. Not all staff were accessing mandatory and safeguarding training although levels of training had improved.

Staff based their care on clinical guidelines and pathways that were easily accessible in the clinical areas to facilitate timely and effective care. Care pathways were not all updated and not all of them indicated when practice should be reviewed, to ensure best practice guidelines were still being met. The emergency care centre took part in national and local audits, to assess the outcomes of patients who were cared for in the department.

The department offered a 24-hour, seven-day service with medical staff providing care directly or reviewing to ensure effective diagnosis and treatment. There was good multidisciplinary working.

Throughout our inspection, we saw patients and relatives being treated with dignity, respect and compassion. We heard staff using language that was appropriate for patients to understand their treatment and to be involved in decisions about their care.

The service had systems to facilitate flow of patients through the department. The department was generally achieving the target of 95% of patients being seen within four hours, which was a target set by the Department of Health. Staff followed procedures to escalate problems to more senior management for action when there were indications of delays in patient care and flow.

The service ensured that patient's individual needs could be met. The service responded to complaints but this had not always been within the trust target of 25 days. There was evidence that learning from complaints occurred.

There was strong leadership and management across the service. Staff reported an open and supportive culture, with good relationships across the professionals.

The service was relatively new and had been designed to meet the future needs of the community. The department was active in seeking ways to improve the service

Urgent and emergency services

Are urgent and emergency services safe?

Good

We rated safe as good because:

The service had a system for reporting incidents. Serious incidents were investigated and there was evidence of lessons learnt and shared.

There was good infection prevention and control. Equipment was maintained. Staff managed medicines effectively. There were systems to respond to emergencies and any deterioration in patients' health or concerns for safety.

The service had recruited five emergency nurse practitioners to undertake medical roles in the emergency department to support the doctors.

However, there was a lack of senior medical cover for the emergency department due to national shortages. This had been on the trust risk register for over 18 months. There was high use of locum medical staff to cover shortfalls in middle grade doctor cover. However, the trust mitigated this risk by using a group of locum doctors who were well inducted to the service to cover shortfalls in medical cover.

Senior management did not use an acuity tool to ensure the department had the required registered nurses on duty but there were processes to manage staffing when they fell below recommended levels.

Not all staff were accessing mandatory and safeguarding training although levels of training had improved.

Incidents

- Never events are serious, largely preventable patient safety incidents that should not occur if available preventative measures are implemented. There had been no never events reported in the emergency care centre and no serious incidents reported.
- ECC reported incidents using an electronic reporting system. Staff we spoke with were confident about using the system and told us how they could request feedback as the reporter and how outcomes from the reports were shared with the whole team.
- Between September 2014 and August 2015 the ECC had reported 136 NRLS incidents, 35 incidents related to paediatric services.11 of all the reported incidents were classified as low harm, three moderate harm and three severe harm. The rest were reported as no harm. The severe harm reports were investigated using root cause analysis. This is a framework used to identify the reasons why an incident occurred to allow learning from the incident and prevent it from reoccurring.
- Almost a third of the no harm reports were related to blood transfusion documentation, such as mislabelling of samples. This issue had been raised in the July 2015 team meeting minutes and requested that staff checked information with a second member of staff at the patient's bedside to reduce errors.
- We looked at two root cause analysis of incidents and saw that there had been a full investigation with reporting of the lessons learnt across the department. An example of this was a change to care pathways for patients and flag alerts applied to Medway, the IT patient administration system (PAS).
- The trust had a morbidly and mortality strategy, which the ECC fed into through Safecare (governance) meetings.
- Staff we spoke with were aware of their responsibilities under Duty of Candour, which was introduced as a statutory requirement for NHS trusts in November 2014. Information to be reported under duty of candour requirements was included in the electronic incident reporting system. We saw information leaflets in the waiting area informing patients about the trusts responsibilities when things go wrong.

Cleanliness, infection control and hygiene

- All of the areas visited were visibly clean and uncluttered, including waiting areas, sluices and toilets. Bins were clean and not overfull and there were adequate bins for both clinical and general waste. All sharps (needles) bins were below the marked levels.
- There were no reported cases of Clostridium-Difficile (C Diff) or MRSA within the department.
- There were handwashing facilities throughout the departments and alcohol based hand gel at frequent intervals in staff areas.
- Personal protective equipment was accessible in all the treatment areas and we observed staff using and disposing of them appropriately.
- We observed staff to be compliant with bare below the elbow policy. We saw staff washing their hands before interacting with patients.

- Weekly nursing checks were undertaken to measure infection prevention. These included hand hygiene measures, adhering to uniform policy, intravenous cannula care, indwelling catheter care, clean equipment and diarrhoea management. The department had received accreditation in infection prevention and control as they had reported 100% compliance in all these areas between May 2014 and June 2015.
- Two of the rooms in the emergency assessment unit had ensuite facilities for isolation and infection control purposes.
- We were told the department did not have a link nurse for infection control.

Environment and equipment

- The ECC included a four bay resuscitation room, in this area patient trolleys were sectioned off by curtains. The major illness cubicles, minor illness cubicles and emergency assessment area cubicles were all individual rooms, divided into eight bedded sections called pods. This provided patients with privacy and dignity in these areas.
- There were secure areas between the pods for staff only. Within these areas staff had direct access to the rooms patients were in and they could observe them through individual windows.
- The paediatric area/pod consisted of eight cubicles which were also used as 24-hour short stay beds.
- All areas in ECC had sufficient waiting areas where patients were seated following registration at reception, awaiting triage. The areas were spacious and clean, however there was no facility to offer privacy when patients approached the reception desks.
- There was a separate waiting area for children who had been triaged. The area was bright and clean with a variety of age differential toys. We were told the toys were cleaned daily by a staff member and we saw that toys were physically clean and well maintained. There was also a television in the waiting area.
- We were told that if the paediatric waiting area was busy with children and families, those children over the age of 12 years and their families were asked to wait in the main waiting area of the ECC.
- Within the minors cubicles we saw equipment trolleys that were clean and well stocked. With each trolley there was a cleaning and stock checklist that had been signed and dated on a daily basis.
- We examined the resuscitation trolleys and monitoring equipment throughout the department. We found them to be checked on a daily basis and ready for use in an emergency. The anaesthetic trolleys in the resuscitation area were checked on a daily basis by theatre staff.
- A standardised log book for recording resuscitation checks was introduced in EAU on 7 October 2015. This showed a continuous record of EAU resuscitation trolley checks.
- Almost all equipment observed was portable appliance test checked; one outstanding item was highlighted to staff at the time of inspection.
- Staff informed the housekeeper when equipment had a fault and the housekeeper reported this to the medical electronics department. There was access to a medical equipment library to ensure there were no shortages of equipment.
- The trust took part in the patient led assessment of the care environment (PLACE, 2015). The results showed the emergency department scored 100% on the cleanliness and condition of the environment, 90% for providing privacy for patients and 68.97% for dementia care.

Medicines

- The emergency department had two Omnicell, a central pharmacy automation system. The system was checked and replenished on a daily basis by pharmacy. It was connected to the trust IT system which ensured that every drug withdrawal was connected to a patient.
- To withdraw controlled drugs, two members of staff were required to finger print operate the dispenser. Controlled drugs were checked on a daily basis by two members of staff and recorded in the controlled drugs book.
- There was a further Omnicell within the paediatric area of the department, which was operated to the same standard.
- We observed the dispensing of medication to a patient. We were assured that appropriate checks were undertaken to ensure patients were medicated safely, and according to medication prescribed in notes.
- Within the minor cubicles there were locked medicine cabinets containing analgesia. There were no controlled drugs in this area. The senior nurse on shift was the key holder. However, we were also told that the key was at times kept in a drawer. This was highlighted to the nurse at the time of inspection as a safety risk.

- We examined a number of patient group directives (PGD). These allowed nurses to administer drugs such as analgesia to patients, without a doctor's prescription, in order to provide prompt treatment. Out of the 11 PGD's we looked at, five were past the date by which they should have been reviewed to ensure they were up to date with best practice. However, we were provided with evidence that the PGD's on the trust's intranet were up to date.
- The temperature of the medicines fridges was recorded once per day and was within range, however minimum and maximum temperatures were not recorded. This meant staff would only be able to see the current temperature of the fridge and would not be aware if the temperature had been outside of the 2-8 degree range. This was brought to the lead nurses' attention at the time of inspection.
- Fridge temperatures were recorded in the same way at Blaydon walk in centre and it was brought to the attention of staff at the time of inspection. Some medicines can become ineffective if they are not kept at the correct temperature constantly.
- Ten medicine errors had been reported in the last twelve months, these were reported through the electronic reporting system. No patient harm was recorded.
- At Blaydon walk in centre there were locked cupboards to store medication within a key coded room. From observation of the storage of the medication there did not appear to be a robust stock rotation plan in place. We observed one example of medication in the fridge to be out of date. This was brought to the attention of the lead nurse at the time of inspection.

Records

- The emergency care centre used two IT systems for the recording of patients in the department which all patient details were entered onto and from this a paper record was produced for use in the emergency care areas.
- If patients were assessed in triage as requiring GP/nurse practitioner care, the patient's details were entered onto a further IT system. This IT system linked with community health records allowing patients GP instant access to information about care received at the emergency care centre. Discharge information was provided to the patient GP through this system providing continuity of care.
- We examined 29 records across the service. All the records provided a comprehensive assessment of the medical history and a management plan including any diagnostics undertaken or to be completed. All the records examined included a pain score.
- Allergies were documented in the notes and we observed patients to be wearing a red wrist band to raise staff awareness.
- For patients transferred into the emergency assessment unit the records had additional nursing documentation which included a national early warning system (NEWS) chart which was used to identify deteriorating patients early. It also included risk assessments for pressure areas, peripheral cannulation and nutrition.
- Sepsis screening and falls screening was also included and was part of trust CQUIN (Commissioning for Quality and Innovation) targets. We were told this nursing record was used for handover if the patient was transferred to a ward.

Safeguarding

- The trust had a safeguarding policy for both children and adults. The children's safeguarding policy was updated in January 2015 and had a section specific to children who attended the emergency care centre. The adult safeguarding policy was updated in June 2015.
- Urgent and emergency care staff training in safeguarding was below the trust target of 90%.
- 86% of staff had undertaken adult safeguarding training and levels one and two children's safeguarding training. 88% of staff had undertaken level three children's safeguarding training.
- Staff we spoke with knew how to escalate safeguarding concerns and could show us how to access safeguarding links and information on the intranet. The staff knew who the responsible leads were for adult and children's safeguarding.
- We observed staff accessing the trust safeguarding guidelines on the intranet providing details of how to make referrals when they had concerns about a child or adults safety.
- Staff were able to tell us about the training they had received to help them recognise risk factors which may suggest issues of female genital mutilation (FGM) and child sexual exploitation (CSE). We saw patient information leaflets about FGM across the department, which were in more than one language.

- The electronic patient record system included a notification tab when there were safeguarding concerns about a patient to alert staff on the unit.

Mandatory training

- The trust provided data on staff mandatory training. Staff in ECC did not meet the trust target of 90% compliance in nearly all components of mandatory training. For example, 84% of staff were up to date with resuscitation and the deteriorating patient training which should be completed on an annual basis, according to the data provided.
- Emergency care centre staff met the trust target for training in dementia care, corporate induction and patient handling.
- The overall rate of mandatory training across the service was 83%.

Assessing and responding to patient risk

- Patients attended through a single point of access and were streamed to the most appropriate service through triage by a qualified nurse. Patients arriving by ambulance were immediately greeted and triaged by the shift co-ordinator.
- Patients arriving by other means initially presented to the reception desk to await triage by a registered nurse.
- The trust had a target of 15 minutes for initial triage, during our inspection the 29 records we examined informed us that the target was met for those patients.
- The triage nurse would assess the patient for streaming to the appropriate area in the department, providing initial pain relief if required.
- Paediatric patients who attended between 7.30am and 2am were triaged by a paediatric nurse. Out of hours they would be triaged by a nurse who had Manchester triage system training. This was a nationally recognised training tool, which included training on paediatric triage.
- We observed the use of NEWS to assess patient condition. The department used a mobile system that allowed staff to record patient observations onto an electronic system. This then displayed patients NEWS scores onto a screen in the staff area where staff could easily observe the changing condition of patients. The mobile tool alerted staff when patients' condition was changing and required closer monitoring.
- The department had access to a critical outreach team. The ECC was also supported by specialist nurses who would be called to the department, for example, if a patient arrived with chest pain, breathing difficulties or with symptoms of a stroke.
- We were told that patients who were transferred onto the emergency assessment unit would remain there for a maximum of 12 hours, in which time they would have been assessed by the in-patient speciality (medicine or surgery), and either admitted or discharged. The time that the patients spent on the unit was not recorded; this meant that patients were not fully risk assessed after six hours.
- Paediatric patients who deteriorated or required in-patient care were transferred to another hospital by the paediatric retrieval team from Royal Victoria Hospital in Newcastle. There was an up to date policy for transfer of paediatric patients.

Nursing staffing

- Senior staff told us that an acuity tool (for example, Baseline Emergency Staffing Tool (BEST) RCN) was not used to help safely staff the department. Staff rotas were managed using SMART e-rostering.
- The emergency care centre was staffed on a daily basis of: 1am to 8.30pm: nine registered nurses and three health care assistants, 3pm to 2.30am: seven registered nurses and two health care assistants, 3am to 11am: six registered nurses and two health care assistants.
- When we visited the ECC during one evening we found that there were two registered nurses for the eight majors beds, two registered nurses for the four bedded resus area and one registered nurse for the eight minors beds. This was below NICE (2015) draft guidelines for safe staffing which states: one registered nurse to four cubicles in either 'majors' or 'minors', when we visited during the unannounced inspection staffing levels were appropriate.
- The emergency care centre was overseen by a Band 8 modern matron who provided supernumerary managerial support, and would provide clinical support when necessary.
- We were told by staff that they could escalate concerns about staffing levels and would receive a response from management.
- The emergency assessment unit operated on a one registered nurse per pod (four beds) and one healthcare assistant per three pods (12 beds) rota.

- There was one band seven nurse within the department to provide clinical and professional support to junior staff. Senior staff acknowledged that this should be improved and were looking at ways to develop band six nurses to improve staff morale and reduce vacancy rates.
- In the paediatric area, which included the short stay assessment unit for children, there were four qualified paediatric nurses and one HCA between the hours of 7:30am and 8:30pm. Between 8pm and 8am there were two qualified paediatric nurses to care for children remaining in the unit overnight and children sent to the unit from triage in emergency care centre. This met the RCN guidelines of providing at least two paediatric nurse in outpatient and inpatient services.
- Blaydon walk in centre operated 8am – 10pm with two nurse practitioners, one registered nurse, one GP and one health care assistant (HCA).
- We observed a nursing handover. Staff who came on duty were informed by the shift co-ordinator which area they were to work in and provided information, for example alerts. Staff went to the work areas and were provided with information about each patient by the nurse in charge of the pod.
- We were told shortfalls in nurse staffing were covered by staff who already worked in the department by working extra shifts.
- The sickness rate across the entire emergency care centre was variable. Highest sickness rates were in the Blaydon walk in centre (7.98%) and the ambulatory care ward (4.97%). Lowest sickness rates were in ECC (2.7%). The trust target for sickness was 3.4%.

Medical staffing

- According to the College of Emergency Medicine (2015) an emergency department should have at least 10 whole time equivalent (WTE) consultants to provide a sustainable service during extended weekdays and over the weekend.
- Lack of medical staffing was on the trust register. The emergency department had 5.2 WTE consultants, with a vacancy rate of three WTE. A consultant had recently been recruited at the time of inspection.
- Consultant cover was available from 8am to 9pm on weekdays, 9am to 3pm at weekends. Registrar cover was provided for the evening and night, with one registrar on duty 5pm to 12am and one registrar on duty 8pm to 8am.
- Out of hours consultants provided an on-call service to support junior doctors. We were told that a consultant could be in the department within 20 minutes, during out of hours, if necessary.
- The department had eight registrars, with funding for 13 WTE; however, there was difficulty in recruitment due to national shortages.
- The emergency department relied on locums to cover shortfalls in medical cover. We were told that locum staff were used from a known pool of doctors who had previously worked at the trust and knew the systems and process.
- The shortage of medical staff reflected a national picture. Due to inadequate medical staffing, senior management had recruited five emergency nurse practitioners (ENP) to provide support for the doctors. On our unannounced visit we saw ENP's in the department supporting the medical staff.
- An on-call consultant, one registrar and one senior house officer provided medical cover in the paediatric area. These staff also provided medical cover to the special care baby unit.
- The walk in centres at Queen Elizabeth Hospital and at Blaydon had a resident GP, 12-hours a day.
- Ambulatory care accessed consultant cover from the medical directorate during the hours it was operational.
- Once patients had transferred to the emergency assessment unit they were assessed and seen by in-patient speciality doctors; the divisional medical or surgical team.

Major incident awareness and training

- There was a major incident policy, this was accessible to staff at the shift co-ordinators station.
- Staff we spoke with were aware of the policy and the online training. The department undertook major incident exercises every two years; this was led by the Head of Facilities.
- There were protocols in place for dealing with patients suspected of having Ebola virus and equipment was clearly identified in the major incident store room.

- The department had equipment to deal with major incidents such as hazardous material suits and high visibility suits.

Are urgent and emergency services effective?

(for example, treatment is effective)

Good

We rated effective as good because:

Staff were aware of the care pathways to follow. These were easily accessible to staff in the clinical areas to facilitate timely and effective care. However, some paper copies of pathway documents were not all up to date or indicated when a review was needed.

The department took part in national and local audits to measure patient outcomes.

The department offered a 24-hour, seven-day service with medical staff providing care directly or reviewing to ensure effective diagnosis and treatment. There was evidence of good multidisciplinary working.

Staff understood their responsibilities in obtaining consent. Staff demonstrated a good understanding of the principles of the Mental Capacity Act.

Staff were well supported through competency based training. Appraisal rate was 98.15 %, which was above the trust target of 90%.

Evidence-based care and treatment

- Staff had access to Royal Marsden Manual of Clinical Nurse Procedures and Clinical Care Standards for Emergency Departments on the trust intranet.
- Care was delivered to reflect the standards and guidelines and audits undertaken to ensure compliance.
- In the paediatric resuscitation area there was a laminated folder with emergency treatment guidelines which provided on hand information to staff caring for a sick child to ensure the child was given the correct treatment according to their weight and age.
- The ECC had established a care pathway to promote early treatment for neutropenic sepsis (infection) so that antibiotics could be given quickly to promote patient outcomes. Nurses were being trained to prescribe and administer first dose antibiotics to improve time to initial treatment.
- At the co-ordinators station we observed a folder containing pathways of care. However, out of the 14 pathways we looked at 12 were either out of date for review or had no review date.
- ECC consultants were responsible for CEM audits and local audits. We were provided with data relating to local audits undertaken in the department in 2015: CT requesting and reporting in Accident & Emergency, Re-audit of the use of non-invasive ventilation (NIV) in patients with COPD (respiratory disease) and type 2 respiratory failure presenting to A&E.
- Action plans from audits were shared at governance meetings and staff education.
- A specialist nurse immediately assessed patients who attended the department with chest pain, breathing problems or symptoms of a stroke. They were able to 'fast-track' these patients to appropriate in-patient beds.
- During out of hours, a telemedicine facility was used to access clinician 24-hours a day if a patient was suspected to have had a stroke. This enabled nurses in the emergency department, who had been trained, to deliver thrombolysis treatment to provide prompt clinical care.
- The department had a Trauma Audit and Research Network (TARN) consultant lead.

Pain relief

- According to the Picker Report 2014, 30-39% of patients had to wait more than five minutes for pain relief. The trust acted on this, with an action plan to refine the triage process and increase staff establishment, with a completion date of December 2015.
- Patients we spoke with told us staff asked about their pain, nearly all of those patients who had pain said they were treated quickly. However, we had one example of a patient who had been waiting one and a half hours for a nurse to return with pain relief.
- There was a paediatric pain assessment tool and analgesia guideline which we saw displayed at staff workstations in the paediatric unit. This included a pain score, a faces scale, behaviour display examples of

injury and suggested analgesia. It was split into four sections; 'no pain', 'hurts a bit' 'hurts more' and 'hurts worst'. A FLACC (face; legs; action; cry and console) chart was also used to assess and manage pain.
- According to the CQC A & E 2014 Survey the trust scored the same as other similar trusts in response to patients feeling staff did all they could to help control pain.

Nutrition and hydration

- We saw that patients had access to water. We were told that the housekeeper for the unit had received training in nutrition and hydration and had the responsibility of ordering food and drinks.
- Patients who were in ECC had access to snack boxes, 24-hours a day.
- There was regular hot drinks and meals for patients in the emergency assessment unit; a choice of meals could be offered if required.
- Staff could order food for children who were admitted to the paediatric unit for short stay and were able to meet dietary needs. Food (including fresh fruit) and milk was available throughout the day and cold drinks were also provided for families.
- On ambulatory care the waiting room had vending machines where patients could access food and drink.

Patient outcomes

- The trust was slightly above the England average, for unplanned re-attendance rate to the emergency department within seven days for the last two years. The rate for March 2015 was 8%, compared to the England average of 7.2%.
- The Severe Sepsis and Septic Shock survey had the trust in the top (best) quartile for eight of the 12 indicators and in the middle quartiles for the other four.
- The trust was performing in the upper quartile for three of the 11 indicators in the mental Health in the emergency department audit, the lower quartile for two and between the two for the remaining six. It was meeting one of the two fundamental standards.
- For the Cognitive Impairment for Older People audit, the trust was in the upper England quartile for three of the five measures and in the lower quartile for the other two. It was meeting the fundamental standard.
- In the Paracetamol Overdose audit the trust was performing in the lower quartile in three of the five measures and between the upper and lower quartiles for the other two.
- In the Asthma in Children audit the trust was in the lower quartile for nine of the 18 indicators, the upper quartile for four and the middle for another four and not marked in the last one.
- In the Fitting Child audit the trust had performed in the upper quartile in two of the five indicators, the lower quartile for another two and in the middle for the remaining one. They were meeting two of the five standards however not meeting the fundamental standard.
- In the consultant sign off audit (2013), the department performed worse than the England average. The standard stated that patients in the three groups audited should have either been seen by or discussed by a doctor of ST4, middle grade equivalent or above. Following the audit result, medical staff implemented a change in the sign off process, whereby it was documented on the IT system. Consultants in the department told us there was an improvement in the sign off rate.

Competent staff

- Staff we spoke with said they were supported to develop their skills and knowledge and had access to appropriate training.
- Staff who were responsible for triaging patients had completed the Manchester triage training. This was a competency based training programme.
- Staff had undertaken appraisal with a senior colleague. According to data provided, the staff appraisal rate was 98.15 %, which was above the trust target of 90%. Staff were spoke with told us they had received an appraisal.
- Staff could access supervision from a senior colleague. Senior staff told us that work was underway to develop frameworks for staff to meet NMC revalidation criteria.
- Consultant medical staff had current revalidation, according to data provided by the trust. Medical staff undertook weekly training sessions with junior doctors as part of a rolling programme of education to improve clinical practice.
- Medical staff undertook competency based training and completed NHS e-portfolios.
- Nursing staff had a named educational lead within the unit.

Multidisciplinary working

Urgent and emergency services

- We observed good working relationships between the medical and nursing staff in the department. Staff appeared to communicate and work cooperatively between all areas of the emergency care centre.
- There was evidence of good in-reach working from nurse specialists. For example, the NIV nurse specialist would 'fast track' patients to an appropriate in-patient bed for treatment.
- There was access to alcohol and substance misuse liaison team on site.
- There were physiotherapists, occupational therapists and frailty nurses available to assess patients to facilitate timely discharge.
- Mental health services were provided by the on-site psychiatric liaison. Out of hours, the department could access the crisis support team. Senior staff reported they were working with commissioners to improve mental health services in emergency care.

Seven-day services

- The ECC was co-located with x-ray facilities. The emergency department had two x-ray rooms in the centre of the department and could access 24 hour, seven days a week CT scan facilities in the hospital radiology department. The service operated on a 'pull system' meaning patients were called from the emergency department by the radiographer. This prevented a build-up of patients waiting in the x-ray area. During inspection we saw the waiting room was empty and a patient we spoke with said they had been seen immediately for x-ray.
- There was an x-ray service at Blaydon Walk in Centre which operated seven days per week between 8am to 8pm. Out of those hours patients were referred to the emergency department.
- There was seven-day access to pathology and pharmacy services.
- There was on-call access to physiotherapists, radiology, and chaplaincy.
- Out of hours the service had access to on-call consultant cover.

Access to information

- Medical and nursing staff had access to current patient information through a number of IT workstations in the staff corridors between the pods. On the IT systems staff could access current medical history and information about past attendances to the department.
- The emergency assessment unit had developed nursing documentation to facilitate handover to wards.
- Clinical guidelines and policies were accessible through the trust intranet.
- In the emergency department at the co-ordinators station there were screens which displayed the status and waiting times of all patients in the department.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- Staff we spoke with told us they were aware of the Gillick competency and Fraser guidelines used to assess the decision making competency of children and young people. However, the staff in the adult areas of the emergency care centre said they were unlikely to have to apply them as a paediatric nurse triaged all children, unless attending the emergency care centre between 2.30am -7.30pm.
- We saw evidence of staff information on the Mental Capacity Act across the service areas.
- On ambulatory care we saw an example of a patient who was on the adjoining short stay ward that had a Deprivation of Liberty Safeguard (DoLS) in place to ensure their safety. The staff were aware of this patient, what clothes they were wearing each day to ensure they supported the ward in keeping the patient safe, as the exit was on ambulatory care.
- Staff demonstrated understanding of the purpose of the Mental Capacity Act and where to get support if they were concerned about a patient's ability to consent.
- We were provided with an example, from a member of staff, where the specialist link nurse for mental health undertook assessment of mental capacity. The patient was referred to the safeguarding team and DoLS were applied preventing discharge home, to safeguard the patient.

Are urgent and emergency services caring?

Good

We rated caring as good because:

Throughout our inspection we saw patients and relatives being treated with dignity, respect and compassion. We heard staff using language that was appropriate for

patients to understand their treatment and be involved in decisions about their care. All the patients and families we spoke with said they were well informed about their care. Staff supported patients promptly in managing pain and anxiety.

The department had the facility to support families at times of bereavement.

Compassionate care

- During our inspection we spoke to 18 patients and relatives. They told us that staff were polite and introduced themselves. Patients and relatives told us that they were treated with dignity and respect.
- We observed patients being treated with dignity and respect. Their privacy was maintained by curtains being used in the resuscitation bays and the doors were always closed in the cubicles.
- We saw that relatives were able to stay with patients during their time on the unit.
- Friends and Family test (FFT) results for July 2015 reported that there was a 43% response rate of patients eligible to complete FFT in ECC. No FFT had been received for Blaydon Walk in Centre.
- 91% of people who responded to the FFT would recommend services at the ECC. This is higher than the national average.
- For 21 of the 24 caring indicators in the CQC A&E survey, the trust was performing the same as other trusts, and was performing higher than other trusts in the remaining three indicators.

Understanding and involvement of patients and those close to them

- We observed staff being caring and respectful to patients. They explained treatments in a way patients could understand. Patients told us that staff had kept them well informed. They were able to speak to a doctor. Staff explained to them the reasons for tests and procedures being carried out.
- Patients and relatives we spoke to in the waiting room told us they had been informed about waiting times.
- Patients and relatives we spoke to said they had felt involved in their decisions.

Emotional support

- We observed staff communicating in a sensitive and calm manner, providing reassurance to concerned patients and their relatives.
- There was support from chaplaincy services for relatives. We saw a bereavement support pack which included contact details for support agencies and age appropriate information for children.
- The emergency department had access to specialist nurse practitioners who could provide patients and relatives with information and support. The specialist areas with this support were stroke, NIV (respiratory), chest pain.

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

(for example, to feedback?)

Good

We rated responsive as good because:

The department was divided into several areas with patients being streamed to the area best equipped to meet their needs by a nurse qualified in triage.

The service had systems to facilitate flow of patients through the department. The department was generally achieving the target of 95% of patients being seen within four hours, which was a target set by the Department of Health. Staff followed procedures to escalate problems to more senior management for action when there were indications of delays in patient care and flow.

Patients who were transferred onto emergency assessment unit should remain there for a maximum of 24 hours, in which time they would have been assessed by the in-patient speciality doctor and either admitted or discharged. The time that the patients spent on the emergency assessment unit was not recorded.

There were facilities across the service to ensure patients individual needs could be met when they attended a department.

The service responded to complaints but this had not always been within the trust target of 25 days. There was evidence that learning from complaints occurred.

Urgent and emergency services

Service planning and delivery to meet the needs of local people

- The ECC was a purpose built facility aimed to provide integrated urgent and emergency care services for the community, to support future increase in demand relating to the ageing demographics of the area.
- The resuscitation and major illness areas were equipped identically in order that patient capacity could be increased if necessary. For example, the resuscitation bay had three adult bays and one paediatric bay; these bays had extra oxygen and suction points to enable increased capacity.
- The ECC accessed support from the local Major Trauma Centre which was the Royal Victoria Infirmary in Newcastle to promote trauma care outcomes.
- Senior management told us that they were working closely with commissioners and North East Ambulance Service to develop protocols to meet winter pressures and increased patient demands.
- The IT system linked with community health records allowing patients GP instant access to information about care received at the ECC.

Meeting people's individual needs

- The waiting area and triage rooms were spacious, allowing access to wheelchair users.
- The department had access to bariatric equipment.
- Patients who were known to have a learning disability had a red flag alert on their records to ensure their needs were met.
- With permission, patients with dementia were given a wrist band or a badge to alert staff to use red trays and jugs to ensure patients' nutritional needs were met.
- For patients with mental health needs there was a designated room in the emergency department, however senior staff reported that it was not fit for purpose, due to where the room was located in the department. Planning was underway to relocate the room.
- The mental health team for the Gateshead area supported the ECC, when patients with mental health issues attended. This support was only available Monday to Friday, 9am to 5pm. Out of hours the department could contact the crisis service.
- The ECC had a staff member who was the designated link nurse for mental health and dementia.
- There was a room specifically used when delivering sensitive information to relatives; the room was clean and tidy with coffee making facilities. Relatives were able to use the telephone facilities.
- The paediatric area had a play therapist as part of the team for some shifts. The play therapists supported children through distraction to facilitate medical treatment. There was also a 3D television which was used as a distraction tool during treatment to reduce stress and anxiety for children and their families.
- The service had access to translation services. A face-to-face translation service was used rather than a telephone service. The demographics of Gateshead meant that this service was not in high demand.

Access and flow

- The emergency department had no patients waiting over 12 hours from the decision to admit until being admitted, over the last year.
- The percentage of patients seen within four hours had been higher (better) than the national average for the last twelve months. The national target was 95% of patients to be seen within four hours. Trust data reports showed the four hour target was not met in three out of the 12 months between April 2014 and March 2015. Performance achieved in July, August and September gave a quarter 2 performance rate of 95.9%.
- We were told that patients who were transferred onto the emergency assessment unit would remain there for a maximum of 24 hours, in which time they would have been assessed by the in-patient speciality and either admitted or discharged. The time that the patients spent on emergency assessment unit was not recorded; this meant that patients were not fully risk assessed after six hours.
- The percentage of patients leaving without being seen had followed the national average for the last 2 years. In March 2015 this increased to 8% which was higher than the national target of 5%.
- Between January 2013 and February 2015 the average time for handover to initial assessment from the ambulance was less than five minutes, with general time to treatment for the same period being less than 60 minutes. Both were lower (better) than the national average.
- Over the last year there had been 23 black breaches (patients waiting for over an hour in an ambulance at the ED). These had all been within the summer months

and were due to the department reaching its capacity. Senior staff told us this was due to a change in practice since moving to the new building as patients were no longer waiting in the corridors or the resuscitation room. Ambulance handover times were on the trust risk register.

- The emergency care centre used 'vocera', a wireless communication system, to communicate with each other. Staff could call and speak to clinical and nursing staff across the department, including ambulatory care. Staff used the system to give regular updates to the shift co-ordinator about patients in order for them to manage access and flow through the department. It was also used to page staff quickly, for example the clinical nurse specialists.
- We observed the shift co-ordinator, a band six registered nurse, implementing the escalation procedure twice during our inspection. The policy was accessible at the co-ordinators work station. The policy provided clear guidance on when and how to implement the escalation policy, to ensure safe working when the department was full or the hospital bed state was preventing flow of patients through the department. We saw during one of the escalations, the co-ordinator being supported by the hospital bed manager to promote flow of patients through the department.
- Patients had direct access to the ambulatory care ward by GP referral. The manager of ambulatory care attended the emergency department on a daily basis to 'pull through' patients to ambulatory care whose needs were better met in that department. For example, patients who may have a deep vein thrombosis (DVT).

Learning from complaints and concerns

- The service had received 64 complaints between April 2014 and March 2015. A common theme of complaints was waiting times in the departments.
- Complaints were reviewed and actioned by senior management. We were told that they worked within the 25-day guideline set by the trust. However, data received from the trust reported that only 10 (58.2%) of the complaints had been processed within the 25 day target.
- We saw evidence of feedback to staff of changes to practice and procedures following investigations of complaints and incidents, in team meeting minutes and on the staff communication board.
- An example of this was that the department were introducing screens into the waiting areas which provided better information to patients on how long their waiting time would be, depending on which area they had been triaged to.

Are urgent and emergency services well-led?

Good

We rated well-led as good because:

There was strong leadership and management across the service. Staff reported an open and supportive culture with good relationships across the professionals.

The service was relatively new and had been designed to meet the future needs of the community. The department was active in seeking ways to improve the service through engagement in audits and staff development.

Vision and strategy for this service

- The strategy for urgent and emergency care service was included in the trust wide strategy. We were told by senior management that the trust wide strategy was under review at that time.
- Senior management told us their vision was to develop the streaming in the department and continue developing their working relationships with GP's and other primary care services to reduce barriers between services. This reflected the Government's 'Five year forward' strategy that urgent and emergency care services would be redesigned to integrate between A&E departments, GP out-of-hours services, urgent care centres, NHS 111, and ambulance services.

Governance, risk management and quality measurement

- The department's risk register contained three risks. Medical staffing had been on the risk register since July 2014. According to senior staff this was because the trust had been unable to secure employment of senior medical staff for the emergency care centre.

- Senior staff told us they were mitigating this risk by using a small group of locum staff who had previously worked at the trust to cover medical staff shortfalls. They had also recruited five emergency nurse practitioners to support the middle grade doctor role.
- The department took part in team meetings which included agenda items of quality and safety, performance, complaints feedback/themes.
- We saw evidence of issues in ECC being discussed in board level minutes.
- The department took part in national CEM audits and other locally agreed audits.
- The department was working with commissioners and ambulance services to develop a resilience plan to ensure the service had a strategy to manage high demand for care during winter months.

Leadership of service

- There was visible leadership in the service.
- The nursing team was established with experienced staff who provided clinical and professional leadership by supporting and appraising junior staff. Staff were given identified roles on each shift and there were clear lines of accountability.
- We were told that there was a culture of promoting staff development and interests, since the move to the new department building, and a change in the way staff were working across the areas. Staff were able to rotate between the departments of ECC.
- The medical team had responsibility for audits in the department. Staff told us there was a strong educational resource provided by the lead consultants.

Culture within the service

- Staff told us that their line manager operated an open door policy. They felt confident in taking their concerns to management and felt listened to. Staff said that senior management were visible in the department. The staff knew the CEO by name and recognised the senior management team.
- All the staff we spoke with, across the service, told us it was a good place to work. There had been issues with culture in the past but changes in the way the new department worked together had improved. Staff told us that they felt supported at work and that there were opportunities to develop their skills and competencies which were encouraged by senior staff.
- We were told that an increase in staffing would be a positive improvement in the department as a place to work.

Public and staff engagement

- Senior management told us that staff had been actively involved in the development of the integrated service. Since the new department opened, senior staff were aware that staff engagement had not been as actively encouraged.
- The trust took part in the NHS Staff Survey 2014, although there was no data specific to staff working in urgent and emergency services. The national survey showed on a scale of 1-5, with five being highly engaged and one being poorly engaged, the trust scored 3.74. This score placed the trust as average when compared with similar trusts.
- The national survey showed that staff response to recommendation of the trust as a place to work or receive treatment was in the best 20% when compared to all other acute trusts.
- We saw evidence that the service was active in seeking feedback from patients and relatives. There was an IT facility for patients in the waiting room to provide feedback through the friends and family test.

Innovation, improvement and sustainability

- The ECC had established a care pathway to promote early treatment for neutropenic sepsis so that antibiotics could be given quickly to promote patient outcomes. Nurses were being trained to prescribe and administer first dose antibiotics to improve time to initial treatment.
- In the paediatric area, the service had introduced 3D television to act as distraction therapy for children undergoing treatments.
- The ECC was recognised by NHS England as a good example of an innovative building providing emergency care at a single point of access.
- The ECC was ranked in the top three of the CHKS Top Hospital Awards for Accident & Emergency Excellence in 2015.

Medical care (including older people's care)

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

Information about the service

The Gateshead Health NHS Foundation Trust provided medical care, including older people's care services, mainly from Queen Elizabeth Hospital in Gateshead. There was also an Intermediate Care re-assessment and Rehabilitation Unit in Sunderland, a Community Rehabilitation Nursing Team for Older Persons in Gateshead, and day care services in Gateshead. In the hospital, there were 13 medical wards, including an emergency assessment unit, ambulatory care, and a planned investigation unit. In addition, there was the Jubilee Day Hospital, an escalation area and winter pressures ward. The winter pressures ward was due to open in a few weeks after our inspection but we did not get a specific date. There were a number of different medical specialities provided, such as care of the elderly, cardiology, respiratory medicine, gastroenterology and stroke care.

There were 34,729 medical admissions to the trust between January 2014 and December 2014.

We looked at 12 care records. We spoke with 51 patients and relatives and 42 staff, including doctors, nurses, therapists, pharmacists and managers. We visited 12 wards and the Intermediate Care and Rehabilitation Unit (ICAR) in Sunderland, the Woodside Unit at Dunston Hill and the Ellison Unit at Bensham Hospital. The Woodside unit offered day care services to younger people diagnosed with dementia and the Ellison unit was a nurse-led day hospital and community service providing assessment, treatment, and rehabilitation and monitoring of people over the age of 65 with mental health problems. We carried out observations and reviewed performance information from and about the trust.

Medical care (including older people's care)

Summary of findings

We rated medical care (including older people's care) as good overall in effective, caring, responsive, well led and safe.

Staff assessed, monitored and managed risks to patients daily. The medical division participated in national and local audits and took action where outcomes fell below national standards. Patient clinical outcomes were similar or better than national expectation in most areas.

Staff followed systems to report incidents of harm or risk of harm. Managers analysed incidents and provided feedback to staff to help prevent similar incidents. Wards monitored safety and harm-free care, and results were positive. Wards were visibly clean and staff followed infection control principles.

Staff completed patients' records and observations appropriately and escalated concerns about patients to more senior staff in line with trust guidance. Staff made comprehensive assessments of patients' needs, which included considering their clinical needs, mental health, physical health and wellbeing, and nutrition and hydration needs. All relevant staff, teams and services were involved in assessing, planning and delivering patients' care and treatment. Staff worked together to understand and meet the range and complexity of people's needs.

The majority of patients and relatives said that staff were polite, caring and respectful. Patients were aware of what treatment they were having, understood the reasons for it and, in many cases, had been involved in the decisions.

All staff working in medicine had a clear vision regarding person-centred care. Following a recent management governance review, managers were developing strategies to inform the business planning cycle and deliver service improvements and developments.

Staff were generally positive about the leadership and the levels of engagement with their line management through to executive level. There was a positive open culture within teams. Staff were encouraged to put forward ideas for improvement and had been finalists in national awards. The service took account of patient experience and action to improve care where required.

However:

The service faced challenges to maintain suitably qualified, skilled and experienced staffing levels at all times. The medical division had some nursing vacancies. Ward 8 showed the highest number of qualified vacancies. At the 16th October 2015, there were 15 whole time equivalent vacancies across the medical division. The trust was trying to recruit staff and in March 2015, the trust recruited 33 registered nurses. Student nurses received substantive posts following clinical placements.

On ward 23, we found there were some gaps in shifts when staff had asked for additional support to provide 'special' nursing care (individual one to one attention) to meet the physical and mental health needs of patients. This happened on 10 shifts between 18 and 23 October. The business unit was undertaking a business case exercise to increase the staffing establishment of ward 23 to address this. In the meantime the ward utilised additional bank staff in excess of targeted staffing levels

The level of staff completing mandatory training had improved, for example, 76% in April 2015 to 81% in June 2015 but remained below trust targets of 90%. Staff managed medicines appropriately but did not always check that fridges used for storing medicine were cold enough or that resuscitation equipment was ready for use.

Medical care (including older people's care)

Are medical care services safe?

Good

We rated safe as good because:

Staffing levels were managed to safe levels across most of the wards. There were 15 whole time equivalent vacancies across the medical division but the trust was recruiting to fill posts. On ward 23, we found that additional staffing cover was not consistently provided when requested. The rotas showed that between 18 and 23 October 2015, no cover was available for 10 shifts when requested. Staff told us that they would manage patients requiring special assistance together. For example, we saw that two patients requiring this additional assistance were offered care in the same cubicle so that observation could be conducted safely. The trust advised us that systems were in place to mitigate this. Some ward sisters advised that it was difficult to obtain a non-clinical day on a regular basis due to some ward staff shortages.

The level of staff completing mandatory training had improved, for example, 76% in April 2015 to 81% in June 2015 but remained below trust targets of 90%. Staff managed medicines appropriately but did not always check that fridges used for storing medicine were cold enough and there were some gaps in recording checks of the resuscitation trolley on ward 22.

Staff said they were encouraged to report incidents of harm or risk of harm and learning from incidents was demonstrated. In particular, we saw patients at high risk of falls cared for in high visibility bays. There were examples of the statutory Duty of Candour.

The wards were clean. Clinical records were well organised and divided according to medical and nursing input. All contained standard risk assessments, clear lines of accountability and diagnosis and management plans. All staff clearly understood the safeguarding policies and processes and the adult safeguarding pathway was displayed on all wards we visited.

Incidents

- A policy was in place for the reporting and investigation of incidents. Incidents were reported electronically using an online reporting system. Between October 2014 and August 2015 there were 2,051 incidents reported through the medical business unit. Of these 1,621 reported no harm and 15 reported severe harm.
- Between May 2014 and April 2015, 27 serious incidents were reported. The most frequent subject was slips, trips and falls at 55 %. We saw evidence of learning from incidents, such as falls sensors in high-risk areas and that one to one supervision or nursing within a close observation area was in place for high-risk patients and we observed this during inspection.
- There were no Never Events reported between May 2014 and April 2015.
- There were 24 pressure ulcers. Data for 2014/2015 showed that there were two grade 3 pressure ulcers. There were 20 falls and 46 catheter related urinary tract infections were reported in the last twelve months.
- Staff at all levels said they were actively encouraged to report incidents including grade one pressure ulcers. They were confident about reporting incidents, near misses and poor practices. Staff were able to describe recent incidents and the actions taken because of investigations to prevent recurrence. One doctor advised us that he did not record incidents on the basis that he had not witnessed any; however, he understood the procedure for reporting.
- A module was to be added to the trust electronic patient record system (Medway) to support mortality reviews within the trust. We reviewed board meeting minutes, which showed discussions of mortality levels and actions escalated to the mortality and morbidity steering group chaired by the medical director.
- During the inspection, members of staff told us of examples of Duty of Candour. Staff reported using duty of candour to inform patients and their families about incidents and the processes used to investigate them.

Safety thermometer

- The medical division was managing patient risks such as falls, pressure ulcers, blood clots, and catheter acquired urinary infections, using the NHS Safety Thermometer assessment tool. The NHS Safety Thermometer is a tool designed to measure a snapshot of harms each month.
- The trust observed these indicators and displayed information on the ward performance boards. All boards we observed were up to date. Staff told us that individual ward performance was regularly discussed at staff meetings. Minutes of staff meetings confirmed this.

- The results between October 2014 and July 2015 showed a positive increase month on month of patient harm free days. Ward 11 reported in August 2015 that they had 42 continuous days harm free care. Ward 1 reported 100 per cent harm free care and received top performance for harm free care in the trust for September 2015.

Cleanliness, infection control and hygiene

- The wards we inspected were clean. There were weekly cleaning schedules in place and levels of cleanliness audited regularly.
- We reviewed the matron 'walkabout' audit on the Ellison Unit and saw 100% compliance for handwashing and uniform.
- We reviewed data from the other medical wards which saw all wards achieve 100% compliance with handwashing except wards 23 which scored 98%, ward 24 which scored 86.7% and ward 25 which scored 81%. These audits related to 01/08/2015. Ward 25 had scored consistently lower than the other medical wards over a period of four months. We did not see evidence of an action plan to improve this.
- The hospital infection rates for Clostridium difficile (C.diff), figures for 2015/2016 showed 10 cases against a trust target of 19. There were no cases of Methicillin-resistant Staphylococcus aureus (MRSA) reported for the same period.
- The checks of sluice areas on most wards and commodes appeared clean and labelled with the date of cleaning.
- Staff were aware of current infection prevention and control guidelines. We observed staff following good hand hygiene practice on all of the 12 wards we visited. There was adequate personal protective equipment available. We observed patients nursed in isolation with loose stool, and the use of the diarrhoea assessment and management pathway (DAMP).
- Infection control training showed 82% compliance against a trust target of 90%.
- There were suitable arrangements for the safe disposal of waste. Linen that presented an infection risk was segregated and managed appropriately. Colour-coded bags segregated clinical and domestic waste. Sharps such as needles and blades were disposed of in approved receptacles.

Environment and equipment

- Staff on all wards said that equipment including falls sensors was readily available and any faulty equipment either replaced or repaired promptly. Ward 23 held a small amount of equipment stock at all times due to the dependencies of their patients.
- On ward 22 records showed resuscitation equipment had not been checked for seven days.
- Medical devices had correct checks and labels in place to confirm appropriate maintenance.
- Staff told us that the medical devices department coordinated the monitoring of equipment and calibration of scales each year. We saw the asset register and PAT testing schedule, was up to date.

Medicines

- The hospital used a comprehensive medication administration record for patients, for the safe administration of medicines. We reviewed five medication charts, all of which were completed accurately.
- The pharmacist on a weekly basis completed medication audits. Fridge temperatures and controlled drugs were checked at this point, but there were no daily checks of fridges used for storing medicine to ensure these were cold enough and the minimum and maximum temperatures were not always recorded.
- Controlled drugs were stored and managed appropriately.
- Drugs stored in fridges were in date and organised.
- The trust planned to bring in electronic prescribing in 2016 in an attempt to minimise prescribing errors and maximise pharmacy stock efficiency.
- One unsigned prescription was corrected immediately following discussion with a ward nurse.

Records

- We reviewed 12 sets of patient records. The trust used standard nursing care records across the medical division. Nursing records were comprehensive, current and easy to navigate and contained all the information required to support the delivery of safe care.
- The nursing documentation contained a range of risk assessments covering the major risks for patients. Records included risks such as tissue damage, falls and

use of bed rails. Updated risk assessments were seen. Alongside the risk assessment, the trust developed Falls Bundle documentation, which supported the assessment and treatment of patients experiencing falls.
- Information governance training showed 82% compliance against a trust target of 90%.
- We reviewed 12 sets of medical and allied health professional records on four wards, found them to be accurate, legible, signed and dated, easy to follow, and gave a clear plan and record of the patient's care and treatment.
- Records were stored securely to ensure patient confidentiality.

Safeguarding

- All frontline staff we spoke with had received safeguarding training and were aware of their individual responsibilities regarding the safeguarding of both children and vulnerable adults. All wards we visited had an adult safeguarding pathway displayed in the ward area. The medical division-training rate in adults level 1 safeguarding was 82% and children's safeguarding level 1 and 2 was also 82% against a trust target of 90%.
- There was a system in place for raising safeguarding concerns. There was an established safeguarding team for both adults and children. Staff were aware of the safeguarding process and could explain clearly definitions of abuse and neglect.

Mandatory training

- Levels of mandatory training within the medical division were generally below the trust targets although latest figures did show an improvement in the last 6 months. In September 2015, the medical division showed an 86% compliance figure compared to 81% in June 2015. The trust target was 90%. Ward 23 staff said it could be difficult to find the time to complete mandatory training due to pressures on the ward.

Assessing and responding to patient risk

- Staff used the National Early Warning Score (NEWS) to identify patients whose condition was deteriorating. Scores were recorded on the electronic patient system. Staff were prompted when to call for appropriate support and there was seven day 12 hour consultant physician presence. We corroborated this at inspection and found the records to be correct.
- There were pathways in place for each speciality such as chest pain, NIV (Non-invasive ventilation), stroke, falls, and ambulatory care. Pathway compliance included the completion of specific care booklets; however, we found that the stroke pathway had not been completed fully on Ward 22. Staff demonstrated that they understood the stroke tool and escalated changes in the patient's condition appropriately.
- Staff used a variety of different tools such as risk assessments for nutrition, alcohol consumption and pressure care. Stickers were used to identify patients at risk of developing pressure damage 'Save our Skin' and fall's 'Fallen Stars'. We observed these in use during the inspection.
- An acute response team consisting of nurses based within the hospital offered additional support to the medical teams when patients deteriorated.
- The mental health staff employed by the trust supported ward 23 (a dual ward for older people with physical and mental health illness) if patients required additional support with their mental health needs.

Nursing Staffing

- The medical division used an electronic rostering system to calculate the number of whole time equivalent (WTE) nursing staff safely required for each ward. The planned and actual staffing numbers were displayed on each ward.
- During the inspection on ward 23 there was four staff on duty in the late afternoon (two qualified and 2 unqualified caring for 24 patients). Staff advised they had requested an additional unqualified member of staff for a patient requiring 'special' support however there was no cover. The rotas showed that between 18 and 23 October 2015, no cover was available for 10 shifts where additional support was requested. Staff told us there were delays in sending staff to the ward. The ward was visibly busy with several nurse call alarms sounding simultaneously. However, staff said that they would manage patients requiring special assistance together. For example, we saw that two patients requiring this additional assistance were offered care in the same cubicle so that observation could be conducted safely. The business unit was undertaking a business case to increase the staffing establishment of ward 23 to address this. In the meantime the ward utilised additional bank staff in excess of targeted staffing levels.

This was reflected in the average fill rate for nursing assistants of approximately 175% for day shifts and 130% for night shifts based on the monthly average fill rates for the ward.

- On other wards, we observed staff cover arrangements in place and although at times confirmation that shift cover occurred late in the afternoon for the night shift, staff said they felt reassured that cover would be found. Most staff reported that they felt the wards were safe with the staffing numbers in place.
- We reviewed the 2015 workforce analysis report. There were 15 whole time equivalent (wte) registered nursing vacancies. There was a trust wide recruitment strategy, which included interdepartmental working, rolling adverts for recruitment, national advertising, and open day events to attract new staff. The trust was proactive in recruiting student nurses following qualification.
- Nursing handovers worked together with the electronic bed management system, and patient progress documented on to the system and printed off for nurse information sheets. Ward 23 used a Dictaphone to capture handover information, and shared with medical staff as well as nursing staff. However, the recording we observed on the unannounced inspection was of poor quality and did not provide clear information about the status of patients. A written handover also took place.
- Bank staff were orientated to the ward environment and supported locally through an induction process. There was no use of agency staff in the medical division.
- Where there was a deficit in the planned number of nurses on the ward, some sisters said they were counted in the numbers, which influenced managerial times on some occasions.

Medical staffing

- The ratio of consultants was better than the England average. The trust showed 40% consultant cover compared to the 39% England average. Registrars were slightly below at 36% compared to the 38% England average. In the medical division, staff ratios were comparable to the average national data, although there was a slight increase to the percentage of junior doctors employed by the trust. A review of staffing had increased the number of junior medical staff.
- There was appropriate consultant cover, which included a physician of the day. The staffing rotas were complicated, as they were comprised of 22 different consultants. When we spoke with staff, they needed to refer to the hard copy of the rota before confirming the name of the consultant of the day, due to the complexity of the rota. We could not see evidence of any negative impact on patient safety because of this.
- Consultants were onsite between 8am to 8pm seven days a week. No consultants were routinely onsite over night, but offered cover on call and staff reported that there had not been difficulties contacting consultants when required. Locum staff were used when required.
- Handovers were both verbal and electronic using the integrated bed management system. During inspection, we observed medical handover on the Emergency Assessment Unit (EAU). Consultants, speciality trainees and junior doctors attended this. Staff reported that this was undertaken seven days a week.
- A Consultant Geriatrician and Older Persons Psychiatric Consultant provided medical cover on ward 23.

Major incident awareness and training

- There was a major incident plan in place and staff we spoke displayed an understanding of this.
- The trust and regional partners had escalation/ resilience plans, which were used when situations required it. For example, when bed capacity was reduced the North East Escalation Plan (NEEP) was used, this graded one (normal) to four (severe pressure) on beds. During our inspection, the trust was at a NEEP level 2.

Are medical care services effective?

Good

We rated effective as good because:

People's care and treatment was planned and delivered in line with current evidence-based guidance, standards, best practice and legislation. Local and national audits of clinical outcomes were undertaken. Pain relief, nutrition and hydration needs were met.

Most patient outcomes were similar or better than national expectations. Where outcomes were lower, there was evidence of action to improve. Staff had the skills and knowledge to carry out their roles effectively and in line with best practice. Staff worked jointly to understand and meet the range and complexity of people's needs.

Medical care (including older people's care)

Consent to care and treatment was obtained in line with legislation and guidance, including the Mental Capacity Act 2005. Patients were supported to make decisions and, where appropriate, their mental capacity was assessed and recorded.

Evidence-based care and treatment

- Staff used a combination of National Institute for Health and Care Excellence (NICE), and Royal College guidelines to determine the treatment they provided. Local policies reflected up to date clinical guidelines. We spoke with doctors in relation to the NICE guidance in relation to intra venous (IV) fluid management. It was not clear the guidance had been included within the trust policy.
- The Annual Safe Care Audit Plan 2015/16 specified a range of planned audits, in which the service participated.
- We reviewed several of the medical care division policies on the trust intranet, which were in-date approved and showed review dates.
- We saw evidence of local audits within each of the medical specialities, such as medication documentation audits infection control, cannulation, urinary catheters management and stroke audits.
- The endoscopy unit had Joint Advisory Group (JAG) accreditation. JAG accreditation is the formal recognition that an endoscopy service has demonstrated that it has the competence to deliver against the measures in endoscopy standards.
- There were condition specific care pathways in place, to standardise and improve the care for patients, for example, for the care of patients with stroke, non-invasive ventilation (NIV) and the assessment of chest pain.
- Patient documentation used care standards that reflected best practice and in line with current NICE guidelines, National Service Frameworks and the Royal Marsden Manual of clinical nurse procedures.
- Quality measure audits were completed at ward level, which included hand hygiene, uniform, equipment and falls audits. However; documented action plans following these audits were not evident in all areas.

Pain relief

- Patients received pain relief as prescribed and there were systems in place to make sure additional pain relief was accessible through medical staff if required.
- Patients said staff asked about their pain and if they required any pain relief and had no concerns about the management of their pain.
- Specific questions regarding pain management were included in the patient experience survey. Results showed an improved satisfaction rate of 5.92 / 6 (six being highly satisfied) for the period April 2014 – March 2015 and 5.92/6 for the period of April 2015 – June 2015.
- A pain tool was accessible on the electronic observation system. We saw this in use during our inspection to ensure effective pain management for patients.
- The pain nurse specialists were developing pain champions on ward areas. There was evidence of extra training to support this.

Nutrition and hydration

- Patients had their nutritional needs assessed using the Nutritional Risk Score (NRS), patient weights recorded on admission and weekly thereafter. We saw completed records and referrals to dieticians as required. We observed food charts in use for the first three days of a patient's admission on the ICAR unit to help identify any nutritional concerns.
- Records showed fluid balance charts were accurately completed.
- There was discretion used during protected mealtimes so that relatives were able to support their family members.
- We observed red water jugs for patients at risk of dehydration and these were within patients reach.
- Ward staff met with the catering department and nutrition link nurses to discuss patient feedback regarding choice and portion size. All patents we spoke with stated the food was good. Patients felt the choice and quality of food was satisfactory.

Patient outcomes

- The level of mortality calculated using the Standard Summary Hospital level mortality indicator (SHMI) showed the trust had death rates in line with expected levels. Using the HSMR standard (a risk-based assessment of 56 conditions, which account for 80% of deaths) the trust was below (better) than the national average of 100 deaths at 91.84.
- In the Sentinel Stroke National Audit Programme (SSNAP), the trust showed mixed results; several areas showed an improvement for example, the stroke discharge process and use of occupational therapy.

However, scanning, and speech and language therapy for patient centred and team-centred key indicators were towards the bottom of the scale. The overall SSNAP level for the trust was D which remains low but was slightly, better than the previous ratings it had received.

- We saw an action plan to improve the therapy targets, with a completion date of April 2016. Progress reports suggested developments had been made.
- There was an acute stroke integrated care pathway and record for patients. We visited the stroke wards and observed patients receiving therapy support. Occupational therapists and physiotherapists visited the ward daily and worked alongside the medical team. Patients were directly admitted to the ward from the Emergency Assessment Unit (EAU), which ensured consistent treatment from the appropriate wards following consultant assessment. Staff were aware of the stroke pathway access and flow guidance but the patient booklet was not completed fully.
- In the National Heart Failure Audit, the trust was performing better than the national average in 10 of the 11 measures. The only one they were not was cardiology. We saw evidence of regular meetings by the cardiology team to promote improvement.
- Performance in the National Diabetes Inpatient Audit (NaDIA) showed that out of the 20 indicators the trust was performing better than the England median in 12 and worse than the median in eight. The worst performing indicators were visits by the specialist diabetes team, medication errors, and prescription errors, admitted with foot disease, meals suitable, choice and able to take control of diabetes care. We spoke with the medical core services team who were fully aware of these results and were rolling out specific training in the next few months.
- Two out of three non-ST-Segment-Elevation Myocardial Infarction (nSTEMI) indicators were better than the England average. For example, a cardiologist saw 96.4% of nSTEMI patients (compared to the national average of 94.3%) and 65.8% of patients were admitted to the cardiac unit compared with the England average of 55.6%. The standardised relative risk of re-admission rate for elective admissions was better than the England average. Non-elective rates were slightly worse in general medicine.

Competent staff

- In October 2015, the trust dashboard showed that 86.32% of staff had received an appraisal / personal development plan (PDP) 100% of staff had received corporate induction.
- Student nurses told us a university educator supported them; they said they received good support from their ward-based mentors and received a good balance of practical skills and theoretical knowledge. The students we spoke with advised us of recent job offers and support with the preceptorship programme.
- Allied health professionals and support staff experienced support to participate in external training relevant to their role.
- Junior doctors said they felt supported through their induction programme. They told us there was sufficient teaching in the medical division.
- Some non-registered staff told us there were opportunities for development. There was evidence that ward nurses received support through link nurses.

Multidisciplinary working

- Multidisciplinary teams (MDTs) worked well together to ensure coordinated care for patients. From our observations and discussions with members of the multi-disciplinary team, we saw that staff across all disciplines genuinely respected and valued the work of other members of the team.
- On wards 23 (care of older people) and EAU (Emergency Assessment Unit) we observed integrated MDT working, occupational therapists and physiotherapists based on the wards worked alongside nursing and medical professions. We spoke with health care assistants (HCAs) who were encouraged to work alongside allied health professionals. The rationale for this was to share areas of good practice and provide consistency of support for patients.
- Therapy staff said they felt a valued part of the MDT.
- Psychiatric consultant support was available for ward 23. Staff reported effective liaison between mental health and general nursing staff. There was shared learning between Registered General Nurses (RGN) and Registered Mental Health Nurses (RMN) due to the dual characteristics of the ward. Staff spoke about the unique opportunities of learning within this environment.

Seven-day services

- Consultant cover was available Monday to Friday on all the medical and care of elderly wards where daily ward rounds took place. After 8pm, there was a consultant on-call.
- An on-call physician along with an acute physician working out of the Emergency Care Centre provided seven-day cover on the EAU.
- The trust had implemented a 'physician of the day' initiative. Additionally the trust also had a matron in charge of the hospital site seven days per week working 8am – 8pm.
- Bed meetings took place three times a day on EAU; this process included the patient flow team, duty matron and bed management staff.
- There was a gastroenterology GI bleed service on call rota 365 days per year.
- Staff we spoke with informed us there was access to on call physiotherapists, radiology and chaplaincy services.
- There was specialist nursing staff for chest pain and assessment, stroke and NIV.
- An acute response team was based within the main hospital to provide 24/7 nursing support and overnight bed management.
- There was a senior manager and director on call for the trust.

Access to information

- Doctors said they received test results and information promptly.
- Guidelines were stored on the trust intranet pages and were accessible to staff.
- We were shown handover sheets, generated by the electronic bed management system; they contained detailed information.
- Each patient had an information board at the bed head, this was updated each shift and detailed the patients' consultant and nurse responsible for their care during that shift.
- Units based off the main hospital site were able to link into the trust electronic patient systems effectively.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- Patients were asked for their consent to procedures appropriately and correctly. We saw staff obtaining verbal consent when helping patients with personal care.
- We reviewed two Deprivation of Liberty Safeguards (DOLS) urgent and standard authorisation forms. The ward matron supported by the safeguarding lead nurse had completed them to a high standard. A capacity assessment was undertaken appropriately, a best interest's form completed and a referral made to the mental health team. An appropriate individual had countersigned the forms.
- Records showed that every time staff completed a DOLS application, this was logged on the electronic reporting system for review.
- Staff said that all Mental Capacity Act (MCA) assessments were shared with the safeguarding team.
- We reviewed MCA documentation in three health care records, which were completed to a good standard.

Are medical care services caring?

Good

We rated caring as good because:

Most patients and relatives told us staff delivered compassionate care, which was polite and respectful.

The trust performed about the same as other trusts in the 2014 CQC Inpatient Survey and scored better within the 'leaving hospital' results.

Staff responded compassionately when people needed help and support to meet their basic personal needs.

Multi-disciplinary teams shared patient information in a compassionate, respectful manner.

Patients we spoke with were aware of what treatment they were having and understood the reasons for this and, in many cases, had been involved in the decisions made about their care.

Compassionate care

- The percentage of patients who, according to the national Friends and Family test would recommend the services was consistent with or higher than the national average for 2014-2015. Data showed an overall score at 96%.
- We observed staff discussing patients care during the daily safety huddles and MDT meetings with care, respect and compassion.

Medical care (including older people's care)

- Patients felt involved in every aspect of their care and decision making process.
- We spoke with 51 patients during our inspection; they were very complimentary of the care they were receiving. Patients said staff were helpful and provided a high standard of care. Two patients said that staff on ward 11 were particularly busy at night but that their care was not compromised. One relative confirmed they had been a patient in medicine several times and had always received 'excellent care'.
- We observed nurses on all wards we visited, responding to patient call bells in a timely manner.

Understanding and involvement of patients and those close to them

- Patients and relatives said they felt involved in their care.
- They told us they had sufficient opportunities to speak with the consultant and other members of the multi-disciplinary team looking after them about their treatment goals. This enabled patients to make decisions about and be involved in their care.
- Patients told us that if they did not understand any aspects of their care that the medical, nursing or allied health professional staff would explain to them in a way that they could understand.
- Families and friends were offered flexible visiting around mealtimes to support those who required additional nutritional support.
- The trust performed around the same as other trusts in relevant questions in the 2014 CQC Inpatient Survey such as nurses answering questions in a way patients could understand.

Emotional support

- We saw on ward 23 an activity co-ordinator who provided support to patients, especially those living with dementia and memory loss. Staff informed us that due to the dual purpose of the ward, the post provided therapeutic care and support. During our inspection, we spoke with families who felt this support was 'fantastic'.
- Almost all patients said they felt emotionally supported by staff.
- Patients had access to chaplaincy support 24 hours per day.
- The mental health liaison team provided support for patients identified with low mood; we saw evidence of this interaction in patient notes and support plans.

Are medical care services responsive?

Good

We rated responsive as good because:

There was service planning and delivery to meet the needs of the local population.

There were processes in place to ensure patients were cared for in the right place at the right time. Patient flow was a priority, and the patient flow team proactively managed this. Multiple moves of patients during an admission were monitored effectively.

The needs of patients were met on most wards. There was openness and transparency in the management of complaints. Complaints and concerns were taken seriously and improvements made.

Service planning and delivery to meet the needs of local people

- There were links with commissioners and other providers, including the ambulance service, during the planning and delivery of services. However, staff told us that there had been several meetings to discuss lack of patient transfer ambulances but no action plan was in place.
- Medicine was involved in several service development and transformational initiatives jointly with the clinical commissioning group (CCG) such as respiratory, stroke, heart failure, ambulatory care and frailty services.
- Stroke models had recently been redesigned to tailor these to the needs of the local population.
- Work streams continued to support long-term conditions such as diabetes and heart failure.

Access and flow

- Staff and managers identified patient flow as a divisional priority; the patient flow team proactively managed capacity, demand and undertook appropriate escalation in line with trust policy.
- Teams worked to ensure patients avoided multiple moves to other wards during an admission. We reviewed trust data, which identified 29% of inpatients, had one inpatient move between the period of April 2014 and June 2015. 15% of patients experienced two or more inpatient moves in the same period.

Medical care (including older people's care)

- The trust had a dedicated patient flow team with a 24-hour presence in the trust. The team consisted of; a patient focused bed management team supported by a duty matron working 12 hours a day, seven days a week and offering clinical support. Overnight the bed management responsibility was with the acute response team. A senior manager on-call was also available 24/7 to respond to bed pressures. The team met three times a day to monitor the flow of patients in the trust, this role was led from EAU.
- Patients identified safe for discharge moved from the base ward to the discharge lounge; releasing beds on base wards whilst patients waited for take home medications and transport.
- The discharge lounge was open Monday to Friday until approximately 5pm; however, staff told us that it was open until the last patient went home. Staff were able to work flexibly to accommodate this safely. There were plans to open the discharge lounge on a Sunday during the winter pressures period.
- Staff felt the greatest challenge to timely discharge was the availability of patient transport ambulances which did not always arrive on time.
- There were 1,025 days delayed discharges trust-wide from April 2015 to July 2015. The trust said the main reason for these was waiting for the provision of social care packages.
- EAU was a 22-bedded unit with consultant cover 8am to 8pm. The target for the length of stay on the unit was 8 hours; however, due to the number of side rooms and capacity for beds within the hospital, some patients had stayed on the unit longer. Although trolleys were in situ within the side rooms, specific trolleys had been sought which were wider and had thicker mattresses to aid comfort for patients who were required to stay for longer periods.
- Some wards with more complex discharges had a designated discharge nurse.
- The business unit had a number of teams who facilitated discharge for patients with specific conditions such as heart failure and respiratory problems.
- The 18 week referral to treatment times (RTT) for medical specialities were meeting the England average of 90%.
- The trust wide average length of stay for non-elective admissions was better than the England average in all areas. We asked the trust about the number of medical boarders. Medical boarders are patients who may be admitted to wards other than medical due to bed pressures. At the time of our inspection, there were five patients in wards other than medicine. A list of these patients was produced every morning and the appropriate medical team would review them daily and were responsible for their care.
- The trust also advised us of plans to open ward six specifically to support capacity during winter pressures. At the time of our inspection, this ward remained closed.

Meeting people's individual needs

- A ward sister told us that one to one supervision or nursing within a close observation area was available for high-risk patients; however, there were no examples for us to observe during inspection.
- Wards offered flexible visiting times when required for example, patients at the end of life and encouraged relatives to assist with feeding at mealtimes for patients requiring this additional support.
- The dementia strategy supported the specific needs of patients. The person centred tool "This is me" was a passport system for patients with learning disabilities or dementia.
- A personal carer passport system had also been introduced for carers to access open visiting following the "John's campaign", a campaign for carers to stay with people in hospital who have dementia.
- Access to interpreting service was available for patients whose first language was not English.
- Access to information for patients and their families was good. We saw examples of comprehensive information for patients regarding the management of their health conditions in. several languages.
- To support and promote patients' individual religious and cultural needs there were relevant information sheets available within the clinical areas.
- Chaplaincy services were available 24 hours a day 7 days a week.
- We observed a remembrance display table in the activity room at the Ellison Unit for patients with dementia.
- Patients with dementia were given forget me knot bracelets to wear.
- We saw evidence of dementia training on all wards including the use of "Barbara's story" video.

Medical care (including older people's care)

- There was a challenging behaviour specialist nurse based at the Ellison day Unit. They provided outreach services to care homes by providing assessment and supporting staff.
- Bariatric equipment was available for patients when required. All wards had appropriate disability access.
- On admission to Ward 23 all patients were assessed and reviewed by members of MDT which included general and mental health nurses, geriatricians, psychiatrists, psychologists and a pharmacist.

Learning from complaints and concerns

- Every ward we visited had information about how to make a complaint prominently displayed. Although posters were not always evident for PALS support.
- The duty matron told us that all complaints were discussed during monthly ward meetings and there was evidence of learning from these complaints. This information was shared with staff in minutes of governance meetings. We saw evidence of these meetings.
- Staff followed the trust's complaints policy and provided examples of when they would resolve concerns locally such as complaints about ward moves, treatment plans or lost property or how to escalate more serious concerns where required.
- Each ward board we observed had details of the number of complaints and compliments received.
- The 2014-2015 complaints analysis showed the trust had 234 complaints. The highest number of complaints in medicine was poor communication and staff attitude. We saw that these had been responded to and action taken where possible to prevent further complaints.
- Matrons had an "open door policy" to support patients and their relatives and discuss any concerns.

Are medical care services well-led?

Good

We rated well led as good because:

All staff working in medicine had a clear vision regarding person-centred care. Following governance meetings, review strategies were developed to inform the business planning cycle and deliver service improvements and developments.

We saw effective processes in place to engage the public and stakeholders and robust mechanisms to capture staff and patient experience.

Staff were generally positive about the leadership and the levels of engagement with their line manager through to executive level. There was a positive open culture within teams. We spoke with staff who demonstrated pride and compassion in the care that they provided. Staff were encouraged to put forward ideas for improvement. The service took account of patient experience and action to improve care where required.

There was a culture of collective responsibility between teams and services and wards were encouraged to develop their own 'philosophy of care'.

Information and analysis was used proactively and engaged all staff to ensure ownership and empowerment.

Safe innovation was supported and staff had objectives for improvement and learning.

Vision and strategy for this service

- The medicine business unit were currently developing service strategies for rheumatology, respiratory, cardiology, care of the elderly, stroke and old age psychiatry. Staff we spoke with were aware of the corporate vision of the trust, which was 'placing the patient at the centre of everything we do'.
- Some wards had their own 'philosophy of care', identifying what they achieved well and areas for development on the ward. Two staff (non–qualified) we spoke with on these wards knew of their ward vision.
- Individual staff spoke with pride and compassion about what they thought good care looked like, and how they demonstrated this on a daily basis.

Governance, risk management and quality measurement

- Staff we spoke with were actively encouraged to report incidents for example on ward one staff reported grade one pressure sores.
- Nursing performance dashboards at ward and divisional level measured the quality of care; we observed these on all wards we visited.
- The division had recently reviewed its governance arrangements in relation to risk and Safe Care (the trust governance process). This was to ensure effective

arrangements were in place to manage the business units risk and safe care activity. Standard agenda items and terms of reference were in development for team/ward/department Safe Care meetings. A proposed governance structure and a business unit level standard agenda was approved at the Trust Safe Care Council meeting. The agenda items included safety, clinical effectiveness and patient experience.

- Service line managers determined the risk score of items on the risk register. The areas identified were registered nurse recruitment and redesign of the stroke service. Risks were reviewed every three months and discussed at monthly management meetings, departmental meetings, the operational board and Board-to-Board meetings as part of the performance review.

Leadership of service

- The medical business division had a clear management structure defining lines of accountability and line management responsibility and in recent years had been shortlisted in the Nursing Times awards due to their commitment and evidence of improvements. Staff were clear about the management structure and lines of accountability.
- An improvement tool Excellence in Nursing Everyone Realising Great Innovations (ENERGI) programme was rolled out to improve culture, quality and productivity on the wards.
- The business unit were reviewing the clinical lead structure to increase clinical engagement and input.
- We observed a poster with details of the Nursing and Midwifery Strategy for 2013 – 2016 including work stream meetings. Staff on the Ellison Unit were linked into the work stream; however, said meetings were often cancelled due to ward pressures.
- Duty matrons completed daily walk around visits to each ward and ensured communication was fluid throughout the day to ensure safe patient care. We saw evidence of these walk around audits.
- Ward sisters stated that they met with staff and produced minutes of the meetings for those who were unable to attend on a monthly basis.

Culture within the service

- Many staff spoke enthusiastically about their work. They described how proud they were to work at the trust.
- We found the culture of care delivered by staff across all medical services was dedicated, compassionate and strongly supported at divisional and ward level.
- Consultants told us there was a positive culture and management genuinely listened to consultants and medical staff about issues such as recruitment, training and improvements for medical patients. Most junior doctors reported that they were well supported by senior colleagues.
- A ward sister told us that she "loved coming to work" and "enjoyed working in the care of the elderly". She told us that she was dedicated and believed in putting the patient at the centre of care.
- Band 6 nurses at the ICAR unit had specialist areas of interest and led on service development, education, and clinical standards based on latest research and NICE guidance.

Public engagement

- The trust promoted a transparent culture and encouraged open discussion of concerns and experience from patients and relatives.
- The medical division produced inpatient experience surveys. In the 2014-2015 local survey, the medical division's highest scoring figure was 5.98 for assistance with washing and dressing and lowest was 5.63 for information provided at the ward on visiting, mealtimes, doctors. These scores were out of a possible 6.
- We saw evidence of carer's forums, which had both staff and carer representation.

Staff engagement

- The trust's score within the 2014 NHS Staff Survey of 3.74 was average when compared with trusts of a similar size. Staff motivation was slightly lower at 3.75 than the national average of 3.86.
- Staff we spoke with said they were involved in developing their own ward philosophy and that this helped them to feel valued as part of the team, and developing the vision together.
- There were a number of developments driven and supported by matrons and ward managers for example, the introduction of nursing assistant forums, where guest speakers were invited and best practice shared.
- The trust offered two sessions each year where the director of nursing met with all ward managers for professional updates and networking as well as developing trust strategies.

Medical care (including older people's care)

- Nurses at all levels were encouraged to attend the leadership course ran internally and by the NHS Leadership Academy.

Innovation, improvement and sustainability

- Staff used the ENERGI framework to enhance staff motivation and performance and improve culture, quality and productivity on the wards. The team were finalists in the Nursing Times awards for improving staff experience.
- A unified referral pathway and standardised documentation was being used by GP practices to refer into the diabetes-integrated service. It included advice and guidance for GPs, a specialist nursing helpline and multi-disciplinary clinical assessment. Clear protocols were in place to identify when a patient could be managed within primary and/or secondary care and when care transfer was appropriate and/or possible.
- Stroke services were currently under review, to improve the pathway and develop innovative ways of working with other service providers across the region to allow a more sustainable stroke service.
- There was a frailty programme of work currently underway, which included joint discharge planning comprehensive frailty assessments and a frailty nursing team.

Surgery

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

Information about the service

Gateshead Health NHS Foundation Trust provided a range of surgical services for the population of Gateshead and the immediate surrounding area.

The hospital provided elective and non-elective treatments for colorectal surgery, breast surgery, trauma and orthopaedics and urology.

During this inspection, we visited the following surgical wards: Ward 9, Ward 14, Treatment Centre 26 (T26) and Treatment Centre (T27) as well as the Emergency Assessment Unit. We visited all theatres and recovery areas on site and observed the delivery of care.

We spoke with 12 patients and relatives and 25 members of staff. We observed care and treatment and looked at care records for 17 patients.

Summary of findings

We rated surgical services as good because:

Staff knew the process for reporting and investigating incidents using the trust's reporting system. They received feedback from reported incidents and felt supported by managers when considering lessons learned.

All wards used an early warning scoring system and risk assessments for the management of deteriorating patients. Infection prevention and control was managed effectively.

We saw staff treating patients with compassion, dignity, and respect throughout our inspection. Ward managers and matrons were available on the wards so that relatives and patients could speak with them. We saw patient information logbooks, leaflets, and posters available for patients explaining their procedure and after care arrangements. Patients could access counselling services and psychological support.

All patients had mental capacity assessments. Staff received Mental Capacity Act (MCA) and Deprivation of Liberty Safeguards (DoLS) training as part of staff induction. All the staff we spoke with received training in and knew about safeguarding policies and procedures.

All wards and theatres had an appropriate skill mix during shifts. Generally staff ratio was one to eight and increased to one to six when needed. We reviewed the nurse staffing levels on all wards visited and within

theatres and found that levels of skill mix were appropriate. The hospital had an escalation policy and procedure to deal with busy times and bed meetings monitored bed availability on a daily basis.

Staff treated patients in line with national guidance and used enhanced recovery (fast track) pathways. Local policies were written in line with national guidelines. Staff told us appraisals were undertaken annually and records for 2014 showed that 84% of staff across wards, surgery, and theatres received an appraisal.

Therapists worked closely with the nursing teams on the wards. Members of the multidisciplinary team attended daily handover meetings. The trauma, surgery, and urology directorates delivered a consultant led seven-day service. The orthopaedic surgery service delivery was a Monday to Saturday morning service.

The Emergency Admissions Unit enabled a rapid assessment of patients through identified care pathways. We saw that orthogeriatricians had input into the care pathway of elderly patients. All wards had dementia champions and could access an independent mental capacity advocate (IMCA) when best interest decision meetings were required.

Complaints were dealt with initially informally at ward level and escalated as necessary to ward managers and matrons in line with trust policy. Complaints were discussed at monthly staff meetings where training needs and learning was identified.

The department held joint clinical governance and directorate meetings each month. The directorate risk register was updated following these meetings and action plans were monitored across the division. Staff said speciality managers were available, visible and approachable; leadership of the service was good, there was good staff morale and they felt supported at ward level. Staff spoke positively about the service they provided for patients and emphasised quality and patient experience.

Are surgery services safe?

Good

We rated safe as good because:

Staff were familiar with the process for reporting and investigating incidents using the trust's electronic reporting system and feedback was given from a senior level.

Patients at risk of pressure sores had management plans. Records showed risk assessments were completed at each stage of the patient journey from admission to discharge, with an early warning scoring system used for the management of deteriorating patients. We observed theatre staff practice the 'Five Steps to Safer Surgery' and complete the World Health Organisation (WHO) checklist appropriately.

Wards and patient areas were clean and monthly cleanliness audits were undertaken by domestic services.

Mental capacity assessments were undertaken and Mental Capacity Act (MCA) and Deprivation of Liberty Safeguards (DoLS) training was delivered as part of staff induction. All the staff we spoke with were aware of the safeguarding policies and procedures and had received training.

Planned staffing levels for wards worked on a one to eight ratio. In times of greater patient need, ward staff ratio's increased to one to six. We reviewed the nurse staffing levels on all wards visited and within theatres and found that levels of skill mix were appropriate. However, there were areas of both nursing and medical staff shortage, but the trust were actively recruiting to these posts. The hospital had an escalation policy and procedure to deal with busy times and bed management meetings were held to monitor bed availability on a daily basis.

Surgical consultants from all specialities led ward rounds and were involved in handovers.

Incidents

- There had been no never events and 23 serious incidents reported between April 2014 and June 2015. Pressure damage was the cause of 14 of these incidents on ward 14 and the completion of investigations were in

a timely manner. We saw evidence of information from the root cause analysis (RCA) and the associated action plans. Since the implementation of the action plans, the rate of pressure damage on ward 14 reduced by 50%.

- Staff members were familiar with the process for Duty of Candour. Senior management explained that patients were advised verbally when an incident had occurred and following investigation, patients were informed of cause, outcome and given an apology in writing. Staff received feedback from all investigations during team meetings; band seven (ward manager) forums and Safe Care meetings.
- Two of the patients we spoke with on Wards 9 and 26 told us they were kept up to date with treatment options and all questions were answered to patient and family satisfaction. The Safe Care patient booklet gave procedure specific information and empowered patients to challenge poor practice, if necessary.
- There had been 16 surgical site infections identified in 2014/2015 from the time of admission to 30 days post discharge. This identified an increase of surgical site infections from 12 in 2013/2014 to 16 in 2014/2015. This was an increase of 1.6% to 2.4%. In response to this increase, audits of the patient notes and outcomes for the surgical site infections in hip replacements took place. Two patients received revision of total hip replacement because of surgical site infection in 2014/2015.
- Morbidity and Mortality meetings occurred as part of the Safe Care Campaign with quarterly meetings taking place to discuss Root Cause Analyses and action plan timelines. Meeting minutes were observed and were comprehensive. Lessons learned information was available to risk leads and safeguarding leads who then fedback to ward staff.
- Ward managers communicated information to staff, and regularly "walked wards" to check staff received essential updates. However, there was uncertainty at middle management level when asked, "How do you know your ward was safe today".
- Ward managers were visible and proactive. One to one communications, notices, catch up sessions and away days were undertaken and communication between teams promoted. Returning staff from sick leave had catch up with briefings as part of their return to work documentation.

Safety thermometer

- The trust used the NHS safety thermometer and performance tool, which recorded evidence of all new, harms; falls with harm and new pressure ulcers. The results were displayed on boards on all wards and theatre areas we visited. Monitoring took place during matrons' meetings followed by communication sharing with wards and departments.
- There were three urinary tract infections; two new venous thrombo-embolisms (VTE) from July 2014 to July 2015 reported. Safety thermometer information showed 96.7% harm free care.
- Pressure ulcer data was provided over a twelve month period. 57 were graded at level two, 16 at level three and 14 at level four. These figures incorporate all medical wards including cardiology, gastroenterology and geriatric medicine.
- There were no new pressure ulcers reported at grade four during the same period and only 2 at grade three.
- Ward 9 showed an increase in May 2015 to June 2015 in falls incidents, and investigations had showed that one complex patient fell 11 times, all recorded as harm free. There were six instances of patient harm from falls on Ward 9 in the 12 months to July 2015.
- We found work had been carried out to minimise the risk of falls for patients by using falls pads, monitors, non-slip socks, and the use of a new falls risk assessment, which identified those at risk of falling by placing a "falling star" sticker on the patient name board.
- A ThinkSAFE project was in progress within the pre-assessment unit and T26 addressing falls risks. Falls prevention information was held within the patient logbook, which was created with the specialist falls nurse.
- Pressure damage was the most commonly reported incident on Ward 14. We saw evidence of the implementation and sharing of action plans with the multi-disciplinary team. Multiple staff groups had been involved in this work including the senior management, Practice Development Team and Tissue Viability Nurses (TVN). All attended weekly meetings to review pressure damage audits.

Cleanliness, infection control and hygiene

- Infection control information was visible in all ward and patient areas.

- Wards and patient areas were clean. We observed staff wash their hands, use hand gel between patients and observed staff comply with 'bare below the elbows' policies.
- All elective patients undergoing surgery were screened for Methicillin Resistant Staphylococcus Aureus (MRSA) and procedures were in place to isolate patients when necessary in accordance with infection control policies. Any abnormal test results were shared with patient's GPs to ensure they received appropriate treatment. Patients also received antimicrobial whole body cleansing wash to help reduce potential infections such as MRSA post-operatively. There had been zero incidences of MRSA and five incidences of Clostridium Difficile (C.Diff) reported since April 2015 in the surgical directorate.
- There were systems to isolate patients awaiting elective surgery pre-operatively from patients requiring emergency surgery. We found that bed managers and the infection control team dealt with the isolation process. Transfer to theatre or the treatment centre did not occur for those people in isolated areas until they were clear from infection.
- The Diarrhoea Assessment and Management Pathway (DAMP) process commenced prior to the results returning as a proactive precaution. During that time, staff and family members used protective clothing when visiting the patient and signs were displayed.
- During April 2015, the trust sent 191 stool samples for screening. Fifteen of the patients were discharged / or had died prior to review therefore the DAMP chart completion and other aspects of care were unknown. For the remaining 176 patients, 138 patients had a DAMP record (78% compliance), of which only 73 were fully completed (53% compliance). On review, it was found that 108 patients were appropriately isolated (61% compliance). There was evidence of long sleeved gowns being in use for ninety-one of the isolated patients being reviewed (84% compliance).
- We found each department had a weekly and monthly cleaning schedule for domestic staff, housekeepers and nursing staff. Joint walkabouts with the Infection Prevention and Control Nurse (IPCN) and the matron were undertaken and actions fed back to ward and departmental managers.
- Wards undertook weekly audits including hand washing (100% compliance), compliance with uniform policy (91% compliance) and equipment cleanliness (100% compliance).
- Domestic services undertook weekly environmental audits to monitor the cleanliness of wards. Results showed Ward 9 achieved an overall score of 98.69%, Ward 14 scored 98.76% and Ward 21 the lowest at a score of 97.59%
- During the inspection, we observed clinical waste was disposed of according to relevant guidelines and protocols.

Environment and equipment

- The wards appeared bright and in a good state of repair.
- Staff in all areas had undergone medical devices competency based assessments and records were held for staff in all the individual areas as per policy.
- Care and Quality Accreditation Framework (CQAF) provided assurance that staff were complying with recommended standards relating to safety. For example, areas of practice which had to be achieved included demonstrating a safe working environment, overall patient safety, storing of records, patient cultural needs being met and the maintenance of high nutritional standards.
- Cardiac arrest and suction equipment checks were completed daily and weekly, this was documented within the ward areas, and compliance was validated through CQAF process.
- All equipment maintenance was up-to-date and portable appliance tested (PAT) according to regulation.
- Orthopaedic theatres had bought new camera stacks for the four surgery centre theatres. Additionally, a pinpoint device for use in laparoscopic procedures was in place. A programme of theatre light replacement was also underway. Relevant training was available for new items of equipment.
- Bariatric training was available for staff and was been provided by occupational therapists. Surgical services had access to appropriate bariatric equipment as required.
- Housekeeper roles and "back of house" functions had been explored to reduce downtime and create a smoother flow of equipment and improve efficiency.

Medicines

- We found allergies were clearly documented in the prescribing document used. We checked six records at random and found all six of them to be correctly completed.
- Ward managers were aware of the local microbiology protocols for the administration of antibiotics and liaised with pharmacy prior to prescribing for MRSA and C.Diff.
- All medicines were prescribed and administered in line with the trust policy and procedures. Each ward area had dedicated pharmacists, who liaised with the ward team regularly and attended senior nursing staff monthly meetings.
- A pharmacist prescriber was based in the POD area (private bed space) for elective orthopaedic patients to complete drug history and prescribe regular medicines for elective orthopaedic patients on admission.
- Controlled Drugs (CD) checking took place on a weekly basis as per trust policy; some areas performed checks that were more regular. The pharmacy department performed quarterly audits of controlled drugs records.
- Staff working on the wards were required to attend a mandatory yearly update on storage and recording of CDs. Newly qualified staff were required to attend training and complete the e-learning safe medicate programme prior to being able to administer these drugs and were encouraged to report errors in an open and honest way.
- An area of improvement was the storage of Intravenous Therapy (IVT) on Ward 9 and this was being addressed with the installation of appropriate storage lockers.
- The pharmacy department monitored storage of medication in refrigerated units and the pharmacy technicians logged weekly temperature checks, which were all within the correct limits. The pharmacy department retained this information. However, there was no evidence of daily temperature checking.

Records

- The surgical wards completed quarterly health care record audits to check for accurate completion. Electronic management of the requesting and reporting of pathology and radiology results were through the Integrated Clinical Environment (ICE) system used within the trust. This was accessible to primary care departments for easier access to results.
- The wards and theatres had regular CQAF visits where document validation took place in accordance with current NMC guidelines. Results from T27 have shown good outcomes for record keeping in clinical care for documentation and recording.
- Fully completed records in black ink and with legible handwriting were observed on the wards. We saw junior doctors writing their notes on labels during the ward round and attaching them to patients' notes afterwards. There was concern that this may result in missing notes or errors with logging confidential information, this was addressed during inspection.
- We observed that patient records were stored securely and no patient identifiable information was visible to people attending the ward.
- We found a high standard of documentation on surgical wards with written records of pre-assessment in anaesthetic and nursing notes. The surgical wards were piloting a patient held information booklet, which contained information relating to pre-assessment, admission, and discharge.

Safeguarding

- Senior managers told us that staff aimed to safeguard adults during the patient journey as per trust policy.
- All safeguarding training was undertaken through mandatory training. We found that 82% of staff had received safeguarding adults' level one and two training against a trust target of 90%.
- The wards all had safeguarding leads with specific leads having undertaken advanced investigation training. The medical staff were aware of how to report safeguarding issues and relayed the process with confidence when asked.
- When we spoke with nursing staff, they demonstrated a good level of knowledge in relation to safeguarding triggers, forms of abuse and the processes followed.
- Matrons identified the level of staff competence when random safeguarding checks were completed. These checks included looking at records and talking to staff.

Mandatory training

- The trust performance reports for the surgical services care group showed mandatory training completion results were variable for each surgical ward.
- The standard compliance rate was 90% for each training programme. Overall, training results showed 76% of staff had received patient handling (refresher) training, 80%

had received resuscitation and the deteriorating patient training. Overall training rates were 81%. However, when records were broken down by wards, one had achieved 38% of mandatory refresher training while all other wards had achieved over 90%.
- Most staff we spoke with confirmed they were up to date with mandatory training. However, those in ward 9 felt they were behind with training due to the ward being used for escalation during particularly difficult winter pressures.
- Senior managers told us that training rates were increasing due to easier access to eLearning.

Assessing and responding to patient risk

- The trust used the National Early Warning Score (NEWS) risk assessment system and had recently implemented a new electronic method for recording and monitoring NEWS scores. This allowed staff on the ward to electronically record observations, with trigger levels to generate alerts which helped with the identification of acutely unwell patients.
- NEWS risk assessments and sepsis screening tools were used and we saw evidence of full completion. The staff members we spoke with were aware of escalation procedures.
- Patients who visited pre-assessment began the care pathway. We found evidence of comprehensive risk assessments in surgical records. Information included the completion of cognitive assessment tools, falls risk, alcohol support (visited by alcohol prevention team), pressure ulcer risk, bed rails, mouth care.
- The trust ensured compliance with the Five Steps to Safer Surgery through application of the World Health Organisation (WHO) surgical checklist. The WHO checklist audit showed note completion at 100%, sign in at 91%, time out at 99%, and sign out at 93%. We observed that theatre staff followed the 'Five Steps to Safer Surgery', and completed the World Health Organisation (WHO) checklist appropriately.
- We chose six records at random. All had fully completed WHO documentation prior to surgery. We also observed correct surgical site marking on a patient immediately prior to their surgery.
- There was 24-hour, 7 day access to therapeutic endoscopy but out of hours Interventional Radiology was more ad hoc.
- There was 3-tier surgical medical cover. Junior doctors supported by middle grade doctors or above on a 24-hour basis with immediate and reliable access to consultants. None of the doctors we spoke with expressed any concerns about the support they received or reported any difficulty in accessing advice from more senior doctors.

Nursing staffing

- The surgical wards had specific nurse staffing levels for each shift, which were agreed by the Director of Nursing on a ratio of one (nurse) to eight (patients). Where there was variation between weekday and weekend, there were scheduled differences in the elective workload. Where staffing levels were below the agreed levels, the duty matron assessed the staffing situation across the trust, and made a clinical decision about deployment of staffing resources.
- Ward establishments were under review to ensure there were the appropriate numbers of staff on each ward to meet the agreed levels. Surgical wards had 20 whole-time equivalent (WTE) nursing vacancies from their established level. The average fill rate for nursing staff on ward 9 was 104.3 % on day shift with 95.2% on night shift. Ward 14 nursing fill rate was 105.2% for day shift and 104.3% for night shift. T26 and T27 staffing levels were at 90.4% and 84.2% for day shift and 102.3% and 102.6% for night shift. Recruitment was ongoing. The trust report to the Board if the safe planned staffing fell below 75% or above 125%.
- Within surgery, in ward 9 and ward 14 in particular, there had been occasions when a one to six nursing ratio was required due to increased dependency of patients, and it was necessary to select staff from other wards to support using escalation processes.
- T26 and the Chemotherapy Day Unit showed a surplus of staffing, while the Pre-assessment Unit was short of nursing staff but had a surplus of other clinical staff to provide support.
- Theatres experienced a number of staffing challenges due to high sickness levels, staff turnover, and difficulty filling vacancies. Plans were in place to tackle sickness absence, and fill vacant posts.
- Theatre support workers were in development to address the skills gap with qualified nurses and operating department practitioners.
- Sickness levels decreased from 25% to 10% following changes to the staffing ratio of one to five instead of working at the ratio of one to eight.

- The trust did not use bank staff for substantive nursing posts and tended to use its own staff for back fill. There were no concerns raised regarding staff levels in post-anaesthesia recovery.

Surgical staffing

- Five of the eight units were short of medical staff as of March 2015. Theatres showed the greatest deficit in all staff numbers, while Ward 14 and PODS were also understaffed. This left the service 19% short of its overall staffing targets.
- There was a newly appointed trauma co-ordinator to ensure that patients had their multiple needs managed throughout the care pathway including current and future rehabilitation.
- The medical skill mix was similar to the England average at consultant level at 39% (England average 41%). Middle career (5%, England average 11%) and registrar group (31%, England average 37%), were lower than the England average and there were higher than the England average at junior doctor level at 24% (England average 12%).
- There were medical staff locums working in the surgical department. Ward managers' rostered new starters with existing staff for two weeks for induction. The trust tried to minimise the use of unfamiliar locum staff.
- We found the general and orthopaedic wards, both elective and acute had consultant led ward rounds, but the consultant led vascular ward round was undertaken weekly. Staff reported they were well supported by senior staff and did not feel practice was unsafe. All wards undertook a full morning ward round with senior staff. However, evening rounds were not as routinely undertaken.
- There was availability of 24 hour consultant led care for all surgical specialties. A middle grade doctor or above was available to see urgent patients within 30 minutes.
- Surgical assistants were introduced into theatre to bridge a gap with lack of junior medical cover and provided consistency in support of consultants while in theatre. These had been utilised in orthopaedic theatres.
- Junior doctors had dedicated morning handover times with comprehensive written handover sheets. We saw a handover which was consultant led. All acute and existing patients were discussed with results reviewed and management plans agreed.

Major incident awareness and training

- Surgical staff participated in training, to test the business continuity plans and escalation processes. The plans have also been tested 'table-top' and by telephone. The trust major incident response plan was in place and available to staff on the trust intranet.
- There were business continuity plans for surgery and senior staff explained these during a group interview. These included the risks specific to the clinical areas and the actions and resources required to support recovery.
- A trust assurance process was in place to ensure compliance with NHS England core standards for emergency preparedness, resilience, and response.
- The trust's major incident plan provided guidance on actions to be undertaken by departments and staff, who may be called upon to provide an emergency response, additional service, or special assistance to meet the demands of a major incident or emergency.

Are surgery services effective?

Good

We rated effective as good because:

Patients were treated in accordance with national guidance and enhanced recovery (fast track) pathways were used. Local policies were written in line with national guidelines. A range of standardised, documented pathways and agreed care plans were in place across surgery. Patient outcomes were better than or the same as national standards.

Nurses discussed pain relief with elective patients and provided information on the type of pain relief they could expect to receive as part of their procedure. Staff also gave information leaflets about their specific type of pain relief.

Nutritional and hydration support for surgical patients on each ward was seen as a priority. Dedicated housekeepers supported patients to consume food and fluid. They identified patients at risk of malnutrition by working with nurses, patients and their families. There was a trust-wide housekeepers meeting with the nutritional nurse specialist to share best practice and encourage standardisation across all wards.

Surgery

All cancer pathways and vascular services had multidisciplinary team (MDT) meetings, which included nurse specialists, surgeons, anaesthetists, and radiologists.

Evidence-based care and treatment

- Patient treatment was in accordance with national guidance from the National Institute of Health and Care Excellence (NICE), the Association of Anaesthetics, and The Royal College of Surgeons. We saw evidence of an appropriately written National Confidential Enquiry into Patient Outcome and Death (NCEPOD) assessment record.
- The outcome of the Bowel Cancer Audit in 2014 showed the trust was better than the England average for three measures and achieved better than average with more than 80% case ascertainment or data completeness. Likewise, the Lung Cancer Audit 2014 results were as expected in comparison to the national averages for all three measures.
- Surgical services regularly reviewed NICE guidance to ensure compliance with the latest guidance. For example, the trust stopped the use of Ostenil injections for joint and tendon pain for patients following NICE recommendations.
- The pre-assessment service followed NICE and local guidelines, with audits, which ensured compliance. Changes to practice included a pharmacy prescriber based in the pre-assessment area to prescribe drugs for orthopaedic elective patients, and patient flow pilots which included staggered admission times for elective patients.
- A range of care plans were in place across surgery. Examples of these include Enhanced Recovery for colorectal surgery; Emergency Surgical Pathway from the Emergency Admissions Unit (EAU) to wards, patient plans and evaluation used by nurses, medical staff, OTs and physiotherapists. Fractured Neck of Femur Pathways for trauma and orthopaedic wards were in use and the Hip and Knee replacement Joint Care Pathway followed the principles of Enhanced Recovery.

Mortality

- The trust's mortality steering group had regular surgical input. All surgical mortality cases were discussed at the regular Safe Care sessions when a range of medical staff were present to review the case and discuss lessons learned.
- An example of work carried out to scrutinise and improve outcomes for patients was the involvement in the National Emergency Laparotomy Audit 2014. This highlighted that mortality (13%) was significantly better than the predicted mortality rate (21%) for the patient mix. There were a number of areas for improvement, including rates of consultant review within 12 hours of admission, rates of CT scans performed and reported pre-operatively, and the percentage of patients over 70 years who received specialist elderly care input.
- A specialist nurse undertook management of mortality within the trauma and orthopaedic department with responsibility for collecting fractured neck of femur patient data. This improved the monitoring of the service and opportunity to make improvements promptly.
- According to the National Joint Registry Report covering 2014/2015 data, the trust performed well for mortality in elective hip and knee patients.

Pain Relief

- The trust was taking action to improve the acute management of pain within its services. Specialist pain nurses had delivered training to ward staff regarding pain management.
- Ward pharmacists regularly reviewed drug records for pain medication. Various pain relief methods were used for major surgery to assist with pain relief post-operatively which improved patient comfort.
- There were Patient Group Direction (written instructions for the supply or administration of medicines) for pain relief to be given as part of discharge for patients on wards.
- The introduction of an electronic observation tool provided comprehensive data on patient pain scores. There was a limited acute pain service available; the Acute Response Team provided additional support 24 hrs daily, seven days per week. There was a well-established chronic pain team and service.
- The trauma and orthopaedic rapid recovery meeting which was in place for post-operative hip and knee replacements, reviewed evidence and best practice on pain control with input from anaesthetists, pharmacists and ward nurses to optimise pain management. Only 67% of patients were meeting the trust audit standards

for pain control in recovery in June 2015. Recommendations discussed during a Safecare meeting included improving the acute pain service and re-auditing.
- A&E doctors assessed all patients with a suspected fractured neck of femur and once diagnosis was confirmed, patients were assessed for a fascia iliac block. The orthopaedic trauma coordinator carried out a monthly audit: on average approximately 50% of patients were given a block.
- Nurses within pre-assessment discussed pain relief with elective patients and provided information on the type of pain relief that patients could expect to receive as part of their procedure. Patients were given information leaflets on pain relief.

Nutrition and hydration

- Priority was given to appropriate nutritional and hydration support for surgical patients on each ward. Dedicated housekeepers supported patients to consume food and fluid. They identified patients at risk of malnutrition by working with nurses, patients and their families. There was a trust-wide housekeepers meeting with the nutritional nurse specialist to share best practice and encourage standardisation across all wards.
- Snack rounds were carried out on all surgical wards to supplement scheduled meals and ensure that patients had high calorie options throughout the day.
- The health record audit included checking whether patients received a nutritional risk assessment on admission and whether this risk assessment was reviewed within the required timescales. We observed appropriately completed fluid and nutrition balance sheets.
- The nutritional risk assessment identified the levels at which dietician referral was recommended. The dietetics service received electronic inpatient referrals and provided input to all wards as required.
- Arrangements were in place for when enteral feeding was required out of hours as part of a protocol to ensure that patients did not have to wait for a dietician to be on duty.
- Pre-assessments offered tailored nutrition and hydration guidance to patients and provided all elective patients with fasting instructions to follow on the day of their surgery.

Patient outcomes

- The trust relative readmission rates for elective surgical patients for general surgery were 115, which was worse than the England average of 100. Trauma and orthopaedics were also worse at 127. However, urology readmission rates were better at 66. For non-elective surgical patients the standardised relative readmission rates were worse than the England average for general surgery (122), trauma and orthopaedics (135) and vascular surgery (159).
- The National Bowel Cancer Audit (2014) showed better than England average results for all indicators. The clinical nurse specialist involvement was 97.8%, against the England average of 88%, discussion at multi-disciplinary team was 100%, England average 99.1% and scans undertaken were 97.2% with the England average being 89.3%. We found that 52.8% of patients undergoing major surgery stayed in the hospital for an average of more than five days (better than the England average of 69.1%).
- The Lung Cancer Audit 2014 results showed the percentage of patients receiving surgery (13.8%) was less than the England average (15.1%). The audit showed results similar to the England average for multi-disciplinary team discussion (94.9%, England average 95.6%) and better results for scans undertaken before bronchoscopy (95.8%, England average 91.2%).
- The trust participated in the National Hip Fracture Audit. Findings from the 2014 report showed the hospital was better than the national average in many areas. Examples were patients being admitted to an orthopaedic ward within four hours (72.1%, national average 48.3%), falls assessment (100%, national average 96.8%), bone health medication assessment (99.2%, national average 97.3%) and surgery on the day of or after day of admission (88.5%, national average 73.8%).
- The Hip Fracture Audit 2013/14 highlighted that the trust scored better than the England average for nine of ten measures. However, a higher percentage of patients developed pressure ulcers. Following an RCA and the implementation of actions plans, the level of hospital acquired pressure ulcers halved by 50% in 2014/2015.

- We found the National Emergency Laparotomy Organisational Audit 2014 showed 8 out of 28 measures were not available. For the 2015 patient audit results, the trust scored amber/red against five of 11 measures and action plans were observed which addressed this.
- The Joint Care Pathway audit took place every two to three months in a multi-disciplinary setting, and both monitored and improved the pathway. The trauma coordinator maintained the fractured neck of femur database. The joint care coordinator collated information on the quality of hernia repairs, varicose vein surgery, hip replacements, and knee replacements and reviewed results to trigger actions for improvement.
- Patient reported outcome measures (PROMs) matched national improvement levels and had a comparable proportion of patients to the England average. The trust have made changes to reduce the time patients were followed up for precautions from 12 weeks to 6 weeks and discussed improvements in post-operative analgesia; reduction in the time tourniquet was used in theatre and thrombo embolic guidelines.

Competent staff

- Records showed 83% of staff within the surgical services department had an up to date appraisal against target rates of 100%. We saw evidence to confirm appraisal rate data.
- There was training for scrub staff in theatre to increase knowledge and skills with orthopaedic trauma and elective equipment. Other training delivered in areas was laparoscopic ports and handles, versapoint equipment; a system for intrauterine surgery and the pin point system to offer clear definition of tumour margins.
- The corporate induction, moving and handling training, violence and aggression level one and two training courses achieved 100% attendance.
- Staff we spoke with felt able to discuss their training needs with their line manager. Many discussed opportunities to further their career and stated they were encouraged to undertake external university modules appropriate to their training needs.
- Trust wide roadshows provided support for revalidation by identifying expectations and continued education required for revalidation.
- The trust sponsored four, band two level nurses to gain their foundation degree due to a national shortage of scrub nurses.
- The trust provided an HCA training programme, which covered basic English, Maths, and National Vocational Qualifications at levels one and two.

Multidisciplinary working

- There were established multi-disciplinary team (MDT) meetings for all cancer pathways plus vascular services. These MDTs included nurse specialists, surgeons, anaesthetists, and radiologists. We were told that MDT self-assessments for peer review demonstrated the benefits of the multi-disciplinary approach and promoted decision-making.
- The Colorectal Enhanced Recovery Programme clinic operated weekly for patients requiring major bowel surgery, with multidisciplinary input from pre-assessment nurses, colorectal nurse specialists, physiotherapists, dieticians and consultant anaesthetists. Complex patients were booked for cardiopulmonary exercise testing to assess risk prior to surgery.
- The trauma and orthopaedic department worked closely with a range of disciplines to maximise outcomes for patients. MDT ward rounds took place including physiotherapy, and occupational therapy input alongside the surgeon. Three ortho-geriatricians provided ward cover on the trauma and orthopaedic wards.
- Ward staff worked closely with the local authority when planning discharge of complex patients and when raising safeguarding alerts.

Seven-day services

- Daily ward rounds took place for all patients and patients were seen on admission at weekends.
- Access to physiotherapy, occupational therapy, and diagnostic services were available seven days a week.
- Pharmacy staff were available on site during the week and there was an on call pharmacist available out of hours.
- The trauma and orthopaedics directorate delivered a consultant led trauma service. Elective activity was not carried out when consultants were covering trauma services and cases were discussed at the handover meeting every morning.

- Orthopaedic consultants had access to trauma lists 5.5 days per week, but there was no dedicated trauma list Saturday afternoon or all day Sunday. We found that trauma was required to share the emergency list with other specialities at these times.
- The general surgery and urology directorate delivered a consultant led seven-day emergency surgical service.
- We found that consultants visited over the weekend and cover was provided by experienced junior medical staff out of hours.

Access to information

- Risk assessments, care plans, and test results were completed at appropriate times during the patient's care and treatment. Records were available to staff enabling effective care and treatment.
- There were appropriate and effective systems in place to ensure patient information was co-ordinated between systems and accessible to staff.
- Staff had access to policies, procedures and guidelines on the trust intranet system. All staff felt confident in accessing the information they required.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- We looked at clinical records and observed that patients had consented to surgery in line with the trust policy and Department of Health guidelines.
- Mental capacity assessments were undertaken by the consultant responsible for the patient's care and Deprivation of Liberty Safeguards (DoLS) were referred to the trust's safeguarding team.
- Consent, Mental Capacity Act (MCA) and Deprivation of Liberty Safeguards (DoLS) training was delivered as part of staff induction. The development of Advanced Nurse Practitioners had enabled patients to consent in a timely manner. MCA and DoLS assessments were included in risk assessments.
- We found policy and procedures in place, ensured that capacity assessments and consent was obtained by middle grade level staff or above. Elective patients were informed about consent as part of their pre-assessment process and were given information regarding risks and potential complications.
- All staff received consent training as part of their induction and this was supplemented by dementia training, which 82% of nursing staff on each ward had attended. Surgical wards were taking part in the CQC National Audit of Dementia.
- There was access to an independent mental capacity advocate (IMCA) when best interest decision meetings were required.

Are surgery services caring?

Good

We rated caring as good because:

We observed the treatment of patients to be compassionate, dignified, and respectful throughout our inspection. Ward managers and matrons were available on the wards so that relatives and patients could speak with them as necessary. We saw patient information logbooks, leaflets, and posters available for patients that explained their procedure and after care arrangements.

Patients and relatives said they felt involved in their care and they had the opportunity to speak with the consultant looking after them. Patients told us staff kept them well informed and explained the reason for tests and scans. Patient and family feedback was very complementary.

Compassionate care

- The NHS Friends and Family Test (FFT) showed a response rate of 34.1% which was slightly worse than the England average of 37.4%. Between 83% and 100% of patients would recommend the service to their family or friends.
- The National Cancer Experience Survey 2014 ranked the trust as the second best in the country for overall experience of cancer care. The investment of Cancer Nurse Specialist roles ensured all cancer patients had a named keyworker to whom they had easy access at any point in their treatment journey.
- A patient from a Jewish community stated his "beliefs and religious needs had been respected and understood".
- Each patient felt their privacy and dignity had been respected and they were happy with the quality of care they had received.

Surgery

Understanding and involvement of patients and those close to them

- All patients said they were made fully aware of their surgical procedure and that it had been explained to them thoroughly and clearly. Patients and relatives said they felt involved in their care and had been given the opportunity to speak with the consultant looking after them.
- Patients told us staff kept them well informed, explained why tests and scans were being carried out and did their best to keep patients reassured.
- We saw ward managers and matrons were visible on the wards so that relatives and patients could speak with them.
- Friends and relatives were welcome to attend the orthopaedic Joint Care Clinic with patients if they required support. As part of the elective surgery pre-assessment process, patients had the opportunity to bring relatives or friends along to the consultation should they so wish.
- Patients we spoke with were complementary of the patient information booklets given prior to surgery. Patients felt they were better educated, supported, and prepared for their surgical procedures.

Emotional support

- A multi-faith 24-hour chaplaincy service was available.
- Clinical psychology support services commissioned by the trust supported patients on pathways, including breast cancer services and the chronic pain service.
- The urology and breast cancer nursing teams provided support for psychosexual issues arising out of cancer diagnoses and treatment.
- The urology team brought together over 50 prostate cancer patients for an evaluated conference to discuss the challenges of living with or after prostate cancer.
- The Stomates Support Group provided peer support and advice in a supportive and safe environment.
- We found that all patients discharged from T26 were signposted to a monthly arthritis care group (Arthritis UK). The ward manager and the joint care coordinator attended most meetings to answer questions and offer support. There were plans to signpost patients to this group using the ThinkSAFE logbook.

Are surgery services responsive?

Good

We rated responsive as good because:

The hospital had an escalation policy and procedure to deal with busy times and matrons and ward managers held capacity bed meetings to monitor bed availability.

The Emergency Admissions Unit provided a rapid assessment of patients through identified care pathways. The service was responsive to the needs of patients living with dementia and learning disabilities. All wards had dementia champions. There was access to an independent mental capacity advocate (IMCA) for when best interest decision meetings were required.

Patients were treated based on national guidance and enhanced recovery (fast track) pathways were used. Therapists worked closely with the nursing teams on the wards and staff told us they had good access to physiotherapists, occupational therapists, and speech and language therapists.

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

Service planning and delivery to meet the needs of local people

- The trust was actively working with commissioners to provide an appropriate level of service based on demand, complexity and commissioning requirements. This included changes to vascular and urology activity.
- To ensure services were cost effective theatres barcoded items used in theatre and identified areas of waste.
- Satellite clinics operated from Blaydon, Riverside, and Washington to enable closer to home access to services for patients.
- The joint care clinic was attended by a multidisciplinary team, which included physiotherapists, OTs, consultants, and the joint care coordinator to provide a 'one-stop' clinic.
- There were drop-in clinics available for Gynae-Oncology patients to allow their pre-assessment to take place immediately after their outpatient consultation.
- The trust worked in partnership with other trusts to improve financial sustainability.

Surgery

Access and flow

- Individual theatre usage was consistent across quarter three. Two theatres had remained consistently above 90% usage and one theatre had operated at this capacity for two out of three months. One other theatre and the maternity theatre had seen consistently low usage throughout the same period. Overall, theatres showed effective utilisation as five of the 11 theatres were above 80% usage for June 2015.
- Cancelled operations not rebooked within 28 days, was zero at all times until January 2015. Between January and March 2015 there were 16 operations cancelled and those patients were not treated within 28 days.
- The majority of cancellations on the day were due to clinical reasons with patients being medically unfit for a surgical procedure. A total of 543 cancellations were made in relation to general surgery and Trauma and Orthopaedic surgery from May 2014 to April 2015. For example 121 were due to ward bed unavailability, 113 due to list over runs, 178 due to operations no longer being necessary and 192 patients were medically unfit for surgery.
- Orthopaedics employed visiting surgeons to help manage the high demand. A foot and ankle surgeon would commence with the trust in January 2016 and recruitment was underway for an additional upper GI surgeon to reduce waiting times.
- Pre-assessment of elective patients was organised to take place as early as possible in the elective pathway once patients were added to the waiting list.
- At an operational level, flow was maximised through theatres by employing a range of strategies. The POD area had staggered admissions times, with morning and afternoon admission times to prevent patients waiting longer than necessary.
- The orthopaedic service operated electively up to six days of the week. Elective admissions were planned based on consultant availability and complexity of the procedures. We found the trust operated on less complex cases on a Friday and Saturday due to reduced medical cover over the weekend. This was on the surgery risk register.
- The elective ward had daily consultant led ward rounds, Monday to Friday. Work was ongoing to review the options available to the department to enhance the care provided to patients and to increase flexibility with theatre lists.
- Two emergency nurse surgical practitioners were in post and were responsible for supporting junior doctors to review surgical patients in the emergency assessment unit (EAU). This was to ensure that diagnostics were ordered and decisions to admit made promptly.
- A cancer tracking team monitored progress of all diagnosed patients until their treatment started. This ensured cancer patients received the most rapid treatment in line with national standards. Root cause analyses of breaches demonstrated that timely access and reporting of colonoscopy investigations had been challenging for the trust. A test scheme for colorectal cancer referrals had commenced.
- The trust followed a transfer policy regarding the movement of patients onto orthopaedic elective wards. This policy was in place to minimise the risk to elective patients post-surgery, to identify appropriate patients to reside from medical wards, and to separate elective and trauma patients.
- The current length of stay for trauma, orthopaedic and general surgery patients was in line with the national average.
- Discharge planning began at the pre-assessment stage. The trust set a planned date of discharge as soon as possible after admission. Surgical wards worked with the discharge liaison team to reduce delays in handing over care to social services or nursing home providers for those patients with complex needs.
- A newly created theatre matron post helped facilitate the theatre agenda to improve flow of theatre schedules.
- The trust tried to ensure that one bed was available for emergency orthopaedics. These beds were not ring fenced and would be used if required in times of pressure.

Meeting people's individual needs

- Surgical teams' personalised patient care in line with patient preferences, individual and cultural needs.
- Interpreting services were available for patients whose first language was not English.
- The surgical unit worked closely with the learning disability nurse specialist and applied the 'This is me' personal patient passport / health record to support patients with learning needs.

- Whiteboards behind patient bed areas identified special requirements such as falls risk and dietary needs. Blue wristbands and forget-me-not personal information booklets were used for patients with dementia, and Barbara's story training was in place for all staff
- There were close links between specialist nurses, such as vascular nurse specialists, colorectal nurses, breast care nurses, dieticians, Parkinson' nurse specialists, pain nurse specialists, psychiatric liaison and tissue viability nurses.
- T26 provided accommodation for families of patients with learning disabilities. This enabled them to support their family member when required.
- Ward information boards identified who was in charge of wards for any given shift and who to contact if there were any problems.
- We found that two cubicles in the day surgery unit could be adapted to meet the needs of children or dementia patients. The walls had metallic paint enabling décor to be change to meet the needs of the patient for examples poster and signage.
- We found the use of private rooms for patients with specific needs was available. The Peter Smith Surgery Centre Wards had 60 ensuite single beds and individual pre-assessment clinic rooms, which provided privacy and dignity.
- Leaflets were available for patients regarding their surgical procedure, pain relief and anaesthetic. Alternative languages and formats were available on request.
- Ward managers were clear about zero tolerance for discrimination. There was a large Jewish community accessing the trust. Support for Jewish patients included no limit on visitor numbers or visiting times, access to special diet, religious material, and specific cutlery.
- There was good access to the treatment centre and wards. There were lifts available in each area and ample space for wheelchairs or walking aids. The Peter Smith Surgical Centre had comfortable chairs, sofas, cafe and a patio area available for patients and visitors.
- There were no mixed sex accommodation breaches between August 2014 and August 2015.
- Orthopaedic outpatient clinics were supported by a senior physiotherapist who provided patients with a holistic consultation and had 'one-stop' access to multiple professionals.

Learning from complaints and concerns

- Complaints investigations were carried out through engagement with all those involved and statements were obtained from clinicians where required. Discussions were held at Safe Care meetings to encourage learning and prevent recurrence.
- Consultants used complaints data as part of the medical revalidation process with the trust medical director. We were advised consultants were required to provide evidence that they had reflected on the complaint and put actions in place when required. Ward meetings discussed complaints received as a standing agenda item.
- Complaints were handled in line with the trust policy.
- Patients or relatives making an informal complaint were able to speak to individual members of staff or the ward manager. Themes of complaints were presented at Safecare sessions, with discussion encouraged to share learning and to prevent recurrence.
- In light of the complaints and concerns received across surgery, the trust made changes to practice including: introduction of a cancellation letter; changing a red-flag notification system so consultants received further prompting of un-actioned red flag radiology results; change in documentation made in trauma so that reasons were captured to explain why a patient was allocated to a particular trauma list.
- Ward 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.
- The Independent Complaints Advocacy Services (ICAS) contact details were visible on the ward and throughout the hospital for patients or relatives who needed help with making a complaint.

Are surgery services well-led?

Good

We rated well-led as good because:

Senior Managers had a clear vision and five year plan for the surgical business unit. Staff were able to repeat and discuss its meaning. Joint clinical governance and

directorate meetings were held each month. The directorate risk register was updated following these meetings and we saw that action plans were monitored across the division.

Staff said speciality managers were available, visible, and approachable. They also said leadership of the service and staff morale were good with staff supported at ward level. Staff spoke positively about the service they provided for patients and emphasised quality and patient experience.

Staff on the wards and in theatres worked well together with respect between specialities and across disciplines. We saw examples of good team working on the wards between staff of different disciplines and grades.

Vision and strategy for this service

- There was a draft strategy in place which was waiting ratification. This trust wide strategy included the surgical business unit strategy. General surgery, anaesthetics, pre-assessment, trauma, and orthopaedics began work on their specialty strategies and sharing these at senior staff conferences.
- We met with senior managers who had a clear vision and five-year plan for the surgical business unit. The trust vision was embedded with staff, they were able to articulate to us the trust's values, and the vision was clearly displayed in ward areas.
- The associate director (AD) for surgical services maintained the annual plan for the business unit through discussion with the clinical head of surgery, clinical leads, and the service line managers.
- The trust five-year plan aligned work programmes with the surgical unit plans including expanding services to attract patients from across the North East region to the trust for elective orthopaedic procedures.
- The one-year plan for general surgery included becoming the Breast Centre for South of Tyne & Wear, taking on work previously carried out by other hospitals.
- The one-year plan for theatres included upgrading of theatre 7 to provide further dedicated laparoscopic facilities and the embedding of parallel listing (double table model) and "superlisting".

Governance, risk management and quality measurement

- The risk register for the business unit was updated frequently, with high risks reviewed with input from medical staff, ward staff, and senior management. The associate director met monthly with matrons, service line managers, and the risk manager to review incidents, which had occurred, and any wider risks identified.
- All senior staff in the service including the associate director, clinical leads, service line managers, matrons, and band 7's monitored performance and quality information. Measures included finance, complaints, mortality, and morbidity, cancelled operations, the quality dashboard metrics, capacity and demand information and waiting time performance.
- The trauma and orthopaedic Safe Care event were used as an avenue to discuss any arising governance, safety issues and provided a forum for lessons learned.
- The matrons conducted weekly walkabouts of the ward areas with service line managers and the associate director to measure quality.
- There was a regular performance meeting with the deputy chief executive and director of strategy and transformation. This was facilitated to challenge the quality of the surgical business unit.

Leadership of service

- The associate director and clinical head of surgery led the surgical business unit. The business unit comprised of three service line managers and three clinical leads (for orthopaedics, general surgery, and anaesthetics). Three modern matrons led, managed and supported the ward managers.
- The staff in the business unit were clear about their roles, responsibilities, and accountability. Reinforcement of this was through annual personal development plans, bi-annual reviews, one to one sessions, preceptorship, mentorship, clinical supervision, and annual mandatory training.
- The matrons attended a regular matron forum with all of the trust matrons and the deputy director of nursing. We found the band 7 ward managers had their own regular forum, as did the service line managers.
- The associate director, service line managers, clinical leads and matrons in the Business Unit had completed a range of leadership qualifications which included the NHS North East Leadership Academy (NELA) courses which involved sharing information and learning with colleagues from other trusts.

Culture within the service

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

Public and Staff engagement

- Each ward area held monthly staff meetings, which discussed key issues for continuous service development. We were advised that this forum promoted the culture of openness, support, and inclusiveness for all its team members.
- Theatres had a monthly meeting attended by the associate director, service line manager, and consultants. The service line manager, band 6 and 7 theatre staff along with nominated staff representatives from orthopaedics, anaesthetics, and recovery, attended 'The Voice' meeting held fortnightly.
- There was a bi-monthly 'theatre user' group meeting, which was attended by several staff groups as well as a public governor.
- We found the trust had recently held a musculoskeletal patient engagement event where approximately 40 patients attended and provided feedback on the current service.
- The colorectal, breast, and orthopaedic nurse practitioners held regular meetings with patients to obtain their feedback.
- The National Staff Survey of 2014 showed the overall staff engagement score was in line with the national average.

Innovation, improvement and sustainability

- Recent service improvement included frequent reviews in theatres by all surgeons to reduce the volume of equipment needed and turnaround times. Scheduling issues were being addressed to help smooth the flow of patients through theatre and levels of workload, thereby decreasing over runs and allowing more realistic theatre utilisation and productivity.
- A pharmacy prescriber based in the POD area prescribed drugs for orthopaedic elective patients. .
- There had been recent investment in new theatre kit such as camera stacks.
- An award in orthopaedics for a review of the procurement of implants which led to a significant cost reduction and a service improvement award.
- A dedicated logistics team optimised flow using 'Just in Time' processes to aid the smooth running of theatres.
- The trust informed us they had expanded cardio pulmonary exercise testing to more clinically indicated groups of patient.

Critical care

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

Information about the service

Critical care, sometimes known as intensive care, is care for patients whose conditions are life-threatening and need constant, close monitoring and support from equipment and medication to keep normal body functions going. Services providing critical care have higher levels of staffing, and specialist monitoring and treatment equipment only available in these areas, and the staff are highly trained in caring for the most severely ill patients.

The critical care department (CCD) for Gateshead Health NHS Foundation Trust was at the Queen Elizabeth Hospital. The service was funded to provide care for six level three patients (most dependent patients) and six level two patients (those needing high levels of observation and care). Beds were used flexibly according to the needs of patients. Funding had been secured to allow expansion of capacity to manage a further two level two patients.

The CCD operated within the surgical business service line and in the trauma and orthopaedics/anaesthetics unit.

During the inspection, we visited the CCD and spoke with three patients and five relatives. We spoke with 25 staff, including the clinical lead, doctors, matron, sisters, staff nurses, health care assistants, domestic, dietician and a housekeeper.

We reviewed five care records. We attended a midday 'huddle' and discussed the content and decision-making within the nursing and medical handover. We observed a ward round to find out how information was shared with staff.

Summary of findings

We rated the CCD as good for being safe, effective, responsive and well led, and outstanding for being caring because:

Details of incidents or harm or risk of harm and the lessons learned from investigating them were shared with staff and action was taken to prevent or minimise the occurrence of similar incidents. Staff managed risks positively and proactively to minimise harm and maintain safety. CCD was visibly clean however there were some areas where infection prevention could be better. Equipment was maintained and the environment had sufficient storage and the ability to flex in the use of beds. The department had systems that demonstrated compliance with the Medicines Act 1968 and the Misuse of Drugs Act 1971.

Staff attended induction training to learn about the organisation and mandatory training to ensure they had the skills needed for their jobs. All senior medical staff received annual appraisal and five yearly revalidation, which ensured that they followed good medical practice, as described by the General Medical Council. Patients had timely access to consultant anaesthetists, surgeons and medical input. An acute response team provided critical care support to patients on the general wards. Cover was provided 24 hours a day, seven days a week.

The Core Standards for Intensive Care Units 2013 were followed to determine the number of nursing staff

Critical care

needed for each patient; this included the requirement to have one nurse to care for two patients for level two patients and one nurse to care for one patient for level three patients. The consultant-to-patient ratio was in line with national recommendations. The service followed processes for implementing and monitoring the use of evidence-based guidelines and standards to meet patients' care needs.

The department provided rehabilitation after a critical illness (RaCI), which demonstrated an effective pathway for patients' transition from the CCD to ward-based care and support following discharge.

Data from the Intensive Care National Research Centre (ICNARC) between January 2015 and March 2015 demonstrated that the unit was within statistically acceptable limits for hospital mortality and within the limits for unplanned re-admission within 48 hours when compared to national and peer average.

Staff respected patients' privacy and dignity and treated them with understanding and compassion. Patients and relatives spoke highly about the care they had received. Services were planned and delivered in a way that met the needs of the local population. The importance of flexibility, choice and continuity of care was reflected in the services.

CCD was responsive to patients with complex needs, such as dementia and learning disabilities.

Critical care services were well led. A critical care strategy document outlined the services vision. Staff spoke positively about the culture and the service they provided for patients. Quality and good patient experience and care were seen as a priority and everyone's responsibility. There was a strong cohesive team approach and a low number of complaints.

Are critical care services safe?

Good

Details of incidents of harm or risk of harm and the lessons learned from investigating them were shared with staff and action was taken to prevent or minimise the risk of similar incidents. Openness and transparency about safety was encouraged. Staff understood their responsibilities to raise concerns and report incidents and near misses. Records confirmed that patients' care needs were assessed and care was delivered in a way that protected patients' rights and maintained their dignity. Staff managed risks positively and proactively to minimise harm and maintain safety.

The safety thermometer results showed a good record of accomplishment. Overall, the department was visibly clean but in some areas infection prevention could be improved. Equipment was well maintained and the environment had sufficient storage. Staff could use beds flexibly for level two or level one patients as the unit had two extra fully equipped bed spaces.

Staff followed medicines management systems. Patients' healthcare records were stored in a secure way that promoted confidentiality.

Staff attended induction training to learn about the organisation and mandatory training to ensure they had the skills needed for their jobs.

Patients had timely access to a consultant anaesthetist, surgeons and medical input. An acute response team provided critical care support to patients on the general wards. Cover was provided 24 hours a day, seven days a week.

The service followed the Core Standards for Intensive Care Units 2013 to determine the number of nursing staff needed for each patient. This included the requirement to have one to two care for level two patients and one-to-one care for level three patients. The consultant to patient ratio was 2 consultants to 12 patients during the day and 1 to 12 overnight and at weekends. This was in accordance with national recommendations of 1 to 14.

Incidents

Critical care

- The service had a strong culture of reporting incidents, harm, or risk of harm and learning from incidents. Staff used an electronic system to report incidents, which were sent automatically to the unit manager.
- Between January 2015 and July 2015 critical care did not report any never events, which are defined as serious, largely preventable patient safety incidents that should not occur if the available preventative measures have been implemented.
- There were two serious incidents between July 2013 and August 2015. Staff said all serious incidents were investigated. We reviewed a detailed root cause analysis of one of the incidents. Lessons learnt were shared with staff and an action plan implemented. Investigation into the second incident was continuing. Changes in practice included bowel management checklists completed prior to using the bowel system equipment. There were no previous serious incidents recorded before 2013.
- Pressure ulcers were the most commonly reported incident. There were 34 grade one and 19 grade two pressure ulcers reported between April 2014 and July 2015. To minimise the risk of pressure ulcers, the senior nurse who was lead for the unit on pressure ulcers attended the root cause analysis meeting. The lead also attended work stream meetings with the North of England Critical Care Network, contributing to regional action plans for prevention of pressure damage and the pressure ulcer group.
- Pressure ulcer incidents had improved since January 2015; there had been no reported incidents above grade 2 damage since April 2014.
- Staff told us they received feedback following investigations of incidents of harm or risk of harm. The service used different communication channels to share information, such as team meetings, the midday "huddle", band 7 forums, the anaesthetic and critical care safe care events (clinical governance meetings) and monthly infection prevention together with control surveillance meetings. We saw minutes of these and observed the staff communication system at the midday "huddle", where the nurse coordinator with all staff discussed learning from incidents in attendance.
- Equipment failure was a recognised risk. There had being two incidents where air mattresses kept inflated by pumps were reported as suddenly and unexpectedly deflating. This was reported to the Medicines and Healthcare Products Regulatory Agency (MHRA).
- Some 88% of staff had completed mandatory training for risk management and incident reporting, compared with a trust target of 90%.
- We saw minutes of a monthly morbidity and mortality steering group meeting. However, we did not see any evidence of meetings that involved a multidisciplinary approach and a critical analysis of the information to find out if the incidents could have been prevented or managed differently.
- Staff told us they were aware of the statutory duty of candour, which sets out key principles, including a general duty on the organisation to act in an open and transparent way in relation to care provided to patients. This means that as soon as reasonably practicable after a notifiable patient safety incident occurs, staff should tell the patient (or their representative) about it in person. The department had a system to ensure patients were informed when something went wrong, given an apology and informed of any actions taken as a result. The service's incident forms had a section for the ward manager to complete regarding the duty of candour. We saw examples of a root cause analysis were the consultant spoke with the patient and his relatives and made them aware of the incident as soon as it was detected. The surgical risk manager had spoken with the patient and explained what a root cause analysis involved and the patient received a summary of the meeting as part of the duty of candour.

Safety thermometer

- The NHS Safety Thermometer information was clearly displayed in the main corridor to the unit The NHS Safety Thermometer is an improvement tool for measuring, monitoring and analysing patient harms and harm-free care. Staff were aware of this information. The safety thermometer results for August 2015 showed 100% harm-free care.
- Safety Thermometer information included information about all new harms, new pressure ulcers, Methicillin-Resistant Staphylococcus Aureus (MRSA) and Clostridium difficile (C.difficile) infection rates.
- Between August 2014 and August 2015 there were no reported catheter acquired infections, no reported falls, one venous thromboembolism and five category 2 pressure ulcers.

Cleanliness, infection control and hygiene

- The unit was visibly clean and tidy and we saw cleaning in progress during the visit.
- Needle sharp bins in the areas were no more than ¾ full and all the bins we looked at were dated and signed by a member of staff in line with policy.
- We saw evidence that sinks and showers should be flushed daily to avoid a build-up of pseudomonas and legionella which is a waterborne bacteria; a known infection hazard. This was the responsibility of a housekeeper. However, the daily check list had regular gaps were flushing had not occurred and on one occasion this had not taken place for four consecutive days due to a housekeeper not being on duty. The ward manager had informed us that a health care assistant should do the checks if a housekeeper was not on duty.
- The kitchen used to prepare patients' drinks and food had laminate chipped off the sides of the cupboards and there was no dishwasher available to wash crockery used by patients.
- A monthly audit for checking the cleanliness of equipment was viewed; the results between April 2014 and July 2015 demonstrated 100% of the equipment was clean.
- We saw the results of the monthly cleaning audit for July 2015. This checked all cleaning areas which the domestics were responsible for cleaning. The results showed an overall score of 97.75%, nursing and estates equipment scored 100%. The chipped laminate on the sides of the cupboards had not been addressed during this audit.
- The Infection Prevention and Control Nurse (IPCN) for the trust carried out a monthly audit within the department. Written feedback and an action plan identified areas for improvement. We viewed the last 3 months audits. The results were 100% in most areas audited. The actions and recommendations were to ensure all equipment was cleaned daily as part of the daily regime and after use.
- All uniform, hand hygiene, intravenous cannula management, indwelling catheter management and diarrhoea management scored 100% for the 3 months.
- Hand hygiene was audited on a monthly basis; the results were 100% compliance between July 2014 and July 2015.
- A cleaning checklist which indicated cleaning should be done on the day and night shift was in each patient cubicle. When we checked two of the checklists we found that 8 out of 20 shifts cleaning was done in one of the cubicles and 10 out of 20 shifts cleaning was done in another cubicle. Our findings of high level dust and the checklist would indicate evidence that cleaning could be improved.
- Infection prevention control was included in the mandatory training for staff. 80% of staff were up to date against a trust target of 90%.
- The ward manager informed us all patients are screened for MRSA and pseudonomous on admission to CCD, once weekly whilst in the department and immediately prior to discharge. However, evidence that the screening was 100% was not audited.
- There were no incidents of MRSA bacteraemia from June 2014 to June 2015. There had been one department acquired C.Diff infection. This case was deemed unavoidable at the trust root cause analysis meeting and was successfully appealed at the clinical commissioning group healthcare acquired infection meetings.
- CCD measured the incidence of indwelling catheter infections monthly. From July 2014 to July 2015 they scored 100% other than in January 2015 when they scored 75%, April 2015 they scored 75% and June 2015 they scored 92%.
- Intravenous cannula infections were measured. They scored 100% for 9 months between July 2014 and July 2015. In August 2014, January 2015 and May 2015 they scored 88%.
- The management of the policy regarding the management of patients with diarrhoea scored 100% from July 2014 to July 2015.

Environment and equipment

- Level three patients were nursed predominately at one side of the department and the level two patients at the opposite side. However the beds were used flexibly depending on the patients' needs.
- The layout had cubicles with curtains at the end of the bed. There was appropriate screening between beds to maintain patients' privacy.
- The environment and equipment were in a good state. There was adequate equipment to ensure safe care.
- There was a programme in place for the routine replacement of equipment due to ageing, at the time of inspection a replacement for one of ventilators had been acquired.
- There was a lack of natural daylight in the CCD which could contribute to patients unable to orientate

themselves of the time and place. This was acknowledged and an attempt to improve the light quality by replacing some of the bulbs with ones that provide a better quality light was made.

- There were two resuscitation trolleys, which were kept within easy reach of staff in the unit. We noted throughout 2015 and up to our inspection in September 2015 each day the resuscitation equipment had been checked and signed by staff. However, this was done once per day and the checklist indicated it should be checked twice a day. One trolley had paint chipped off the side and we were informed the department was awaiting a replacement trolley.
- There was a "Difficult Airway Trolley" which we were told was identical to one in the theatre suite and one in the Accident and Emergency Department, to allow staff to become familiar with its placement of its contents. This was checked daily.
- The department had access to a hoist to help lift patients within the bathroom and there was ceiling tracking at each bed to hoist patients. If necessary, a bed was requested from the ward or a bariatric trolley could be hired, from an outside company. Bariatric chairs were available on request from the equipment store.
- There were adequate stocks of equipment and we saw evidence of appropriate stock rotation. Storage of equipment was appropriate, as two formerly used cubicles, provided ample storage facilities.
- Commodes had 'clean' labels attached documenting the time and date when they were last cleaned, which meant staff could be assured equipment they used was clean. No other equipment had clean labels on them.
- In-service testing of electrical equipment (portable appliance or PAT inspection) had been carried out in the department. 'PAT tested' labels on electrical equipment confirmed this.
- Nursing staff told us that staff received the necessary training to ensure they were able to use different types of equipment available in the department. The training was supported by the medical devices lead, this included competency based assessments, which gave assurance that all staff complied with recommended standards relating to safety as set out in the policy.

Medicines

- Staff followed systems that demonstrated compliance with the Medicines Act 1968 and the Misuse of Drugs Act 1971.
- Patient medications were stored in a locked cabinet within their cubicle. The nurse looking after that patient had the key.
- Ward stock medication was stored in a locked room which required a trust identification card to gain access.
- Controlled drugs were stored securely and separately and suitable records were kept. Controlled drugs are medicines that require extra checks and special storage arrangements because of their potential misuse.
- Controlled drugs were checked on a daily basis and a full controlled drug check was undertaken by the pharmacist and nurse in charge on a quarterly basis. We viewed the results which had demonstrated some missing signatures. We checked the controlled drug register and the controlled drugs checking book and found no omissions.
- The storage of medical gases was appropriate.
- The medicine fridge temperature was checked and recorded daily. We checked the records between the 4th August 2015 and 28th September 2015 and found there were no omissions. The medicine fridge was locked and secure.
- The pharmacist attended the ward on a daily basis and obtained a medication history, completed the medicines reconciliation for all new patients and reviewed each drug chart to ensure the appropriate prescribing of medication. The pharmacist told us that they had been involved in the development of in–house guidelines such as the intravenous administration guideline and monitoring of expenditure on medications. Examples were given of how expenditure on drugs had resulted in a cost saving, these included using new anti-fungal prescription guidelines following an audit. The antifungal policy had changed as a result.
- The antimicrobial pharmacist informed us that the CCD received daily input from a microbiologist during ward rounds including weekends. During the ward round patients were reviewed for all aspects of antimicrobial stewardship.
- The department had 29 medication errors from June 2014 and June 2015. These ranged from one to five per month. During the inspection, we viewed a file, which

contained details of the medication errors, the investigation, lessons learnt and a management plan. We saw two nurses checking the infusions at the bedside to reduce errors.
- We reviewed five patients' records, including drug prescription charts; there were no errors noted relating to medicine management. When a medication was omitted a reason for the omission was clearly documented.
- Medications were administered appropriately and at the appropriate time with staff administrating medication in a person centred way. We observed appropriate checks being carried out.
- Intravenous drugs were administered and checked by two nurses and nurses were able to 'talk us through' the correct procedures for administering oral, intramuscular and intravenous drugs.
- Nursing staff informed us that they were required to complete a medication management workbook, which involved competency based assessments. These needed to be signed off as competent before staff were allowed to administer medications to patients.

Records

- Patients' healthcare records were stored in a secure way that promoted confidentiality. Records relating to the patient's current clinical stay on CCD were kept in a lever arch file alongside the patient's medical records in a drawer close to the patient's bedside. All notes were hand written and there was an admission booklet and daily assessment document.
- A risk assessment booklet was completed for each patient, which included risk assessments for falls, nutrition, alcohol consumption, MRSA, bedrails, pressure ulcers and manual handling.
- Documentation included sections for the daily assessment of venous thromboembolism risk and a section to document the patients' capacity for decision making and requirement for declaration of liberty assessment.
- Nursing, physiotherapy and dietician documentation were all kept in the same lever arch file with the medical records.
- We reviewed five sets of records in detail and overall, observations and assessments were consistently recorded and appropriate risk judgements were made in terms of frequency of observations
- An admission document was completed by a junior doctor and verified by a consultant. There was a daily assessment sheet for doctors to complete and an additional sheet for extra notes and other visits.
- Records were legible and filed in chronological order, demonstrating a systematic approach to managing patient information.
- Overall, staff were happy with the amount of documentation. One member of staff commented that the documentation was different between level 2 and level 3 patient notes but there was no duplication. Another member of staff felt that over documentation was better than under and gave an example were the documentation proved very helpful in a coroners court. One consultant commented they felt the daily documentation needed streamlining.
- There was written evidence of regular communication with relatives or patient's representatives.
- CCD completed a quarterly health care records audit. Four case notes were audited in quarter one, quarter two and quarter four 2014 to 2015. The results demonstrated 100% completion in all sections apart from in quarter three the documented evidence for nutritional review was 50% and in quarter one the discharge plan established within 24 hours of admission scored 75%. Action had been identified to improve these areas.

Safeguarding

- Staff were aware of the trust's safeguarding policies and procedures and could accurately describe the process for reporting concerns about safeguarding.
- Mandatory training records showed that 80% of staff were compliant with safeguarding adults level 1 training and 80% of staff were compliant with safeguarding children level one and level two training, which was a joint session for all staff. The trust target for training compliance was 90%
- The department had a safeguarding lead who had undertaken responsible manager and investigation training.
- Safeguarding incidents were logged on the safeguarding database.
- Patients and relatives we spoke with did not highlight any concerns about aspects of safeguarding. They said they felt safe on the unit.

Mandatory training

- Evidence for completion of mandatory training was required at each senior medical staff member's annual appraisal. Currently all senior medical staff working in CCD had completed mandatory training within their last annual appraisal cycle.
- Nursing staff compliance with mandatory training was on average 81% completion rate. The remaining staff were booked on a session in the near future. The highest compliance figures related to corporate induction, moving and handling introduction and practical skills and violence and aggression (conflict resolution) training level one and level two (100%) The lowest was blood safety (72%).
- We spoke to the education lead about mandatory training and how staff progress was monitored; we also asked how they were assured staff were up-to-date with training. A database of the staff training records was kept and updated. Between four and five members of staff were allocated every two months to undertake their mandatory training. All nursing staff within department had a training needs analysis. A board visible to staff with reference to courses and training that each member had attended was on the wall in the staff area.
- Compliance was a mandatory agenda item on the surgical business unit's operational board monthly meeting and compliance with mandatory training was discussed at the band 7 forum. We viewed minutes of meetings which confirmed this.
- The education lead was able to demonstrate how many new starters had completed the required competency packages in the timeframes required. All new staff had a minimum of six weeks supernumerary. They were then allocated to either level one or level two patients for six months. Once they were competent, they changed over to care for patients with different level of care needs.

Assessing and responding to patient risk

- A National Early Warning Score (NEWS) system for acutely ill patients was used, which supported the process for early recognition of those patients who were deteriorating and who required prompt medical assessment and intervention.
- Nursing staff had a good understanding of the NEWS and how it was used across the trust.
- All patients were monitored closely and no concerns were raised in terms of the responsiveness of staff in reacting to the deteriorating patient. This included gaining prompt access to medical intervention.
- Comprehensive risk assessments were carried out and clinical management plans were in line with national guidance. However, there was no evidence of setting physiological goals within the nursing documentation.
- The records showed that risks were managed positively. An example of this was that when a patient returned from theatre with a wide bore nasogastric tube it was changed as soon as possible for a fine bore. This action was taken to prevent pressure damage to the patients' nose that had caused some patients to suffer pressure damage.
- Access to consultant anaesthetist, surgeons and medical input was timely.
- Patients who were due to have an elective operation who required a post-operative intensive care stay were given cardio-pulmonary exercise testing (CPET) pre-operatively. This recorded any risks and the opportunity to prevent complications post operatively. Doctors told us the service enabled doctors to accurately inform patients of their risks undergoing surgery. The CPET team published a retrospective study which concluded that the number of women with high-risk comorbidities undergoing surgery for gynaecological cancer was increasing. CPET had resulted in more women requiring level two admissions to CCD. The number of women developing pulmonary and wound complications had significantly reduced.
- Twice daily ward rounds took place and all patients received an individual treatment plan for the day. A daily midday "huddle" took place, which was a multidisciplinary team (MDT) meeting including consultants, junior doctors, nurses, health care assistants, ward clerk, dietician, pharmacist, rehabilitation team, research nurse and specialist nurse for organ donation. The huddle used a checklist based on the World Health Organisation (WHO) operating theatre checklist. We observed the midday huddle which included a discussion of incidents, information from the MDT, patients who were due to be transferred in and out of the department and the housekeeper was informed of the patients who were able to eat and drink.

Nursing staffing

Critical care

- The Core Standards for Intensive Care Units 2013 were followed to determine the number of nursing staff needed for each patient; this included the requirement to have one-to-two care for level two patients and one-to-one care for level three patients.
- Nursing shift patterns were mixed, including 12 hour and 7.5hour shift patterns.
- The trained nursing staff establishment was 66.71 whole time equivalent (WTE). However, in post in March 2015 were 60.15 WTE. This was a difference of 6.6 WTE nurses. Nurses in post included four band 7 nurses, six band 6 nurses and 24 band 5 nurses.
- Other clinical staff establishment was 11.44 WTE with all posts filled. These included healthcare assistants, housekeepers and a ward clerk.
- Since March 2015 a business case was successful to recruit an additional 5.5 WTE band 5 nurses in aid to open a further two level two beds in the CCD. These posts had been through the interview process and were awaiting start dates.
- The nursing rota aimed to have 10 qualified nursing staff on each shift and 2 HCA's in the day and 10 qualified and 1 HCA at night. This number included a nursing coordinator who was a band 6 or 7 working in a supervisory capacity to provide supervision, training and advice to other nurses.
- Each shift had a coordinator and there was a clinical educator and two band 7 ward managers who were supernumerary and undertook a management role which was in line with national guidance.
- Sickness absence rates were higher than the trust target of 3.5% on the CCD. Between June 2014 and June 2015 it ranged between 2.82% and 8.93% averaging 5.82% per month. There had been long term sickness which was not work related.
- No bank or agency nurses were used to cover shifts.
- Staff working additional hours as overtime or flexible working addressed the staffing shortfalls. A group text was sent to the team to ask if they could cover the shortfall.
- Staff members said that they also had to be very flexible to ensure safe staffing was maintained and patients' care was not compromised. We reviewed the staff rota and found evidence of staff changing their rota at short notice.
- Staff commented that nurses from the department could be moved to cover staff shortages on the wards within the hospital. An example was given that staff could come in to provide extra cover for the department and moved to cover a different ward or department. One nurse explained that they were unfamiliar with the ward environment and how to use the ward electronic system for recording observations. They described feeling unsupported and safety concerns for the patients due to their unfamiliarity with the ward.
- Staff rotas, sickness, annual leave and study leave through electronic-rostering (e-rostering) were managed by the ward managers.
- A specialist nurse for organ donation supported the department when required.
- Patients' transition from critical care to ward based care was facilitated by the Acute Response Team (ART) and demonstrated an effective pathway.
- The ART consisted of four (WTE) band 7 nurses and seven (WTE) band 6 nurses. . There was one nurse working during the day, who saw patients who were discharged from critical care and acute referrals and three nurses on duty during the night. During the night the team of three nurses were responsible for dealing with deteriorating patients, patient flow issues and bed management. Cover was provided 24 hours a day, 7 days a week.
- The nurses in the team had greater than five years post qualification experience and were trained to provide extended nursing roles such as history taking and patient examination.
- The Deputy Director of Nursing, Midwifery and Quality had overall managerial and strategic responsibility for the team.
- A handover process to the wards was used known as SBAR. (This is used to describe the patients' medical Situation, Background, Assessment and Recommendations). It enables staff to clarify what information should be communicated between members of the team and enhanced patient safety.

Medical staffing

- There were nine consultant intensivists and a staff grade doctor who provided senior medical cover between 8am and 6pm Monday to Friday. There were two consultants on the CCD during the daytime.
- Consultants were available 24 hours a day 7 days a week and were able to attend the department within 30

minutes. This was provided as an on call facility and consultants could stay within the hospital when they were on call. Approximately half of the consultants stayed on site when they were on call.

- We spoke with doctors of varying grades about medical staffing levels. We were told the on call consultant often stayed until 9pm and longer if required.
- The consultant to patient ratio was two consultants to 12 patients (2:12) during the day and 1:12 overnight and at weekends. When the extra two beds open at the end of 2015 there would be 2:14 in the day and 1:14 during the night and weekends. This which was in accordance with national recommendations of 1:14.
- There was lack of consultant continuity as the consultants worked a one to four day block on call. This varied from week to week, with up to four different consultants regularly covering the daytime over the course of a week. The Faculty of Intensive Care Medicine Workforce Advisory Group guidance states that five-day blocks of day shifts on critical care have been shown to reduce burnout in intensivists and maintain the same patient outcomes as seven day blocks. Therefore, consultant shifts on the CCD were worse than the guidance.
- There was one vacant consultant post that was on the risk register. We were told the post had been advertised on two occasions however, there were no suitable applicants who could be appointed. At the time of the inspection this position was managed by the consultants covering the vacant on call position on the rota.
- Trainee doctors from a wide range of specialities including anaesthesia, acute medicine, accident and emergency, foundation training and the acute care common stem (ACCS) of training rotated through CCD. We were informed all trainees received training and guidance in accordance to the needs of their speciality and foundation year doctors were never left as the sole resident doctor in the CCD. This was corroborated in discussions with the junior doctors.
- Two detailed medical handovers and a consultant ward round took place every day where doctors had opportunities to discuss cases and learn.
- The General Medical Council Survey 2015 confirmed that the CCD had been supportive to trainee doctors providing a balanced workload and trainees received excellent training opportunities and access to educational resources. The survey reported no areas of concern.

Major incident awareness and training

- The CCD had a major incident policy and business continuity plans.
- Staff were aware of these policies and plans and how to escalate issues during emergency situations which was to the duty matron during the daytime and the acute response team during the night.
- The department had taken part in scenarios, training exercises as part of major incident planning.
- Ward sisters received annual training in October 2013, which included Emergo Training System (ETS), an interactive educational simulation system developed for Teaching and Research in Disaster Medicine and Trauma.
- The major incident response and business continuity plans had been tested during the flu pandemic and during the pseudomonas outbreak in 2010.
- In the event of a major incident or full bed capacity elective activity would be delayed to prioritise unscheduled emergency procedures.

Are critical care services effective?

Good

We rated critical care services as effective because:

Processes for implementing and monitoring the use of evidence-based guidelines and standards to meet patients' care needs were in place. CCD provided rehabilitation after critical Illness and an acute response team which demonstrated an effective pathway for patient's transition from CCD to ward based care and support following hospital discharge. The trust was taking part in the national laparotomy quality improvement programme. A dietician provided dietetic support for patients in line with the core standards for intensive care unit (2013) guidelines. The department had specific feeding guidelines that were frequently reviewed and amended in accordance to best practice

We were informed in 2015 the CCD received an award from the intensive care audit and research centre (ICNARC) for

the most improved CCD for data collection. The data from ICNARC between January 2015 and March 2015 showed the department was within statistically acceptable limits for hospital mortality and within the limits for unplanned admission within 48 hours when compared to national and peer critical care department averages.

Staff were qualified and had the skills to carry out their roles effectively and in line with best practice. The learning needs of staff were identified and staff were supported through meaningful and timely supervision and appraisal. Relevant staff were supported through the process of revalidation. There was effective communication and working between multidisciplinary teams, who met regularly to identify patients requiring review or to discuss any changes to patients care.

A consultant was present in the department from 8am to 8pm at the weekend and bank holidays. They were supported by a minimum of two senior house officer-level doctors. Out of hours cover during the week was provided by a consultant with sufficient intensive care medicine experience.

We judged that patients could be confident that the provider had systems in place to gain consent and that their human rights would be respected whilst in the units care.

Evidence based care and treatment

- A range of local policies and procedures based on up-to-date evidence were followed, including guidance from the National Institute for Health and Care Excellence (NICE), relevant royal colleges and core standards for intensive care units. These were up to date and were easily accessible to staff.
- An example of a compliance with NICE guidance (CG 83) was rehabilitation after critical illness (RaCI). The CCD had a dedicated team of nurses, healthcare assistants and physiotherapists. We were told this model had been copied by other trusts.
- A ventilator care bundle, which is a set of evidence-based interventions, was in place. This included the use of different tubes to provide assistance with breathing. However, medical oversight on a daily basis was not concise or consistent with ventilator acquired pneumonia (VAP) assessment. This was partly because the consultant body had difficulty agreeing on a single definition of what constituted a ventilator-acquired pneumonia.
- The trust was taking part in the national laparotomy quality improvement programme. All patients undergoing an emergency laparotomy in Gateshead were admitted to CCD post-operatively.
- Assessments of patients were completed using the Richmond Agitation – Sedation Score (RASS) and the Confusion Assessment Method (CAM). As a positive result of an audit the amount of sedation given to patients was reduced.
- Other guidelines used included assessments for delirium, pressure ulcer assessments, Adult Respiratory Distress Syndrome (ARDS) and post-operative optimisation for renal, liver and sepsis.
- We saw evidence of local audits in areas of care and changes following audit results. For example changes had been made in the type of catheter used to improve intravenous access.
- There was a clinical lead responsible for audits. Mandatory audits were completed and evidence of other clinical audits assessing adherence to guidance was apparent. The audit list was based on the 2012 Royal College of Anaesthetist and Intensive Care Guidelines. Examples of audits undertaken were cardiac arrest, delirium, sedation holds (which are conducted to avoid excessive sedation) anaemia and sepsis.
- There were continuous patient data contributions to the Intensive Care National Audit and Research Centre (ICNARC) by the junior doctors supported by the ward clerk on the unit. This meant ICNARC staff were able to provide information comparing Gateshead Hospital CCD patient outcomes with similar units nationally. Staff used the information to see how well they were performing and they were encouraged by the results. Mortality outcomes were currently in line with national and peer unit outcomes.
- We saw staff using specific care bundles, which reflected national guidance. We were informed that based on the recent guidance staff have reviewed the eye care and mouth care procedures and had made the necessary changes. This meant staff kept up to date with practice changes.

- We saw evidence and staff we spoke with informed us that all sedated patients had a daily sedation hold. This meant that sedation infusions were stopped to ensure that patients had their level of sedation assessed in line with best practice guidelines.

Pain relief

- We reviewed five patients' records and noted pain scores were recorded appropriately and pain was discussed at ward rounds.
- An acute pain team worked across the trust, including on the unit.
- A pain assessment tool assessed how comfortable patients were and medicine to control pain was offered if needed.
- Medication administration records demonstrated patient's pain had been regularly assessed and the changes made by the doctors.
- We observed all patients on the unit looked comfortable. We spoke with two patients about the management of their pain. They were satisfied with their pain management.
- Relatives told us they were very happy in the way patients were kept comfortable. They said they had not seen their family member in pain or upset.
- Various forms of analgesia were provided according to individual patient's needs including oral medication, continuous infusions, patient controlled analgesia, epidural infusions and local anaesthetic blocks.
- There was quarterly education sessions delivered by the trust's acute pain specialist nurse covering acute and chronic pain management. Epidural updates were delivered three to four times a year.

Nutrition and hydration

- All patients had their nutritional needs assessed using a screening tool on admission, and reviewed weekly and their weight monitored. Nutritional risk scores were updated and recorded appropriately.
- Health records audit undertaken by the trust showed 100% compliance with a nutritional risk assessment within 24 hours of admission and 100% compliance with a weekly review.
- We checked five patients' records and found 100% compliance with two awaiting a review by the dietician that day.
- We saw patients receiving Total Parenteral Nutrition (TPN) land Percutaneous Endoscopic Gastroscopy (PEG) feeds whilst in the unit in line with local policy.
- Feeding regimes were reviewed and adapted appropriately to reflect individualised care. Safety checks for feeding routes and appropriate TPN storage were carried out.
- We saw strict fluid monitoring in place for patients which demonstrated hourly and daily recording for each patient.
- There was a dedicated dietician Monday to Friday, who was involved in nutritional assessments and planning of patients nutritional requirements. The dietician was full time and cover from another dietician was provided for annual leave. This was in line with the Core Standards for Intensive Care Unity's (2013) recommend dietetic input.
- The department had specific feeding guidelines, which were frequently reviewed and amended in accordance to best practice.
- Housekeepers provided nutritional support to patients. They attended regular nutritional link meetings for updates and initiatives within the trust. The housekeepers worked 7 days a week. We spoke with one of the housekeepers who informed us their role included attending the handover so they were aware of information regarding which patient was able to eat and drink.
- The trust had introduced dementia friendly place settings and also red place mats and glasses for patients who were at risk of nutrition and hydration and these had been implemented within the CCD. The CCD has a band 6 identified link nurse who updated the CCD information file and shared information to the team.
- The trust had a weekend enteral feeding regime that could be commenced outside of dietician support hours.

Patient outcomes

- The department contributed to the Intensive Care National Audit and Research Centre (ICNARC) database. We were informed in 2015 the department received an award from ICNARC for the most improved critical care department for data collection from ICNARC between January 2015 and March 2015. The data demonstrated

the department was within statistically acceptable limits for hospital mortality and unplanned admission within 48 hours when compared to the national and peer department average.
- Outcome measures (including ventilated admissions, admissions with severe sepsis, pneumonia, and elective surgical and emergency surgical admissions) were within expected ranges.
- The department actively used the information provided by ICNARC to support improvements in patient care within the trust. Examples included the expansion in critical care capacity after identification of an increase in the number of admissions to department, an increase in the out of hour's discharges and an increase in the number of elective operations cancelled due to a lack of critical care beds.

Competent staff

- Senior medical staff received annual appraisal and five yearly revalidation which ensured that they adhered to Good Medical Practice, as described by the General Medical Council. As part of appraisal, senior medical staff performed a self-assessment on the competence to use medical devices in their practice.
- Annual appraisal included the review of a consultant's personal development plan. All senior members of medical staff were up to date with their annual appraisal and five yearly revalidation cycle.
- The number of junior doctors remained stable and the ones we talked to spoke positively of their learning and development on the unit.
- Junior doctors had a dedicated educational supervisor and a clinical supervisor who supported them through their placement and reports for their annual appraisals and their annual review of competence progression.
- Junior doctors received an induction highlighting the trainee roles, duties and responsibilities. They were encouraged to undertake audits, quality improvement projects and management projects. One junior doctor had undertaken an audit on delirium.
- A teaching programme covering key topics in intensive care took place every Friday between 7.30am and 8am. The teaching programme covered 21 topics in a six month period. There was also a journal club.
- 96% of nurses had an up-to-date appraisal which was better than the trust target of 90%.
- The department had an educational lead that provided support to newly qualified nursing staff and they were placed on an education programme.
- New staff spent a supernumerary period of six weeks. They were assigned to an experienced critical care nurse as a preceptor/mentor.
- The department used the national critical care competencies and all new staff commenced at step one.
- 41 out of 76 of the nurses in the department had a post-registration qualification in critical care. This was in line with core standards in intensive care units (2013).
- More than 50% of nursing staff have completed or were in the process of attaining critical care competencies
- A study week had been arranged to support the induction of new staff. The agenda included safeguarding, pain, and palliative care.
- Study leave was provided to staff for critical care related courses however; some study leave and mandatory training could be cancelled at short notice due to staffing shortages.

Multidisciplinary working

- There was a daily ward round which had input from members of the MDT including nursing, physiotherapy, pharmacy, microbiology and dietician creating a holistic approach in patient care.
- There were good working relationships between the staff groups which extended to the ward environment with the support for patients from the rehabilitation after critical illness team.
- There was input from allied healthcare professionals including speech and language, physiotherapy and dietetics.
- All patients discharged from the unit to the ward had at least one follow-up visit from the acute response team.

Seven-day services

- A consultant was present on the unit from 8am to 8pm at the weekend and bank holidays. They were supported by a minimum of two senior house officer-level doctor.
- Out of hours cover during the week was provided by a consultant with sufficient intensive care medicine experience in line with core skill requirements.
- The acute response team was accessible 24 hours a day, 7 days a week.

Critical care

- Both daytime and out-of-hours junior doctor cover was at safe levels. There was cover for emergencies when required
- Access to x-ray facilities was available 24 hours a day, seven days a week. Computed tomography (CT) imaging was available out of hours however, magnetic resonance imaging (MRI) was not available after 8pm at Queen Elizabeth Hospital, and patients were transferred to Newcastle.
- Physiotherapy services were provided daily, including the weekend. Physiotherapy had an on-call service for urgent matters.
- A pharmacy service was provided 7 days a week. There was an on-call pharmacist available out of hours and on bank holidays.
- A housekeeper and a ward clerk were present 7 days a week.

Access to information

- Guidelines, policies and procedures were easily accessible to staff on the trust intranet site
- Risk assessments, care plans and test results were completed at appropriate times during a patient's care and treatment.
- Paper records were used and there was a plan to move to electronic prescribing by the end of the year.
- An electronic system for requesting, reporting and viewing pathology and radiology results was used. All appropriate staff had access to the electronic system which was accessed by a smart card
- A standardised discharge letter was produced prior to a patient leaving the CCD. This letter was used as a formal handover document for transfer to a ward and a copy was sent to the patient's GP.
- A discharge letter was also produced for all patients who died in the department, which was sent to a patient's GP.

Consent and Mental Capacity Act

- Opportunities for gaining consent written/and /or verbal from patients in CCD were limited due to the severity of the patients' conditions and the fact that many patients were sedated or unconscious.
- We viewed one patient's notes, which accurately recorded decisions to withdraw or withhold care. The notes explained the patients' mental capacity following a completed assessment of their mental capacity, discussions with the patients' relatives and the rationale for limiting treatment, which were all completed. The notes demonstrated that consent was obtained when it was possible. Consent training was provided as part of the induction process, which included how to assess capacity and the fundamentals of obtaining consent.
- Staff reported that much of the care provided to patients was in their best interests and how, for some medical interventions, the patient's family and/or friends would be consulted. Best interest decisions were made in accordance to legislation.
- We viewed information leaflets for procedures for example tracheostomy formation for patients. A consent form for tracheostomy formation had been produced in order to ensure that all appropriate risks were discussed with patients and their families. The tracheostomy documentation was produced with help and advice from 'Intensive Care Unit Steps' which was a group of former critical care patients and their families.
- Staff understood the difference between lawful and unlawful restraint practices, including how to seek authorisation for a deprivation of liberty. Staff had access to a restraining guideline they followed if needed.
- In relation to the Mental Capacity Act 2005 and its related deprivation of liberty safeguards, nurses were able to accurately explain the process for providing care where these issues needed to be considered. Staff received Mental Capacity Act training as part of their safeguarding training.
- There was an identified mental health and dementia work-stream lead within the department. A resource file was updated and available in the staff room.

Are critical care services caring?

Outstanding ☆

We rated caring as outstanding because:

We saw staff respecting patients' privacy and dignity and patients being treated with understanding and compassion. Patients and relatives spoke positively about the care they had received. Family members referred to the care in the unit as excellent.

Critical care

There was a strong, visible person-centred culture. Staff were highly motivated and inspired to offer care that was kind and promoted people's dignity. Relationships between patients, their carers and all levels of staff were strong, caring and supportive.

Consideration of patients personal, cultural, social and religious needs were taken into account and patients' individual preferences and needs were reflected in how care was delivered. The department had innovative projects in place such as the 'terminal discharge home' project which allowed a patient to die at home if they wished. The team had recognized that it was important for children who wished to see parents or relatives in critical care, especially if their parent was dying. Support and educational resources were given to children.

Bereavement support was given by the rehabilitation after critical illness team and special touches following the death of patient were introduced such decorative bags which contained a lock of hair and the supply of ring boxes. Staff facilitated other requests such as allowing patients outside of the unit to see their pets.

All staff were fully committed to working in partnership with patients and their carers and empowered them to have a voice, by asking ex- patients their views and opinions on changes within the service.

Compassionate care

- We observed patients being treated with privacy and dignity. Curtains will pulled around and doors closed when patients had treatments or nursing care given.
- We observed a number of interactions between staff and patients and relatives. Staff were always polite, respectful and professional in their approach.
- We spoke to two patients who were complementary about their care and found staff to be understanding and supportive.
- We spoke to five relatives; they felt staff were compassionate and caring.
- The NHS Friends and Family test showed 100% of patients would recommend the service to family and friends
- We looked at five patient records and found they were completed sensitively and were clearly documented, detailing discussions held with relatives.
- Relatives were encouraged to visit and routine visiting was 1pm to 4pm and 5.30pm to 8pm. We were told by the nursing staff and relatives that visiting was flexible and at the discretion of the nurse in charge. Facilities were available for visitors to stay on site if necessary.
- The team had recognized that it was important for children who wished to see parents or relatives in critical care, especially if their parent was dying. We were told staff welcomed and encouraged such visits, and tried to minimize the fear of the environment for children by ensuring their loved one was in a cubicle, which they could access without seeing other patients. Senior medical and nursing staff explained to children about critical care and what was happening, encouraging them to touch and hug their parent or relative.
- We observed books for children such as "Muddles and Puddles" and "The day the dinosaur died", and soft toys were part of the "bereavement" packs. There was also an activity book for children that acted as a diary to accompany them to school.
- Ex patients, bereaved relatives or children were offered support from the rehabilitation after critical illness team and were encouraged if they wished to visit the unit to help with missing or distressing memories.
- When a patient died, the CCD provided decorative bags with varied contents requested by families such as a lock of hair, the identification bracelets from the patient. Special ring boxes were given for patients' rings to be placed in and small material bags for necklaces. A forget me not card was given to the family, which contained forget me not seeds. Soft toys were given to children.

Understanding and involvement of patients and those close to them

- The nursing staff described how they supported patients, where possible, to be involved in making decisions about their care, but due to the patients serious condition or sedation this was often not possible.
- Family members and/or friends were more often included in making decisions about their relatives or friend's care.
- Feedback was gathered from families and their views were used to improve the service. For example, allowing family members to travel home in the ambulance with the patient.

- Patients with dementia were asked to tell staff about their needs, preferences, likes, dislikes and interests. This enabled health and social care professionals to see the person as an individual and deliver person-centred care tailored specifically to the person's needs.
- In some instances, patients were aware of their medical treatment and we observed staff explaining and supporting patients to understand their plan of care.
- We spoke to two patients who said that staff had explained their condition and treatments to them in a way they could understand. One commenting that the doctors were very open and his wife commented on receiving an excellent service.
- An inpatient survey in July 2015 and August 2015 demonstrated excellent results in questions based around communication, care and compassion.
- The department had an initiative, which started in 2011 named rehabilitation after critical illness (RaCI). Care and support was given to the patient where families and patient diaries were used to support a patient's recovery. A patient's relatives, nurses, doctors, completed these diaries; physiotherapists and anyone involved in the patients care. Useful information was added to help patients understand their stay in CCD and help fill the gap in their memories of their time in hospital. Photographs of individual patients were taken and placed in the diaries to help patients understand what their critical care involved.

Emotional support

- Access to spiritual guidance, religious and multi faith services were available. During our visit we observed a patient receiving religious support.
- Gateshead had a large orthodox Jewish community and we were informed that the Chief Rabbi had visited the department to provide a teaching session for staff about the beliefs and approaches of the Jewish faith community to organ donation, brainstem death, withholding and withdrawing treatment.
- We spoke to consultants about the support they provided to families; they stated that they would often meet families when requested and update them on the progress of the patient.
- The nursing staff told us the nursing and medical team were very open with relatives about the care being provided and the severity of people's illness or injury.
- Follow up support for patients following their discharge from the CCD including patient education was provided by the acute response team.
- We were told staff encouraged families to bring pets (usually dogs or cats) up to the hospital, and they took patients outside to see their dog to help boost patients' morale. The department had facilitated various significant family occasions, including a wedding on the unit.
- Patients deemed to be a high risk of post-traumatic stress disorder, or who experienced symptoms, were referred to a psychologist.
- The department held an annual critical care memorial service on the last Sunday in January, organized by staff, for friends and families of patients who had died. Nursing and medical staff attended the service in their own time. Invitations were sent to families of every patient who had died (they asked families if they wanted to be contacted as part of the bereavement support process), and advertised in the local press. We were told the service was very popular and in excess of 100 people attended the last one.

Are critical care services responsive?

Good

The critical care service was responsive to patients' needs and preferences. Escalation procedures were in place and the beds could be flexed in there use having the ability to deal with unforeseen emergency admissions and periods of peak activity. However, there had been a rise in discharges to the wards between 10pm and 7am as well as an increase in the number of cancellations of elective operations for patients requiring critical care post-operatively. Additional funding had been sought and two further beds were to open shortly which would help address these areas.

The acute response team had a remit to help to prevent readmission to critical care and promote continuity of care for patients. After transfer from CCD to the ward patients were followed up by the acute response team within 12 hours.

Critical care

CCD was responsive to patients with complex needs, such as dementia and learning disabilities. Care plans demonstrated that peoples' individual needs and preferences were central in the planning and delivery of tailored services.

There were innovative approaches to providing integrated person-centred care which involved other service providers.

The unit had a low number of complaints. The majority of complaints and concerns were managed at a local level without the need for issues to be formally escalated. We found evidence that the service responded appropriately to patient's comments and concerns.

Service planning and delivery to meet the needs of local people

- The CCD was part of the intensive care network and members of the team attended network meetings. Escalation procedures were in place locally to refer patients who required specialist services such as neurology, cardiology, liver problems and paediatric care. There was effective referral processes in place.
- The department had the ability to deal with unforeseen emergency by having the ability to flex the use of the beds for level two and level three patients. There was funding for 12 beds with an additional two beds to open shortly. There was capacity for 16 beds in total, if needed depending on the staffing of the unit.
- A business plan for the expansion of CCD capacity had been approved which enabled the appointment of an additional 5.5 WTE nurses to provide an additional two Level 2 beds. Staff would be in post and the additional beds opened in December 2015.

Access and flow

- There was flexibility in the use of beds to accommodate the needs of patients. For example, using a nurse to look after two Level 2 patients rather than one Level 3 patient. This was achieved as the department had 16 fully equipped bed spaces.
- CCD bed usage had remained below 95% between January 2015 and June 2015. During this time the percentage usage has fallen steadily from 93.12% in January and 80.44% in June 2015.
- An audit conducted in November 2014 demonstrated the mean time to discharge was 13 hours 27 minutes. ICNARC defines a delay in discharge from critical care to a ward bed as being over 4 hours from which a patient is reviewed as ready for discharge and the time of discharge. The demand for critical care beds had increased which contributed to a rise in discharges to the wards from critical care between 10pm and 7am. The lack of beds on wards could impact on the unit meeting mixed sex accommodation guidance for patients not requiring critical care. Although we did not see any breaches during the inspection there was potential for mix sex breaches. The unit had recognised this on its risk register.
- Delayed discharge due to insufficient beds on the wards had been recognised, as this can delay the admission of an unwell patient to the department. Staff completed an incident form for all transfers to the ward from critical care between 10pm and 7am.
- There had been 133 patients moved out of hours from April 2014 to June 2015. Delayed discharges and out of hours discharges were on the risk register and actions were being taken to reduce this risk which included a daily bed meeting attended by a critical care sister to inform the bed management team of patients awaiting admission and discharge from critical care. We were informed within the bed meeting there was a discussion of the possible cancellation of elective surgery, which required critical care post-operatively.
- After discharge all patients, with the exception of those discharged for end of life care, were followed up by the acute response team within 12 hours of discharge.
- There was a daily bed meeting at 9.30am, which the night sister completed documentation which identified the current bed state and the possible discharges for that day. Data from 1/9/2014 to 21/4/2015 showed 23 elective operations were cancelled due to no critical care bed being available. These ranged from two to eight cancellations per month. A consultant informed us that emergency admissions were prioritised and all emergency admissions received a bed in CCD.
- National guidance suggests that patients who require intensive care treatment should receive it within four hours of referral. We reviewed evidence that demonstrated that two out of the five patients were longer than four hours. One was 7.5 hours and the other 9.5 hours.

- Data on the electronic IT system was entered when the patient was 'declared clinically ready for unit discharge'. The review of theatre scheduling was undertaken to spread planned critical care admissions throughout the week.
- Re-admission rates to the department were high for patients who had bowel surgery. A consultant informed us that this was due to late complications rather than being discharged from critical care too early in order to free up beds for new admissions.
- The acute response team had a remit to help to prevent readmission to critical care and promote continuity of care for patients who had been critically ill and act as surveillance for the deteriorating patient.

Meeting people's individual needs

- CCD was responsive to patients with complex needs, such as dementia and learning disabilities. The trust had run a large scale project educating staff about caring for patients with dementia and memory impairment. Staff were encouraged to see a short film, "Barbara's Story" to highlight common problems. All the departments' consultants had seen the film.
- Unfamiliarity of the environment and night time disturbances meant that the department was a complex environment for patients with dementia, and strategies were used to support patients such as clocks and televisions in the patients' cubicles.
- The higher incidence of post-op delirium in older patients was recognized, and screening using a delirium tool was undertaken. Doctors tried to avoid delirium-inducing drugs where possible. Records showed the use of the delirium screening tool and an audit had been undertaken which looked at factors and actions taken. This involved the provision of televisions, analogue clocks, patient earplugs and eye masks and a change to plastic bins to reduce the noise levels.
- Two clinical lead nurses for mental health, safeguarding and learning disabilities within the trust were accessed if needed by staff in the department. Staff told us they routinely encouraged a relative or carer well known to the patient to stay at the bedside if they wished and they sought advice from families and carers about patients usual communication aids, likes and dislikes. Where patients had complex medical and communication problems, they adopted the practice of having one consultant lead for the care of the patient, providing consistency in decision-making and communication.
- The department developed a project "terminal discharge home" to allow the patient to die at home if they wished. This was set up in about four hours, including setting up home support, high quality symptom relief and equipment. The central idea was that treatment withdrawal happened at home, including discontinuing ventilation. Structured support at home was offered for the family and patient (daily phone calls, open access) with the offer to readmit, as a "safety net".
- Lessons learnt were used to change and improve practice. We were informed by the lead nurse that one patient had died at home within one hour of the transfer. Since this happened three ambulances now were allocated to support patients at end of their life and take them home as soon as possible to avoid a long delay waiting for an ambulance.
- The project had won awards from the North of England Critical Care Network, and the Trust. It was presented nationally at the Nursing and Midwifery Conference, and the guideline formed the basis of a network guideline, and informed a national project funded by MacMillan, which involved the team facilitating workshops at a national conference on dying at home, and contributing to a draft policy.
- We were told the emotional demands on the staff accompanying the patient home were high, so they ensured a consultant and senior nurse were the escorts, and an informal debrief was usual.
- RaCI ran clinics approximately monthly were patients were seen with their families following hospital discharge. The RaCI nurse referred to other services as needed for example occupational therapy and mental health teams.
- The department had access to interpreters for patients who did not speak English (we were told a number of staff speak two or more languages fluently, and were happy to help in such cases), and for formal processes for example consent for procedures and declaration of liberty applications.
- Written information was provided in the English language only but was available in other languages if required.

- There was a room for holding family discussions that was situated close to the CCD. A local artist decorated the room with a mural in 2010 after feedback was received that the previous family room was stark and unwelcoming.
- There was a relative's room which was due for refurbishment. The room had chairs, there were no facilities to make a drink or use a telephone, however staff told us that drinks were offered to relatives and they could access coffee shops within the hospital.

Learning from complaints and concerns

- The unit had a low number of complaints. The majority of concerns and complaints were managed at a local level without the need for issues to be formally escalated.
- The unit had received two formal complaints between April 2014 to August 2015 and three Patient and Liaison Service enquiries.
- Staff we spoke to could explain the complaints procedure.
- Information on how to raise a concern or make a complaint was readily available to patients and relatives. Support was also provided to people who wished to complain from staff, matron and the hospital Patient Advice and Liaison Service. Relatives said if they did complain they felt confident they would be listened to and treated with dignity and respect during the process.
- Complaints and learning from complaints was discussed with staff individually and at the midday huddle and in staff meetings.
- Documents demonstrated that complaints were reviewed, addressed and responded to by the ward managers quickly.

Are critical care services well-led?

Good

We rated critical care services for well-led as good because:

There was a critical care strategy which outlined a vision. The nursing strategy was developing.

There was a risk register in place, which included controls and measures to mitigate risks. The leadership teams were approachable and open, and were viewed positively by staff. There was a strong cohesive team approach. The management teams engaged with staff and patient engagement and feedback was actively sought.

Staff spoke positively about the culture and the service they provided for patients. Quality and good patient experience and care were seen as a priority and everyone's responsibility.

The department had been recognised for its innovative work through the trust award for service improvement and the North of England Critical Care Network Award for Patient Care and Service Improvement.

Vision and strategy for this service

- The critical care strategy outlined the vision for the unit. This focussed on continuing to effectively maintain the current service and align work programmes within the department to the trust wide programme to help deliver high quality patient care.

Governance, risk management and quality measurement

- There were monthly 'Safecare' (governance) meetings where results of audits were presented. Clinical and nursing staff attended these.
- We viewed a 'Safecare' annual plan 2015/16 for the surgical business unit. This included developing leadership, ensuring feedback from incidents, improving communication and ensuring high quality patient care.
- Complaints, incidents and root cause analyses were shared at the monthly department meeting.
- There was a risk register for the unit, which included controls and measures to mitigate risks. The risk register was updated regularly and risks reviewed with input from critical care doctors, ward staff and senior management. The matron, service line manager and risk manager reviewed the incident reporting system to identify any incidents which had occurred and needed to be managed through the risk register. CCD had two risks on the risk register these were discussed at the trust board meeting.

Leadership of service

Critical care

- There was a service line manager, a clinical lead and a modern matron who led a team of band 7 senior nurses. The matron was on duty Monday to Friday. There was a band 6 or band 7 sister on every shift who was supernumerary and coordinated the shift.
- The clinical lead and the band 7 nurses represented the trust at the North of England Critical Care Network meetings.
- The teams worked well together, were supportive and there was a good sense of joint working and team effort amongst most staff.
- Senior nurses and consultants had good visibility and were well known to staff, however it was felt that the Trust Board was not as visible.

Culture within the service

- Staff spoke positively about the culture and the service they provided for patients. Quality and good patient experience and care were seen as a priority and everyone's responsibility. There was a strong cohesive team approach to work.
- Staff reported good engagement at department level and felt they were able to raise concerns and that these would be acted upon.

Public and staff engagement

- Monthly department meetings discussed key issues. Staff had a daily midday 'huddle' which the whole MDT participated in. Staff reported positive feedback around communication gained from the huddle.
- The staff survey completed in 2014 showed scores were above the national average in the majority of areas other than the managers where they scored below the national average in some questions.
- The department recognised that public engagement to develop services was valuable and they aimed to improve the service using the inpatient survey feedback, the friends and family test feedback, compliments and complaints.
- There was a quarterly 'ITU Steps' meeting (a patient support group) which was attended by patients who had spent time on the department to ensure they had an opportunity to reflect on their stay and ask staff any questions about the care they received. This provided the department with an opportunity to test patient leaflets, review any proposed major changes and discuss the use of funding

Innovation, improvement and sustainability

- CCD was involved in research. The unit had participated in four trials and five national and international data collection audits
- Practice was amended as a result of two trials. New ideas, clinical priorities and on-going projects were discussed at the department's quarterly meetings attended by consultants, senior nurses and colleagues from pharmacy, physiotherapy, dietetics, RaCI.
- Examples of innovation and improvement included the rehabilitation after critical illness service, the facilitation of patients home to die if this was what they choose, the cardio-pulmonary exercise testing (CPET) which allowed objective identification of risk and the opportunity to prevent complications
- Gateshead RaCI team approach had been adopted and copied by other trusts locally, as a model of good practice, and teams from around the UK attended a RACI training event. The Specialist Nurse for RaCI was a finalist in the 2012 Nursing Times award.
- An example of proactive and evidenced based improvement work that had seen cost savings was changes to anti-fungal drug prescription. This change resulted in saving £25,000 per annum by implementing new guidelines based on best international practice.
- The department has been recognised for its innovative work through the trust award for service improvement and the North of England Critical Care Network Award for Patient Care and Service Improvement.

Maternity and gynaecology

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

Information about the service

The trust offered a full range of maternity services for women and families based in this hospital and the community, ranging from a home-birth service for women with low-risk pregnancies to specialist care for women who needed closer monitoring. Two teams of community midwives provided antenatal and postnatal care in women's homes, clinics, children's centres and GP locations across Gateshead. A women's health unit incorporating a pregnancy advisory service also provided a range of treatments for gynaecological problems. The trust hosts the northern gynaecological centre (NGOC). This is a tertiary referral centre providing specialist oncology services for the diagnosis, staging, treatment, and care of women with gynaecological cancer.

The service at Gateshead Health NHS Foundation Trust delivered 2,364 babies between April 2014 and June 2015.

The service offered both medical and surgical termination of pregnancy and carried out 239 medical and 208 surgical terminations between April 2013 and March 2014. There were processes in place to ensure the sensitive disposal of pregnancy remains.

We visited the antenatal clinic, delivery suite, obstetric, pregnancy advisory service, early pregnancy assessment unit, pregnancy assessment unit, antenatal and postnatal ward, and community midwifery services. We spoke with 15 women and 40 staff, including midwives, midwifery support workers, doctors, consultants and senior managers. We observed care and treatment and looked at 10 care records. We also reviewed the trust's performance data.

Summary of findings

We rated maternity and gynaecology services as outstanding. We observed and were given examples by staff and patients of areas of exemplary practice in the care and treatment of women.

The service provided safe and effective care in accordance with National Institute of Clinical Excellence (NICE) recommended practices. Staff monitored outcomes for women using the service continually and took action where improvements were necessary.

Resources, including equipment and staffing, were sufficient to meet women's needs. Staff had the correct skills, knowledge and experience to do their job.

Staff took women's individual needs in planning the level of support they needed throughout their pregnancy. Staff treated women with kindness, dignity and respect. The service took account of complaints and concerns and took action to improve the quality of care.

A highly committed, enthusiastic team, each sharing a passion and responsibility for delivering a high-quality service, led the maternity and gynaecology services. Governance arrangements at all levels, enabled managers to identify and monitor risks effectively, and review progress on action plans. Engagement with patients and staff was strong. There was evidence of innovation and a proactive approach to managing performance improvement.

Maternity and gynaecology

Are maternity and gynaecology services safe?

Good

We rated the safe domain as good because:

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

Staffing levels were set and reviewed at ward and board level using nationally recognised tools and guidance. Medical, midwifery and nurse staffing was in line with national recommendations for the number of babies delivered on the unit each year.

Staff planned and provided care and treatment in a way that ensured women's safety and welfare. Staff followed safety guidance for infection prevention and control. The service managed medicines safely. Records relating to women's care were detailed enough to identify individual needs and to inform staff of any risk and how they were to be managed. There were clear safeguarding processes in place; staff knew their responsibilities in reporting and monitoring safeguarding concerns.

Incidents

- Trust policies for reporting incidents, near misses and adverse events were effective in maternity services. All staff we spoke with said they were encouraged to report incidents and were aware of the process to do so. Staff reported incidents on the trust's electronic incident-reporting system. Staff told us they received feedback about incidents they had reported, with details of the outcomes of any investigations. Junior doctors said incidents and case reviews were discussed as part of their teaching.
- There were 171 incidents reported for the service for April to July 2015. No incidents were classified as 'severe risk' and five were classified as 'moderate risk'. The service completed Root Cause Analysis (RCA) reports. We found evidence of discussion and learning shared with staff, including any changes to guidelines. For example, a standardised Cardiotocograph (CTG) training package, which included formal annual assessments for staff, had been introduced following analysis of an incident.
- There were103 incidents reported in the NGOC between July 2014 to June 2015, one was identified as a serious incident, however, this happened just prior to our inspection and no RCA had been completed. Themes focused around falls, pressure damage, and blood sampling concerns. We were assured that the service was working with the corporate teams to reduce these trends.
- The service used internal communication methods to inform staff of learning and changes to practice (for example, the monthly obstetric "Key Bulletin"). We observed discussion of the key bulletin at team handovers. The consultant team had weekly meetings to discuss caseloads, and plans of care.
- There was one Never Event reported for maternity in 2014/15 for a retained swab. Never Events are serious, largely preventable patient safety incidents that should not occur if proper preventive measures are used. We reviewed the root cause analysis and recommendations, which included managerial and supervisory investigation of the staff involved, a review of the sterile delivery and suture packs, and a review of the policy to assess and embed the culture surrounding suturing. Staff we spoke with could inform us of initiatives to prevent a recurrence.
- Monthly perinatal meetings monitored perinatal mortality and morbidity (attended by obstetric and neonatal staff), reported quarterly to the trust mortality and morbidity steering group chaired by the medical director. Minutes of meetings from February 2015 to July 2015 included examples of the steering group reviewing cases and recommending changes to clinical guidelines and practice as a result.

Safety thermometer

- The service had started using the national maternity safety thermometer. This allowed the team to check on harm and record the proportion of mothers who had experienced harm-free care. The maternity safety thermometer measures harm from perineal and abdominal trauma, post-partum haemorrhage, infection, separation from baby and psychological

safety. In addition, it identified those babies with an Apgar (a method to quickly summarise the health of the new-born) of less than seven at five minutes and those babies who were admitted to a neonatal unit.

- We reviewed the maternity safety thermometer and found mixed results. The results for combined harm free care between September 2014 and August 2015 showed between 62% and 92% of women received harm free care. The median value was 73%; this means that on average 27% of women had some harm during their care.
- The gynaecology ward completed monthly safety thermometer audits. In July 2015 they were identified as one of the top performing wards in the trust.

Cleanliness, infection control and hygiene

- There were no cases of hospital-acquired Methicillin-Resistant Staphylococcus Aureus (MRSA) or Clostridium difficile (C. difficile) in 2014/15, within the maternity unit. However, one case was noted in the NGOC in May 2015, a full RCA was competed and it identified that the ward and treatment was appropriate and did not contribute to the C. difficile diagnosis.
- At the main entrance to the unit, visitors were encouraged to wash their hands at a sink. Areas we visited had antibacterial gel dispensers at the entrances. Appropriate signage was on display regarding hand washing for staff and visitors.
- Observations during the inspection confirmed that all staff wore appropriate personal protective equipment when necessary, and followed 'bare below the elbow' guidance, in line with national good hygiene practice.
- The CQC Survey of Women's Experience of Maternity Services (2013) showed the service scored 'about the same' as other trusts for cleanliness, infection control and hygiene.
- All women received prophylactic treatment for MRSA before undergoing elective caesarean sections, as part of their pre-operative assessment. In addition, the service screened all women who had an emergency caesarean section following the procedure. Data for August 2014 to July 2015 identified four MRSA colonisations on the pregnancy assessment unit, however, there were no cases reported on the antenatal/postnatal ward or delivery suite.
- Data for September 2015 for hand hygiene assessments showed 100% of midwives and medical staff on delivery suite and wards were compliant. During our inspection we noted dust on high-level surfaces in delivery rooms, we mentioned this to staff. When we returned two days later we found all surfaces to be clean.
- Failsafe systems were in place to identify women for Hepatitis B and HIV at booking to ensure care provided followed the correct care pathways. Data between January and March 2015 showed 100% of women were screened for HIV and Hepatitis B.

Environment and equipment

- There was adequate equipment on the wards to ensure safe care specifically, cardiotocography (CTG) and resuscitation equipment. Staff confirmed they had enough equipment to meet patients' needs.
- The service used a CTG training tool to assess staff competence and awareness of the functionality of the equipment. For example, twice-daily checks to ensure the date, time on the CTG was accurately set, and all necessary equipment was available to monitor the fetal heart rate.
- The trust's medical engineering department regularly checked maintenance of equipment and records showed staff carried out equipment checks each day. Staff also completed medical devices training booklets to ensure they were competent in using each device on the unit.
- There was a birthing pool in the unit; however, this was separate from the delivery rooms. We were assured staff tested evacuation from the pool regularly and had the time from collapse to bed at 1 minute 34 seconds. Trust data showed there was a 0.9% water-birth rate in 2013/14.
- All delivery rooms had piped ENTONOX® (gas and oxygen) and other gases. The delivery suit had a fetal blood analyser.
- The design of the unit helped to ensure women and babies were safe. The unit was separate from the main hospital, which allowed for autonomy in the unit. However, this had limitations should a patient require transfer to intensive care unit (ITU). The unit had an emergency transfer trolley which was in place should a women require transfer to ITU. The team would transfer the patient to the trolley, and then call 999 for an ambulance to transfer the patient to the main hospital.
- The service successfully bid for funding which they used to decorate a room in consultation with services users who had experienced infant loss. This room had its own

separate parking and entrance. This room was for women who were experiencing the loss of an infant or who had a child on the special care baby unit. It had its own kitchenette and en-suite facilities.
- The service had made appropriate adjustments to ensure women with a disability had access to suitable facilities. This included adapted bathroom and toilet areas. Specialist equipment for women with a high body mass index (BMI) was available when required.
- During our inspection we reviewed stock and store cupboards. We found some out of date intravenous fluids and hand gels. We also found that some of the emergency trolleys did not have checklists or the stock did not reflect the checklists. For example, the epidural trolley contents did not reflect the checklist for shelf stocks and additional items were present. We highlighted our concerns with senior staff on the unit and when we returned two days later, all our concerns had been addressed.
- There was one dedicated obstetric theatre on the delivery suite, should an emergency occur when the theatre was in use; room six converted in to a theatre as it had an anaesthetic machine in situ ready to use. We raised concern that this may worry mothers in labour, however, this room was used for high-risk labour and delivery and mothers were orientated to the room.
- The neonatal unit was situated just outside the delivery suite doors. Staff we spoke with informed us that paediatric staff could attend emergencies quickly.

Medicines

- Medicines were stored in locked cupboards and trolleys in all clinical areas.
- Medicines that required storage at a low temperature were stored in a specific medicines fridge. All fridge temperatures were checked and recorded daily. There were no gaps in recording. Midwives and nurses told us they received support from the on-site pharmacist, when necessary.
- Records showed the administration of controlled drugs were 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 showed controlled drugs were checked in line with hospital policy.
- There were processes in place to record all medications dispensed by midwives under the patient group directives (PGDs) during the discharge process. This included checks by two midwives and stock control sheets for the pharmacy department.

Records

- Staff kept clinical records to a high standard. We reviewed nine records and all contained a clear pathway of care that described what women should expect at each stage of their labour.
- The service kept medical records securely in line with the data protection policy, if records were needed in another area of the hospital a sticker was placed on the front informing the record should be returned to the maternity unit.
- Risk assessments were completed at booking and repeated at every antenatal visit.
- Women carried their own records throughout their pregnancy and postnatal period of care. The unit used the North East Personal Child Health (NEPCHR) 'red book' this was given to women before the new-born examination and was completed correctly.
- The service used approved documentation for the process of ensuring that all appropriate maternal screening tests were offered, undertaken and reported on during the antenatal period.
- An annual audit of record keeping was presented at the trusts clinical governance forum known as SafeCare annually; in addition, it was compulsory for all midwives to audit five sets of notes before their annual review, two of which must be their own.
- We reviewed the documentation audit dated June 2015 to August 2015. A random review of 66 patient records identified improvements were required in five areas, these were:
  - Is the clinicians name printed and legible along with signature and status? (70%)
  - Has discussion on birth options been documented? (59%)
  - Was the woman risk assessed / screened for MRSA? (68%)
  - Are abdominal palpation findings, including position of the baby recorded before each VE? (64%)
  - Is there evidence that parentcraft was offered? (27%)
- The audit report included recommendations and plans were in place to repeat the audit in quarter four.

Maternity and gynaecology

Safeguarding

- There were effective processes for safeguarding mothers and babies. The service had a dedicated, midwife responsible for safeguarding children, and had recently been given protected hours to undertake this role. The safeguarding midwife worked alongside the named nurse for safeguarding children.
- Risk assessments and clear care pathways were in line with the safeguarding unborn baby's policy.
- Staff demonstrated a good understanding of the need to safeguard vulnerable people. Staff understood their responsibilities in identifying and reporting any concerns.
- The safeguarding lead told us all midwives received annual safeguarding training and community midwives also had face to face supervision at least every four months, all staff we spoke with said they were happy to call the lead nurse if they had concerns.
- Records for the women's services showed 76% of staff had completed level one and two children's safeguarding training; however, 92% of staff had completed children protection level three training. All midwives we spoke with told us they had completed levels two and three safeguarding children and level three enhanced training.
- Records showed 76% of staff had completed safeguarding adults level three training against a trust target of 90%.
- The service reviewed security arrangements in February 2015; part of this review included a drill of the abduction policy in June 2015. The abduction policy was ratified and implemented. The trust board reviewed recommendations, and agreed funding for an infant tagging system.
- We asked staff how they assessed and reported concerns around female genital mutilation (FGM). The World Health Organisation (WHO) defines FGM as procedures that include the partial or total removal of the external female genital organs for cultural or other non-therapeutic reasons. Senior clinical staff told us there had been training about FGM the previous year, which raised awareness. A guideline was in place to support staff in the identification of those at risk of FGM and management. Since September 2014, it has been mandatory for all acute trusts to provide a monthly report to the Department of Health on the number of patients who have had FGM or who have a family history of FGM. In addition, where FGM was identified in NHS patients, it is now mandatory to record this in the patient's health record; there was a clear process in place to facilitate this reporting requirement.
- Private rooms were available on the pregnancy advisory unit to counsel young women. Staff were trained to ask girls aged 13 to16 about their sexual activity and refer to appropriate agencies where necessary. Girls under 13 years were referred automatically to the safeguarding team.

Mandatory training

- Midwifery, health care assistants (HCA) and medical staff attended a two-day obstetric mandatory programme, which included emergency drills, adult and neonatal resuscitation, infant feeding, record keeping and risk management awareness. The service had developed a multidisciplinary simulation course in obstetrics (MUSICO) aimed at midwifery, obstetric, neonatal and anaesthetic staff, and had been recognised regionally as good practice.
- All attendance at training provided by the service (including CTG training) was monitored by the data clerk in the simulation centre, this was separate the trust's electronic staff record, as management recognised that electronic staff record was not accurate. Managers monitored mandatory training monthly and staff were red amber green (RAG) rated, this ensured compliance with staff accessing either eLearning or mandatory training days.
- We reviewed data which showed 100% of midwives and HCAs had attended days one and two of the divisional training. 25% of consultants had attended divisional training; however, this was due following our inspection. 100% of trainee medical staff attended a local training during induction.

Assessing and responding to patient risk

- Midwifery staff identified women as high risk by using an early warning assessment tool known as the Maternal Early Warning System (MEWS) to assess their health and wellbeing. This assessment tool enabled staff to identify and respond with additional medical support if necessary. We reviewed nine records and saw all contained completed MEWS tools.
- Arrangements were in place to ensure checks before, during and after surgical procedures in line with best practice principles. This included completion in

obstetric theatres an adaptation of the World Health Organisation (WHO) surgical safety checklist. The unit used both an electronic and paper version. The pre-operative assessment pack had a paper copy inside them to ensure they were available on the day of surgery.

- An obstetric audit of the WHO checklist for the period May 2015 (sample size of 47) showed 94% completed electronic checklists and 60% completed paper checklists, we reviewed 5 completed checklists and found them to be completed appropriately.
- There were clear processes in the event of maternal transfer by ambulance, transfer from homebirth to hospital and transfers postnatally to another unit.
- The unit used the 'fresh eyes' approach a system which required two members of staff to review fetal heart tracings, which indicated a proactive approach in the management of obstetric risks.

Nursing and Midwifery staffing

- The service met the national benchmark for midwifery staffing set out in the Royal College of Obstetricians and Gynaecologists guidance (Safer Childbirth: Minimum Standards for the Organisation and Delivery of Care in Labour) with a ratio of 1:28 across both community and hospital staff against the recommended 1:28.
- The service used an acuity tool to assess workload. The head of midwifery and managers reviewed staffing levels and skills mix each month. There was a safe staffing and escalation protocol to follow should staffing levels by shift fall below the agreed roster. The service was innovative in managing workloads and could utilise staff flexibly, for example, using non-clinical midwives (including the Head of Midwifery and Matron) where necessary.
- We found staffing levels were displayed on the entrance to all wards and there was a correlation between planned and actual staffing numbers.
- The service commissioned a Birthrate Plus® review in July 2014 and completed in September 2014. It has led to the development of a maternity support worker role to increase skill mix, within the midwifery teams. Staff had been appointed; however, not all pre-employment checks had been completed. An additional 6.64 whole time equivalent (WTE) midwives had been added to the establishment.
- Women told us they had received continuity of care and one-to-one support from a midwife during labour. The trust reported the percentage of women given one-to-one support from a midwife was good.
- The service used a formal patient escalation and handover tool (SBAR). The SBAR tool was used to document calls women made to the unit and during formal handovers. We observed handovers on delivery suit and the community midwives, which were comprehensive. On the delivery suit there was a further bedside handover, we observed handover between midwives and again this was concise.
- The service used bank midwives from their own staffing establishment should shifts require cover, the total hours worked was monitored by management to ensure staff were not working too many hours, which could affect patient safety.
- We found that the nursing establishment was set at 1:8 for those working within the NGOC. We were informed that there are some gaps in establishment, however, were assured the service was using effective processes to increase the staffing establishment.

Medical staffing

- The medical staffing mix for the maternity and gynaecology service across the trust was worse than the England average, with 27% consultant grade staff compared to the England average 35%. In the weeks before our inspection a new consultant had started which had increased labour ward cover. Middle grade staff, that is doctors with at least three years as a senior house officer or at a higher grade, was 4% at the trust and the England average was 8%. The trust had higher than the England average for registrar level staff, which formed 58% of the staff, against an England average of 50%. Junior doctors, those in foundation years one or two, made up 12% of staff, with the England average at 7%.
- The delivery suit had consultant cover 60 hours per week. There was also a resident consultant on call one night per week. We spoke with five consultants who all corroborated this information. This was in line with the Royal College of Obstetrics and Gynaecology (RCOG) recommendations for the number of births.
- The consultant obstetricians provided acute daytime obstetric care on the labour ward and participated in out-of-hours' work when they were on call for the obstetrics and gynaecology units.

- Multidisciplinary ward/board rounds took place at 08.45am, 1.30pm, and 8.45pm for all women and review of critical care women as their condition dictated, the labour ward coordinator also took part in the medical handovers.
- Consultants met once a week to discuss their caseloads, and risk, and said this was a useful forum to ensure consistent care was provided to all women.
- All consultant posts were appointed to; with a locum consultant working in maternity and NGOC whilst awaiting substantive appointments.

Major incident awareness and training

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

Are maternity and gynaecology services effective?

Good

We rated effective as good because:

The service used national evidence-based guidelines to determine the care and treatment they provided and participated in national and local clinical audits. Patient outcomes were routinely monitored and action taken to make improvements.

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

Women reported having their pain effectively managed and there were choices for managing pain. An anaesthetist was on duty to administer epidurals. Women were offered support to feed their baby's, and food and drinks were always available for mothers.

Patient outcomes were monitored using the maternity dashboard not all patient outcomes were within expectations; however, we saw that investigations were underway in areas of concern.

Multidisciplinary working was good between hospital and community services and support from allied healthcare professionals and specialist expertise was available to women using services.

Evidence-based care and treatment

- Medical and clinical staff reported having access to guidance, policies and procedures on the hospital intranet.
- We could see from our observations and through discussion with staff that care was in line with the National Institute for Health and Care Excellence (NICE) Quality Standard 22. This quality standard covered the antenatal care of all pregnant women up to 42 weeks of pregnancy, in all settings that provided routine antenatal care, including primary, community and hospital-based care.
- The care of women who planned for or needed a caesarean section was seen to be managed in line with NICE Quality Standard 32. For example we saw evidence of a discussion with a consultant before an elective caesarean and a debrief after birth.
- There was evidence to indicate NICE Quality Standard 37 guidance being met. This included the care and support that every woman, their baby and as appropriate, their partner and family should expect to receive during the postnatal period. There were arrangements in place that recognised women and babies with additional care needs and referred them to specialist services. For example, there was an on-site special care baby unit (SCBU).
- Staff were consulted on guidelines and procedures, which were regularly reviewed and amended to reflect changes in practice. Policies and procedures were available on the trust's intranet and were ratified by the

Safecare group. The policies we reviewed (post-partum haemorrhage, multiple births, pre-eclampsia and raised blood pressure) were all in-date and in line with best practice.

- We found staff in the fertility control service followed The Abortion Act 1967 and Abortion Regulations 1991. This included the completion of the necessary forms (HSA1 and HSA4).
- We found the care of women using the services were in line with Royal College of Obstetrics and Gynaecology (RCOG) guidelines (including 'Safer childbirth: minimum standards for the organisation and delivery of care in labour'). These standards set out guidance about the organisation, safe staffing levels, staff roles, and education, training and professional development.
- NHS Litigation Authority Clinical Negligence Scheme for trusts, maternity clinical risk management standards was assessed in February 2013 against five standards. The service had held level three since January 2010 and was reassessed in the monitoring of their own implementation of the level one approved documents. Each standard contained 10 criteria giving 50 criteria. In order to gain compliance at level three 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 40 out of 50 for safety standards such as high risk conditions, postnatal and new-born care, clinical care organisation and communication.
- The unit was implementing the NHS funded Saving Babies in North England (SaBiNE) which was a care bundle for still birth prevention, through improved antenatal recognition of fetal growth restriction. Antenatal care pathways reflected the enhanced monitoring the project needed, resulting in increased antenatal monitoring for all pregnant women.

Pain relief

- Women received detailed information of the pain relief options available to them, this included Entonox piped directly into the delivery rooms and poolroom.
- Clinical records showed pain was assessed throughout labour; however, this was not documented on the MEWS charts.
- The service provided a 24-hour anaesthetic and epidural service. The trust did not collect this data, however, between March 2015 and August 2015 an average 92% of women received the pain relief they wanted in labour.
- An audit of women's experience of their care between March and August 2015 showed between 83% and 100% of women received the pain relief they wanted during labour.

Nutrition and hydration

- There was a public health midwife with a strategic lead for infant nutrition; this role included training staff and breastfeeding peer supporters ("breast buddies"). When we inspected, there were 14 peer supporters providing breastfeeding support in the community and 12 ready to start training.
- Breastfeeding initiation rates for deliveries that took place in the hospital for April 2015 to 2013 to June 2015 were reported as 61%, which was below the target of 66%.
- The trust was implementing United Nations Children's Fund (UNICEF) Baby Friendly Initiative standards. The unit had achieved stage one accreditation and were working towards stage two of the accreditation process.
- Women told us they had a choice of meals and these took account of their individual preferences, including religious and cultural requirements. Women we spoke with said the quality of food was good.
- Patients admitted the gynaecology ward had their nutritional status assessed via the MUST (Malnutrition Universal Screening Tool) risk assessment. This identifies a patient's current nutritional state, patients are reassessed and changes in score are monitored and acted upon. Dietary requirements are assessed and any requirements are recorded and communicated to the housekeeper and documented on boards above patient's beds. The NGOC also has a link dietitian.

Patient outcomes

- There were no risks identified in maternal readmissions, emergency caesarean section rates, elective caesarean sections, neonatal readmissions or puerperal sepsis and other puerperal infections (Source: HES 2014/15; Intelligence Monitoring Report May 2015).

Maternity and gynaecology

- Emergency caesarean section rates were 16%, which was comparable with the England average of 15%. For elective sections, the service achieved 8% which was better than the England average of 11%.
- The service achieved a normal vaginal delivery rate of 64%, which was better than the national average of 60%.
- The National Neonatal Audit Programme (NNAP) includes two questions that would apply to the maternity area. The report for 2013 indicated the location achieved 100% compliance with temperature taking of babies born at less than 28 weeks and 6 days. The unit scored 72% for 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, this was worse than the NNAP standard of 85%.
- Trust data showed the antepartum stillbirth rate over 24 weeks between April 2015 and September 2015 was one. In comparison this was better than 2014/2015 data which showed seven. This improvement in the rates of stillbirth was attributed to the implementation for the SaBiNE care bundle. We reviewed data which showed the detection rate for small for gestational age was 56.1% this was higher (better) than other participating units with a detection rate of 34.4%.
- The number of 3rd and 4th degree tears was above the trust target between April 2015 and June 2015 at 16 and the target was less than three, however, staff we spoke with identified that the increase in numbers were due to training and improved detection of anal sphincter injuries.
- There were no unplanned maternal admissions to the intensive care unit (ITU) between April 2015 and June 2015.
- The service reported an average of HIV coverage for 2014 to 2015, during the same time fame there was a 100% referral rate for women identified to have Hepatitis B.
- During 2014 to 2015 the services reported an average of 2.2% of avoidable repeated new-born blood spot tests which was in line with national guidance.
- NGOC outcomes were monitored quarterly using an outcomes meeting which discusses cases which involved major gynaecological oncology services. The mortality rate for the NGOC was reported to be 1.8%.

Competent staff

- The head of midwifery, matron and managers, monitored staff training monthly. The appraisal rate was 85% this was below the trust target of 90%, however, we were assured processes were in place to address this.
- We reviewed the training programme for obstetrics covering 2015. Subjects covered included, antenatal and new-born screening, and public health initiatives. The training programme also included skills drills in subjects such as cord prolapse (including at home) and breech delivery, shoulder dystocia, eclampsia and obstetric haemorrhage.
- Newly qualified band 5 midwifery staff had a period of 'preceptorship', where they received additional support and went through a programme of competencies. Staff reported the level of support and training was "very good." This included a safe to medicate programme which was compulsory for staff to complete before being able to give prescribed medications as qualified staff, other skills included time in operating theatres, during which midwives increased their previous knowledge acquired through midwifery training. This included scrubbing for surgery. Staff reported they had worked to achieve their band 6 status; which was awarded on completion of the band five competencies.
- Healthcare support workers were required to attend training to support the delivery of services and examples of subjects covered were the care of deteriorating patients and MEOWS, maternal observations, skills drills, breech births, eclampsia and neonatal life support.
- Staff working in both maternity and gynaecology confirmed they had an annual performance review or were expecting to have one in the immediate future. Staff we spoke with informed us the review offered a chance to discuss their performance and development needs, this was a valuable and positive opportunity.
- Revalidation was part of appraisal process for medical staff and was coordinated by the medical director's office. Staff we spoke with reported no difficulty in getting an appraisal done.
- All midwives had a named supervisor of midwives. Staff said they had access to and support from a midwifery supervisor. They reported the process was very similar to the annual performance review. 83% of the supervisors of midwives (SOM) were band seven and above, the ratio of SOM to midwives was one to 12 which was in line with recommendations. The 2014/15 local supervisory authority (LSA) report identified that

SOM's did not have protected time to undertake annual reviews with staff in a timely manner. This was addressed and processes were put in place to give SOM's one day a month to undertake their supervisory role.

- The results of the General Medical Council National Training Scheme Survey 2015 showed educational and clinical supervision, induction and adequate experience for junior doctors was within expectations for this trust.
- Junior doctors attended protected weekly teaching sessions and participated in clinical audits. They said they had good ward-based teaching, were supported by the ward team and could approach their seniors if they had concerns.
- We reviewed evidence that shows gynaecology nursing and secretarial staff had a mandatory training compliance rate of between 96% and 100%, however the compliance rate amongst senior medical gynaecological oncology staff was 25%. The service was undertaking action to address this, for example mandatory training sessions were being held in the department.

Multidisciplinary working

- There was good multidisciplinary working. All staff, including those in different teams and services for example consultant and nursing and midwifery worked collaboratively to ensure the best possible care was provided to their patients.
- Staff were involved in assessing, planning and delivering women's care and treatment. The service participated in regional and local multidisciplinary team networks in areas such as fetal medicine.
- There was access to medical care for women who had other conditions, for example, specialist medical antenatal clinics for women with comorbidities.
- Women had access to interventional radiology for cases of placenta praevia (where the placenta presents before the foetus); this service was available in main theatres before elective caesarean section and performed in partnership with the radiology team.
- We observed communications with GPs summarising antenatal, intrapartum and postnatal care in medical records.
- Staff confirmed there were systems in place to request support from other specialties such as physicians, consultant microbiologists and pharmacy.
- Midwives at the hospital and in the community worked closely with GPs and social care services while dealing with safeguarding concerns or child protection risks.
- The health visitors and the community midwife team worked together to identify and report potential risks to hospital staff, risks were notified to health visitors, and community midwives had access to pathways about vulnerable women.
- Staff confirmed they could access advice and guidance from specialist nurses/midwives, as well as other allied health professionals.
- Patients and staff we spoke with provided examples of multidisciplinary working in practice, for example working with multiple allied health professionals, medical and surgical specialities to support women during pregnancy and childbirth.
- The NGOC held a weekly multidisciplinary team meeting where all new and returning cancer patients from the region are discussed. This meeting is attended from representatives from around the region either in person or by teleconference.

Seven-day services

- An obstetric theatre team was staffed and always available. A team was also on call out of hours. One consultant anaesthetist was allocated to delivery suit Monday to Friday 8am to 6pm. In addition, a duty anaesthetist was available for maternity services 6pm to 8am. An appropriately trained anaesthetic assistant, also present on the labour ward 24 hours a day, supported the anaesthetist.
- There was medical staff presence on the labour ward 24 hours a day.
- The pregnancy assessment unit was open 24 hours, seven days a week and triaged all emergency admissions, pre operation checks, elective ultrasound scan lists.
- Urgent ultrasound facilities were available 24 hours a day seven days a week through the on-call medical team and midwife sonographers.
- Community midwives provide 7 day cover with postnatal clinics available at the weekends

Access to information

- Patients who used the women's health services had access to informative literature. We saw examples on display, such as whooping cough in pregnancy, smoking cessation, pathway through labour and optimal infant nutrition.
- Copies of the delivery summary were sent to the GP and health visitor to inform them of the outcome of the birth episode. We spoke with community midwifery staff who informed us they had regular contact with health visiting services.
- The walls in the postnatal ward had very little information on them; however, families requested the ward to "look like a hotel."
- The maternity unit had its own version of the trust corporate branding. The unit also had its own dedicated area on the trust website. Pregnant women and their families could access this site and take a virtual tour of the unit plus helpful videos, for example, how to change nappies and helpful tips for breastfeeding.
- Information to support the fertility control pathway included leaflets about medical and surgical pregnancy termination and being 'undecided about your decision'.
- Processes were in place to ensure that vital material was obvious in the maternal health record using different coloured plastic pockets to store different types of information that might be needed in an emergency,

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- Women confirmed they had enough information to help in making decisions and choices about their care and the delivery of their babies.
- Consent forms for women who had undergone caesarean sections detailed the risk and benefits of the procedure and were in line with Department of Health consent to treatment guidelines.
- There was a system to ensure consent for the termination of pregnancy was carried out within the legal requirements of the Abortion Act 1967. We reviewed an audit of 84 records between October 2014 and December 2014 which showed the service was working within legal requirements. The service planned to re-audit in 2016.
- The service had robust systems in place to monitor the consent forms and followed processes to ensure that all staff obtaining consent were qualified to do so.
- Staff had a good understanding of mental capacity and described the process of caring for women who may lack capacity. We reviewed evidence, which showed how this worked in practice and multiagency approaches to support women who were having their capacity assessed however no specific training data was available.

Are maternity and gynaecology services caring?

Outstanding ☆

We rated maternity and gynaecology services as outstanding for caring because:

Overwhelmingly we received feedback that care was excellent and compassionate. Women reported being treated with respect and dignity and having their privacy respected at all times. Women told us that nothing was too much trouble for staff.

The friends and family test was continually positive and scored very high consistently.

We observed staff demonstrating a strong, visible person centred culture throughout the service. Staff were highly motivated and passionate about giving exceptionally high standards of care.

Information was provided in ways that could be understood and women felt involved in making informed decisions about their care. Partners were involved and were made to feel comfortable and able to ask questions.

Staff took into account the individual needs of women and their partners and ensured appropriate support was provided to them.

Compassionate care

- Results from the CQC Maternity Service Survey 2015, showed the service scored better than other hospitals in two of the 19 questions about antenatal care, labour, birth and postnatal care, with the other areas scoring about the same as other hospitals.
- All women we spoke with were positive about their treatment by clinical staff and the standard of care they had received. Women told us they had a named midwife. They felt well supported and cared for by staff, and their care was delivered in a professional way. Comments included, "brilliant birth experience", '"staff

sensitive, happy with every stage of the procedure", and, "had every confidence in the staff". Three families asked to speak with us during our inspection of the postnatal ward and delivery suite each described consistent care, also mentioning their care had improved with each pregnancy experience.

- Results of the NHS maternity Friends and Family Test showed between April and July 2015 an average 97% of women would recommend the antenatal care, which is better than the England average at 95%. 94% of women would recommend their birth experience, this is below the England at 97% , 96% of women would recommend the postnatal ward compared to the England average at 94% and 100% of women would recommend the community postnatal care, compared to the England average at 98%. The response rate for the FFT in this service was low, however, there was no negative feedback noted. We saw staff proactively promoting patient experience projects, including the NHS Friends and Family Test, which included a feedback card and envelope system to improve the response rate.
- The NGOC FFT showed between April and July 2015 97 to 100% of patients would recommend the service.
- The service also undertook monthly inpatient surveys. The results of which were posted at the entrance of each clinical area in the women's unit for example 100% of patients were treated with kindness and understanding. All results were positive.
- We observed positive interactions from all staff from ward domestic to consultant with women and their partners. Staff were seen to be calm and compassionate, altering their communication style depending on the situation. We heard staff providing advice and encouragement, as well as dealing with urgent situations with calmness and efficiency.
- Partners and families we spoke with overwhelmingly told us that staff were caring and go the extra mile to care for their loved ones.
- We spoke to a domestic who told us that she loved her job and although it was busy at time she wanted to make a difference for all of the families.

Understanding and involvement of patients and those close to them

- Women were involved in their choice of birth, at booking and throughout the antenatal period. Women we spoke with said they had felt involved in their care; they understood the choices open to them and were given options of where to have their baby.
- We noted the rate of home births was low (below 1%); however, between March 2015 and August 2015 the inpatient survey identified 62% of women recalled the choice to have their baby at home. Records showed staff discussed birth options at booking and during the antenatal period. Supervisors of midwives, and the consultant team were also involved in agreeing plans of care for women making choices outside of trust guidance, focusing on supporting women's choices of birth while ensuring they were making fully informed decisions.
- Staff recognised and respected women's needs, always considering their personal, cultural, social needs into account. For example a father was supported in helping his wife breastfeed and care for their new-born when she was incapacitated.
- Staff showed determination and creativity to overcome obstacles in delivering care and achieving a positive and safe pregnancy and birth experience for women.
- Results from the CQC Maternity Service Survey 2015 showed the trust scored better than other trust for patients having confidence in the staff caring for them during labour and birth. The service was working closely with the local Jewish community to ensure that services were appropriate for their individual needs. The service has developed a 'Sabbath box' which supports families on the Sabbath with specific foods and equipment.
- The NGOC provide ancillary beds for family members whilst their relative is undergoing surgery, this is because due to the nature of the service some patients my travel and long distance for treatment.

Emotional support

- Bereavement policies and procedures were in place to support parents in cases of stillbirth or neonatal death; this was supported by a midwife with a special interest in the care of the bereaved. People's emotional and social needs were highly valued by staff, for example, the service had recently worked with a family who had experienced stillbirth to improve facilities for other families experiencing the loss of a baby. The bereavement room was self-contained and had a

separate entrance so women and their families experiencing pregnancy loss did not have to use the same entrance as families taking their babies home and celebrating.
- There were effective and confidential processes for women attending the pregnancy advisory service. Staff supported women to make informed choices about their termination of pregnancy options at a difficult time.
- Women were experiencing pregnancy loss were sensitively supported by staff regarding their choice about the disposal of foetal/placental tissue.
- Staff were fully committed to working in partnership with their patients, for example a patient informed us staff had recognised she would benefit from a clear plan of care, and had asked permission to act as their advocate. The patient informed us they felt empowered by this and the staff "had her best interests" in mind.
- Staff discussed with us how they cared for a women following a bereavement. It was clear that women of all stages in their pregnancy loss and their families were dealt with compassionately. Staff provided care and support to parents, relatives and each other. Staff offered the chaplaincy service to women to provide extra support. Bereavement services included the provision of a private room with a separate entrance; this meant that women who had undergone a pregnancy loss did not exit the unit through the same route as pregnant women and women taking their new babies home.
- Women we spoke with following labour told us that the midwives were friendly and supported them which made them feel calm and cared for throughout the birth
- The NGCO offers relatives the opportunity to visit consultants to debrief following the death of a loved one if they wish.

Are maternity and gynaecology services responsive?

Good

We rated the responsive domain as good because:

The service was aware of its risks, the need to ensure services responded to meet increasing demands, with the overall aim of the service was to be the provider of choice.

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

Facilities in maternity were set up in a way that enabled staff to be responsive to the needs of women and their families. There was access to investigation, assessment, treatment and care at all stages of the pathway. Where women had additional healthcare-related needs, there was access to specialist support and expertise.

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

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

Service planning and delivery to meet the needs of local people

- The service worked in a multiagency partnership with other agencies to support young mothers for example the Family Nurse Partnership (FNP), the Clinical Commissioning Group (CCG) and the antenatal early help pathway for vulnerable young women. All partners worked together to improve education, care pathways and clinical outcomes for teenage parents.
- Services engaged with mothers through social media to develop a network of mothers and families through to support service improvement through the Birth, Babies and Beyond forum. This group supported the service in redeveloping the maternity reception area and had been involved in the development of the QE Maternity Strategy
- The service consulted with patients to identify what would make their hospital stay more comfortable. This led to the development of a family room on the postnatal ward, so younger siblings could play in safety without disrupting other patients.
- We observed, community midwives planning their workloads to consider the needs of the service to enable women to have the flexibility, choice and continuity of care wherever possible.
- A postnatal debrief service called Birth Revisited was available for all women following birth. The supervisors of midwifery led this, and women received written

information summarising the discussion to ensure women had a documented understanding, which would support their emotional well-being in the postnatal period.

Access and flow

- Between April 2015 and September 2015 the service achieved 88% of bookings appointments before 12 completed weeks' gestation this was above the trust target of 87%
- Women received an assessment of their needs at their first appointment with the midwife. The midwifery package included all antenatal appointments with midwives, ultrasound scans and all routine blood tests as necessary. The midwives were available, on call, 24 hours a day for home births as needed. Community midwives were on call for home births and delivery suit cover if it was busy. The numbers on call would flex depending if there were an imminent home birth.
- Bed occupancy for 2013/14 was between 54% and 66%, however for 2014/15 the bed occupancy ranged between 71% and 84%. This increase in occupancy was due to an increase in booking numbers following the services push to be the "provider of choice" and a reduction in the number of beds on the postnatal ward.
- The pregnancy assessment unit (PAU) was open 24 hours a day, seven days a week and incorporated day assessment and triage. Women were referred by the community midwife, GP, A&E or by self-referral. The PAU also supported the labour ward and was able to start induction of labour for low risk women; also the unit had elective scan lists over the weekend.
- 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 8.8, against an England average of 8.
- Senior staff we spoke with and evidence provided by the service showed the service had not closed to admissions or deliveries for 15 years before inspection.
- The termination of pregnancy care pathway outlined the route for medical or surgical termination of pregnancies. Access to the service was available subject to best practice guidance. The number of medical abortions between April 2013 and March 2014 was 239. Surgical termination of pregnancy was carried out on 208 occasions for the same period.
- The service did not collect data about the percentage of women seen by a midwife within 30 minutes and a consultant within 60 minutes during labour. However, staff told us all women were seen immediately on transfer to the central delivery suite, however, they were seen by a consultant in accordance to need, for example, a low risk woman would not need to be reviewed by an obstetric consultant.
- Staff we spoke with informed us clinic follow up scans were not always available on the days of consultant clinics, which resulted in women returning for consultant reviews on different days. Staff we spoke with said this could be quite time consuming and caused some tension as women became frustrated with multiple trips to the antenatal clinic.
- All patients referred to the NGOC by the Thursday afternoon are added to the MDT discussion list for the following Monday, during this discussion a plan is formulated ready to be discussed with the patient the next day at clinic.

Meeting people's individual needs

- There were arrangements to support individuals with complex needs, with access to clinical specialists and medical expertise, for example, arrangements were put in place to support a woman with complex health and social care needs. There was a network of midwives and consultants with special interests in teenage pregnancy, drug and alcohol, perinatal mental health, bereavement, smoking cessation and high risk pregnancy.
- 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.
- Staff could explain how the translation service was accessed and used
- Midwives said they encouraged 'normalisation' about women's experiences, providing a good environment, as relaxed as possible, "with lots of information and informed choice."
- Women who were in early labour were sent home or could mobilise on the ward, however, an estates plan was in place to change the function of some rooms which would be used for women in the stages of early

labour and induction. Evidence-based guidance showed that women who were reviewed in a designated area away from the delivery suite experienced shorter labour and less medical interventions (Evidence Based Guidelines for Midwifery-Led Care in Labour Latent Phase, Royal College of Midwives, 2010).

- The postnatal ward had four single en-suite rooms in which partners could stay on a reclining chair, patients we spoke with felt valued being able to spend time together on the postnatal ward.
- There were processes to ensure disposal of pregnancy remains were handled sensitively. Women were provided with a choice of how they would like to dispose of pregnancy remains, following pregnancy loss or termination of pregnancy.
- Specialist nurses undertake holistic needs assessments, which ensure the emotional needs prior to surgery.

Learning from complaints and concerns

- Complaints and concerns were included on a performance dashboard and regularly monitored at SafeCare meetings.
- Both formal and informal complaints were treated with the same seriousness by the service. Staff offered to meet the complainant when complaints were received; this was supported by the PALS team. Meetings were followed up in writing, detailing the outcome. Between July 2014 and June 2015, the service received 10 formal complaints. We reviewed these cases and the outcomes of which were appropriate, duty of candour was appropriately applied in all cases. Themes of these complaints included communication, staff attitude and debriefing.
- The service produced a quarterly complaints litigation and PALS (CLIPA) report, which went to the Trust Board, and detailed all complaints for the previous three months.

Are maternity and gynaecology services well-led?

Outstanding ☆

We rated the well-led domain as outstanding because:

Leadership in maternity and gynaecology services was outstanding. We found a strong, cohesive senior leadership team who understood the challenges of providing good quality care managed the service and had identified effective strategies and actions needed to address these. This was particularly evident with the configuration of services which were well-developed and understood throughout the maternity and gynaecology departments. We also found strong departmental leadership who were supported in developing further leadership skills and to take ownership of their own departments.

Staff of all levels and experience were encouraged to submit ideas and were empowered to develop and implement solutions to provide a high-quality service.

Governance arrangements were embedded at all levels of the service and enabled the effective identification and monitoring of risks and the review of progress on improvement action plans. Regular robust detailed reporting at departmental and board level enabled senior managers to be aware of performance and where action plans had improved services.

A positive culture of openness and candour with a collective responsibility for quality, safety and service improvement was evident. Public and stakeholder engagement was seen as a priority. The views of the public and stakeholders were actively sought through engagement, recognising the value and contributions they brought to the service. Staff were encouraged to drive service improvement and used creative and innovative ways to ensure they met the needs of women who used the service.

Vision and strategy for this service

- The service could demonstrate a clear short-term and long-term strategy, for maternity and gynaecology services, however, the time of inspection this was in draft. The strategy included a programme to ensure services and patient activities were physically organised in a way to optimise operational efficiency and a better patient experience. Senior staff we spoke with informed us the views of service users and frontline staff were sought to develop the strategy.
- In the interim, the Head of Midwifery (HOM) had developed a progression and transformation plan which was shared with the band seven managers to ensure the service was focused on improvement.

- The NGOC had a strategy which included all aspects of the care provided and aims to become the provider of choice for both staff and patients for gynaecological oncology across the region and wider.

Governance, risk management and quality measurement

- There was a well-defined governance and risk management structure. The maternity risk management strategy set out clear guidance for the reporting and monitoring of risk. It detailed the roles and responsibilities of staff at all levels to ensure that poor-quality care was reported and improved.
- Comprehensive quarterly risk management reports were produced and presented at SafeCare meetings highlighting good practice and lessons learned. This report was also shared with all staff through the team leads.
- The service demonstrated a dedicated focus on understanding and addressing the risks to patient care. The risk management midwife worked proactively with wards, audit leads and supervisors of midwives and fed into the governance processes to recognise and raise concerns and ensure safe practice. For example staff were offered debriefing immediately after an adverse event and then again by a line manager within 24 to 48 hours.
- Performance and outcome data was reported and monitored through the performance dashboard. Any outliers (services lying outside the expected range of performance) were reviewed and timely action taken. For example, we asked the risk management midwife about the number of 3rd and 4th degree tears identified on the dashboard, we were advised that an investigation was currently underway and initially there were no trends identified.
- Local risk registers assisted the patient quality, risk and safety committee (PQRS) to identify and understand the risks. There were six risks identified for maternity and gynaecology: all had a current risk level as 'moderate risk'; the register described the risk, existing controls and gaps, and action necessary. For example, the risk of infant abduction, the service was reviewing electronic tagging systems and had raised awareness with staff to challenge suspicious behaviour; we observed this in practice during our time spent on the unit. We found there was clear alignment of what staff had on their 'worry list' with what was on the risk register.
- The Trust Board had a responsibility to review performance against the quality indicators on a monthly basis. Monitoring was carried out through the quality performance dashboard and the board received progress updates against any improvement projects. Regular meetings and ongoing communication was evident between the head of midwifery and director of nursing.
- Governance documents clearly identified the roles of the supervisor, of midwives and the local supervising authority. Supervisors of midwives told us they attended in this capacity and not in a dual role. This was in line with recommendations by the Nursing and Midwifery Council.
- All staff we spoke with had an awareness of the new Duty of Candour regulations that came into effect on 27 November 2014 and had been communicated in the staff bulletin. Policies on being open were already in use and an open culture was observed for reporting and responding to incidents and complaints.
- The service had completed a gap analysis following the publication of the Kirkup report (2015). All identified gaps had clear actions documented against them; we reviewed evidence that this analysis had been reviewed by the SafeCare meeting and commissioners.

Leadership of service

- Maternity and gynaecology formed part of the surgical business unit. There was a clear managerial structure, which included strong clinical engagement. We found the consultant body to be cohesive and proactive in decision-making, with innovative approaches to areas such as sub-specialisms and job planning.
- Leadership was encouraged at all levels within the service. Team leads were supported to complete the trust leadership programme.
- We observed a strong, cohesive leadership team who understood the challenges for providing good quality care and identified strategies and actions to address these. This was evident in the implementation of the SaBiNE work stream which included review and analysis of the number of stillborn babies and the launch of the care bundle.
- The head of midwifery and matron were seen in clinical areas and had a good awareness of activity within the service during the inspection. Staff we spoke with

informed us the HOM and matron would be seen in uniform and work clinically if needed. Staff were clear about who their manager was and who members of the senior team were.
- Staff we spoke with informed us the consultant body would offer support before it was asked, for example they would ask staff on the PAU if any patients needed review.

Culture within the service

- An open, transparent culture was evident where the emphasis was on the quality of care delivered to women. The service encouraged a 'no blame' culture where staff could report when errors or omissions of care had occurred and use these to learn and improve practice. For example, following the Never Event, the midwife involved had taken the lead in ensuring staff were trained in the new procedures put in place to mitigate a recurrence.
- We observed strong team working, with medical staff and midwives working cooperatively and with respect for each other's roles. All staff spoke positively and were proud of the quality of care they delivered. Some junior doctors commented that although it was a small unit, it was a "fantastic unit" to work in.
- Staff told us about the 'open door' policy at department and board level. This meant they could raise a concern or make comments directly with senior management, which demonstrated an open culture within the organisation.
- Staff we spoke with felt supported by the management team during times of ill health, we were informed of an instance where the head of midwifery had emailed a member of staff to say she hoped an appointment had gone well.
- Staff we spoke with informed us they had been student midwives at the trust and elected to stay in the organisation as they felt valued. We were told of instances where apprentices had been placed with the service and had gone on to apply for a position as a health care support worker and had been appointed.
- The maternity team were nominated for the staff awards by their patients and won the" Patients Award" 2015.

Public engagement

- The service actively sought the views of women and their families. The Birth, Babies and Beyond group was a highly functional group which met monthly and had engaged with up to 100 women. Not all attended the monthly coffee mornings; however, all were kept informed of news and developments.
- The service had developed a virtual tour of the unit and parentcraft video's for example changing a nappy, on the trust website.
- We reviewed evidence, which showed the trust had attended career fairs in the local community to enable students to make a fully informed career choice, this included work experience opportunities, which involved shadowing a midwife.
- The HOM and matron worked closely with the Safeguarding lead nurse and the local young women's project to understand what the service could do to support young women in pregnancy, childbirth and the postnatal period. This work led to the development of a set of standards young women would like staff within the service to appreciate.
- The service had a link midwife to work specifically with the Jewish community.

Staff engagement

- There were no directorate specific results in the 2014 NHS staff survey results for staff engagement. The national survey showed on a scale of 1-5, with 5 being highly engaged and 1 being poorly engaged, the trust scored 3.74. This score was the same as other trusts.
- We spoke with staff and in all areas staff were very engaged and felt involved in service development.
- The HOM had begun to link with a neighbouring trust to begin a process of sharing learning and resources.

Innovation, improvement and sustainability

- All staff spoke passionately about the services they offered and the creative ways they worked to ensure they met the needs of women using those services**.** They explained how their systems and processes were always developing in line with latest research and guidance. We saw some areas of exemplary practice, this included the full implementation of the Saving Babies Lives care bundle, the service was already realising a reduction in the number of still births as below;
  - 2013 total - 13 deaths (1798 deliveries)
  - 2014 total – 11 deaths (1810 deliveries)
  - 2015 Jan – July – 1 death (1079 deliveries to date)

Maternity and gynaecology

- Antenatal care pathways had been amended to reflect the increased surveillance required by the project.
- The trust was reaccredited in February 2013 at level three (highest level) accreditation against national maternity clinical risk management standards. This showed a record of accomplishment of delivery of care to a high standard and in line with evidence-based practice.

Services for children and young people

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

Information about the service

Services for children and young people included a paediatric emergency assessment pod and an 8-bedded, 24-hour children's short stay assessment unit based in the emergency care centre. A children's day unit and children's outpatient department were located together in a separate building. The service also provided a special care baby unit (SCBU) with 12 commissioned cots. Four of the consultant paediatricians worked in the community where the services provided included general community work, services for children with special educational needs, neurodevelopment clinics and feeding clinics. There was no children's inpatient ward.

During our inspection, we spoke with six medical staff and 12 nursing and allied healthcare professionals and reviewed 19 sets of healthcare records. We also spoke with 13 families.

Summary of findings

Services for children and young people were good.

Medical and nursing staff monitored safety, risk and cleanliness, and staffing levels were in line with national guidance. Staff knew how to report an incident of harm or risks of harm using the trust reporting mechanisms, incidents were discussed and managers took appropriate action.

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 and described their care as 'outstanding'. There was a strong person-centred culture and staff worked in partnership with patients and their families, going beyond the call of duty to meet the needs of children in their care.

The service looked after the needs of children and young people and staff were responsive. A positive, visible and proactive management team led the team. The service had a clear vision and managers were in the process of developing a strategy to support this. The service had also introduced innovative improvement 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 an incident of harm or risk of harm using the trust reporting mechanisms. We saw these were discussed and appropriate action taken by the management team however, when we reviewed prescription charts in the special care baby unit (SCBU), we found three unreported medication errors.

All clinical areas were visibly clean and regularly monitored for standards of cleanliness, staff were trained to use all equipment and the environment was safe. The outpatient waiting area was decorated with educational friezes giving healthcare information and was warm and welcoming.

The paediatric emergency assessment unit had an Omnicell system for the safe storage and dispensing of medicines. Within the children's day unit, medicines were stored securely however we found the labelling system within the drug cupboard did not correspond with the position of medication on the shelf.

Medical records were accurate and stored safely. Overall, records included all appropriate information however, we found several entries not signed and dated by the relevant clinician or healthcare professional.

Members of staff of all grades confirmed they received mandatory training, although training records did not always accurately reflect training uptake. Records showed not all staff had completed paediatric immediate or advance life support training, however we saw there was an action plan to address this and reviewed rotas that showed there was at least one trained member of staff in paediatric or advanced life support on each shift.

Levels of nursing and medical staff were adequate to meet the needs of children and young people and managers reviewed staffing levels regularly.

There were processes and procedures to ensure children and young people were safe. The service took a proactive approach to safeguarding patients from abuse and focused on the early identification of children subject to a child protection plan. Safeguarding leads and mangers encouraged staff to complete a 'cause for concern' form if they had any concerns about a child or young person. The named nurse for safeguarding children reviewed forms regularly. When we reviewed a selection of forms however, we found not all forms identified whether a child was already subject to a protection plan.

Incidents

- The trust had an incident reporting policy. Staff reported incidents of harm or risk of harm using the risk management reporting system which sent alerts electronically to the matron and ward sister. One of the senior nurses was also a trained incident investigator. Staff said they felt very confident reporting incidents and near misses.
- We saw evidence that staff discussed incidents regularly at monthly Safecare meetings attended by medical and nursing staff with senior managers from the service. Staff we spoke with told us incidents, subsequent actions and lessons learned were discussed daily at handover meetings. There was a process in place to update and inform staff who could not attend. Junior doctors said incidents and case reviews were discussed with them as part of their teaching.
- The organisation's 'Being Open' policy complied with the Duty of Candour requirements. Training had been offered to medical staff, managers and senior clinicians. Managers said that this was ongoing and was also part of the mandatory training package for consultants.
- We saw documented evidence of root cause analysis and actions plans resulting from reported incidents. For example, an error made during the administration of medication led to a review and new guidance for staff.
- There had been no never events or serious incidents reported between May 2014 and April 2015. Never events are incidents determined by the Department of Health as serious, largely preventable patient safety incidents that should not occur if the available preventative measures have been implemented correctly.
- There had been no pressure ulcers, falls or catheter acquired urinary tract infections recorded between June 2014 and June 2015.
- There were 35 incidents reported between April 2014 and March 2015. We reviewed incident data for the period 1 April 2015 to 31 July 2015 during which 16 incidents had been reported. Of those, 12 were classified as 'no harm'; three were 'low harm' and one

'minor harm'. Two incidents reported personal data sent to the wrong person while four incidents related to the administration of non-controlled drugs. Recorded outcomes showed apologies had been made and explanations provided to parents.

- Perinatal mortality and morbidity was monitored through the monthly perinatal meetings attended by medical and nursing staff from paediatric and maternity services. Outcomes were reported quarterly to the trust mortality and morbidity steering group chaired by the Medical Director. There was a lead paediatric consultant for child deaths across Gateshead who was also a member of the Child Death Overview Panel. Information and learning was shared across the team.

Cleanliness, infection control and hygiene

- All areas we visited were visibly clean. There were handwashing facilities at the entrance of each clinical area. Antibacterial hand gel dispensers were also available at various locations within each unit and checked daily by a healthcare assistant. There were posters on display, designed by children and young people, to promote good hand hygiene and the use of hand gels. One parent we spoke with said how good they thought the staff were at maintaining hand hygiene.
- The cleanliness of the clinical areas was assessed every week using a 'five measures' audit tool. There were weekly presentations to staff about the results, which were displayed on public notice boards in the unit.
- The matron carried out regular environmental audits with the infection control nurse to monitor cleanliness and to ensure good standards were maintained. Records showed all areas were consistently good.
- We saw evidence of cleaning audits in the special care baby unit (SCBU) and cleanliness logs for the daily cleaning of equipment.
- Personal protective equipment was readily available to staff to use and we observed staff using it appropriately. We also observed staff adhering to 'bare below the elbow' guidance, in line with national good hygiene practice.
- Data on Methicillin-Resistant Staphylococcus Aureus (MRSA) bacteraemia was recorded on a neonatal dashboard and there were no current cases. Following a run of MRSA colonisations in 2014, the trust developed an action plan and a new flow chart of what action should be taken for any future positive screenings. All babies admitted to the special care baby unit (SCBU) were screened for MRSA and this continued on a weekly basis.
- Toys within the waiting areas were clean and the nursery nurse was responsible for ensuring they were cleaned daily using antibacterial wipes and hot soapy water. Staff told us there was a policy in place for this.
- We saw evidence of clinical waste disposal units, for example, sharps boxes for the safe disposal of needles. Staff told us bins were emptied regularly.

Environment and equipment

- Children's services had a dedicated day unit and outpatient department housed within one building, detached from the main hospital building. It was on one level and the main entrance was accessible through a sloping ramp. Within the outpatient waiting area, the walls were brightly decorated with pictures, posters and wall friezes containing educational content. We were told the nursery nurse had developed these friezes with involvement from local children and patients and they were updated seasonally. For example, a display promoting safe sun care had been removed and was in the process of being replaced with fire safety advice in preparation for bonfire night.
- We saw evidence of processes to ensure that equipment was safe and we saw documentation for checking and cleaning equipment. Equipment and devices were maintained in partnership with the trust medical devices department, electronics department and the supplies team. Equipment we checked had been PAT (portable appliance test) tested and when we noticed one item had expired, a member of staff took immediate action.
- Staff we spoke with told us they knew who to contact if they needed to report any faults and felt confident the system was robust.
- Staff were trained to use the equipment. For example, paediatric nurses attended a joint training session with staff from the urgent care team in the use of equipment in the emergency care centre.
- A trained nurse checked the resuscitation and phlebotomy trollies in the outpatient department daily. We saw they were equipped appropriately, the expiry dates were within range and staff we spoke with knew what to do in an emergency.

- There was a laminated checklist for the resuscitaire in the special care baby unit (SCBU). We saw there were two items missing. There was no gastric tube size 6 in the top drawer and no endotracheal tube length chart.
- SCBU was located in a shared building with maternity, behind the main hospital site. Staff explained the rooms were set up to ensure babies were safe and to create a comfortable and relaxing atmosphere so parents felt supported in caring for their child. However, we found access to cots and incubators in the two special care rooms was restricted as one side (the long side) of each cot was against the wall. This restricted access in an emergency. To mitigate this risk, staff transferred babies to the high dependency unit (HDU) (along the corridor in the same building) for resuscitation and stabilisation. Senior managers in the trust were aware of the space issue. Although the current compliment of cots in SCBU was 12, the median occupancy per day was eight. There was a plan to reduce the number of cots to eight on a permanent basis from April 2016, which would increase the amount of space on the unit. Babies were transferred in and out of the unit to maintain the capacity levels of the cots and staff followed the Neonatal Inter-Hospital Transfer policy if a baby required specialist intensive care.
- A recent complaint had been made from a parent who felt isolated in one of the two 'quiet rooms' in the corridor between SCBU and maternity. Although the complaint was partially upheld, we were told the trust had plans to remodel those rooms for transitional care. The location of these rooms meant parents would be isolated from healthcare professionals. Charitable funds had provided funding to upgrade the unit to improve the environment and meet the needs of families and we were informed this work would commence in 2016.

Medicines

- The trust had a policy for the administration and storage of medicines. Staff we spoke with told us they followed this policy. Medicines management was part of the preceptorship training package for newly qualified nursing staff and specific training was provided when new medications or procedures were introduced. For example, we saw evidence that staff were certified to prepare, administer, record and dispose of intranasal diamorphine for children.
- Staff were encouraged to report incidents about medication errors and we saw documented evidence to support this. We also saw evidence of a root cause analysis and subsequent action plan following a medication calculation error. Staff told us actions resulting from medication errors were discussed at Safecare meetings and ward meetings. However, when we looked at 11 prescription cards in SCBU, we found three medication errors. Although the trust informed us staff had administered the medication (vitamin drops), we did not see this documented on the relevant card.
- The paediatric emergency assessment pod had an Omnicell system. This system ensured patients would not receive any medication that had expired. The pharmacy department staff ensured the stock levels were maintained. For the administration of controlled drugs, the system required two staff fingerprints before drugs were dispensed.
- Medicines were stored securely in the day unit. Storage cupboards and fridges were tidy and locked. During the day, the trained nurse on duty retained the keys. Out of hours, the keys were held within the paediatric emergency assessment pod. However, the labelling system within the drug cupboard did not correspond with the position of medication on the shelf. There was a potential risk of a member of staff reading the label on the shelf and reaching for the incorrect medication due to its incorrect positioning.
- We were told the pharmacy team checked the medicine storage unit and refrigerator weekly. The medicine refrigerator temperature did not seem to be checked and recorded daily using the minimum and maximum temperatures to monitor any temperature deviations. We saw the temperature was 2oC, which, upon opening the door, rapidly changed to 5oC. Staff we spoke with thought pharmacy were responsible for this.
- There were two refrigerators in SCBU, one for drugs and another for breast milk. There was also a freezer used for storing breast milk. We saw evidence they were checked daily by nursing staff and all temperatures were accurate.
- Staff said they had 24-hour access to pharmacy for information and advice.

Records

- Records were managed and handled safely. We spoke with a member of the administrative staff who explained the process of retrieving and returning medical notes and we did not see any unattended notes during our inspection.

- We reviewed 19 sets of care records throughout children's services. Overall, they were completed accurately and included appropriate information, including risk assessments. However, we noticed not all entries were signed and dated by the relevant clinician.
- Health care records were audited quarterly by the trust Safecare team and there were weekly audits on paediatric early warning scores (PEWS) charts.

Safeguarding

- The trust had a safeguarding children policy and a safeguarding children supervision policy. Staff felt the safeguarding team had a high profile across the organisation and could explain what actions they would take if they had concerns about a child or young person.
- The trust had a Named Nurse safeguarding children lead and a Named Doctor. Before the inspection, the trust did not have a Designated Doctor for Safeguarding Children and this was highlighted as a risk on the paediatric risk register. During the inspection, we were informed a new Designated Doctor had been appointed and an internal consultant had already been identified to undertake the role of Named Doctor.
- The safeguarding lead told us relationships with the Local Safeguarding Children's Boards (LSCB) at Gateshead and Sunderland were good and the Director of Nursing sat on the Gateshead LSCB board.
- Data provided to us by the trust showed 94% of staff from children and young people's services had received safeguarding children level three enhanced training. Mandatory safeguarding children training was delivered by the named nurse. Levels 1 and 2 were amalgamated and delivered as one 45-minute session. The training package included signs and symptoms of child sexual exploitation (CSE), female genital mutilation (FGM), radicalisation, child trafficking, neglect and learning from serious case reviews (SCR). The named nurse also included an update on the lessons learned from the Savile investigations. This training was mandatory for all staff. Level 3 training covered these topics in more depth and was a two-hour face-to-face session for staff that were directly assessing and caring for children and young people. The named nurse told us the LSCB and other external facilitators provided training. One member of staff we spoke with told us she had recently attended a joint training session with colleagues from the maternity team about female genital mutilation (FGM).
- At the time of inspection, Gateshead had the highest number of unborn children subject to a child protection plan in England. The named nurse received daily updates from Gateshead local authority (LA) about children who were subject to a protection plan and this was recorded on the electronic database, Medway.
- There were systems to ensure children and young people were safe. For example, children who visited the hospital from other areas were tracked using their unique NHS number. This enabled the service to identify children who were subject to a child protection plan elsewhere.
- The named nurse and named doctor also had access to a local safeguarding database, which was shared with the safeguarding team from the neighbouring NHS trust who provided community services for children and young people. The database included information about children who were subject to a child protection plan plus data collected from 'cause for concern' forms.
- Staff completed 'cause for concern' forms if they had any concerns about a child or young person. They would take any appropriate safeguarding action at the time and were encouraged to inform parents. The named nurse collated and reviewed the forms, which, on average, amounted to approximately 90-100 per month and updated the safeguarding database. There was a safeguarding checklist to support staff and those we spoke with told us they felt confident completing the forms and raising alerts. Staff could contact the named nurse for information or advice and access relevant guidelines on the trust intranet. The trust also had a checklist for staff to use when safeguarding children and young people; this checklist was on display at staff workstations.
- We reviewed 10 'cause for concern' forms. We saw evidence of appropriate action taken, for example referrals to social care, including one made by the named nurse. Forms were also completed when the behaviour of an adult with parental responsibility presented a risk to a child. However, on eight of the forms we reviewed, it was not clear whether staff had checked if a child was already subject to a protection plan.
- The trust had a child abduction policy and its own police officer. Staff we spoke with told us this had recently been tested and staff were successful in apprehending the 'suspect' before they could leave the hospital premises.

- Access to the day unit, SCBU, the paediatric emergency assessment pod and short stay assessment unit was restricted and accessible by a keypad entry code only.

Mandatory training

- The target for mandatory training compliance was 90%. Information provided to us by the trust showed 85% of staff had achieved the required level of compliance. Staff were notified by their line manager when their training was due.
- Only 36% had completed Paediatric Immediate Life Support (PILS) training and Advanced Paediatric Life Support (APLS) training. 53% of staff had completed Newborn Life Support (NLS) training. A statement from the trust acknowledged significant unplanned absence had affected the provision of some training and, as a result, a recovery plan had been established and due to take effect in autumn 2015. The current nursing rota showed there was at least one APLS trained nurse on duty per shift in paediatrics and NLS trained nurses in SCBU. We reviewed an action plan, developed to increase the number of APLS and PILS trained staff, and the trust was currently awaiting further training dates.
- We saw evidence medical staff had completed Advanced Paediatric Life Support (APLS) and Newborn Life Support (NLS) training however, the lead paediatric consultant for SCBU told us his NLS training certificate had expired six years before. Evidence provided to us by the trust showed the consultant had successfully completed APLS training in 2010 and attended a northern neonatal network newborn stabilisation workshop in 2012.

Assessing and responding to patient risk

- Between 7.30am and 2.00am paediatric-trained staff triaged children and young people who attended the emergency care centre.
- Children's services used the paediatric early warning scores (PEWS), an early warning assessment and clinical observation tool. This included a clinical observation chart, coma scale and additional information such as pain score tools with an assessment table to assist clinical staff in determining what action should be taken for an ill child. Staff explained the chart would assist with determining whether a child required transfer to a tertiary centre for children such as at Newcastle.
- SCBU did not use a new-born early warning trigger and track (NEWTT) however, senior clinicians and nursing staff were in the process of introducing a national early warning score (NEWS) chart on the postnatal ward.
- The trust had a paediatric patient transfer protocol which was developed with local trusts that provided inpatient care. The ward manager told us the need for transfer was usually determined at the point of presentation in the paediatric emergency assessment unit. Staff were clear about the process and also explained if the child had complex needs, they would be transferred to the specialist children's hospital in Newcastle. Staff acknowledged there could sometimes be delays in transfer as the trust was reliant upon the North East Ambulance Service for transport. In such cases, the patient would be admitted to the short stay assessment unit and remain there overnight.
- There were guidelines for the safe transfer of care from SCBU to neighbouring trusts who provided more specialist support and care. The nearby Royal Victoria Infirmary in Newcastle provided a dedicated neonatal transport service.
- Within the emergency care setting, there was a paediatric escalation plan in place to support the paediatric emergency and short stay assessment units if there were any pressures on capacity. It identified triggers and actions for staff to follow in such an event.

Nurse staffing

- Staffing levels in SCBU were in line with the standard recommended by the British Association of Perinatal Medicine There were 4.0 whole time equivalent (WTE) band seven nurses in the neonatal service who were supported by 4.0 WTE band six neonatal nurses and 4.50 WTE band five neonatal nurses. The team also included 3.0 WTE healthcare assistants. There was a planned process for succession planning in SCBU. Band five nurses had been seconded into band six posts and there were also opportunities for rotation between paediatrics and SCBU.
- Staffing in SCBU was monitored daily on the perinatal team dashboard.
- The paediatric nursing team was led by 1.0 WTE band seven-ward manager. There were 1.8 WTE band six and 15.29 WTE band five paediatric nurses. They were supported by 4.29 WTE healthcare assistants plus 1.0 WTE band four nursery nurse.

- Rotas were produced every four weeks using the SMART rota system; the ward sister also planned an extended 12-week rota which was developed with nursing staff. The rota was inclusive of all units and nursing staff worked across all areas. We were told this worked very well and enabled the service to cover any anticipated shortfalls well in advance.
- Children's services met the Royal College of Nursing guidance in relation to paediatric nurse staffing levels. In the paediatric emergency assessment pod and short stay unit, between 7.30am and 8.30pm, there were four qualified paediatric nurses and one healthcare assistant. Between 8.00pm and 8.00am there were two qualified paediatric nurses and one qualified trained nurse between 6.00pm and 2.00am.
- Between July 2014 and July 2015, the monthly sickness rate average for children's services was below the trust-wide average for this period. Sickness rates in SCBU increased in April and May 2015. The shortfall caused by sickness absence was managed using bank staff. Overall, the number of bank staff used in children's services was lower than the trust as a whole. It only exceeded the trust average over this short period.

Medical staffing

- Medical staffing levels were in line with Royal College guidelines. According to the Health and Social Care Information Centre, the skill mix was similar to the England average for junior doctors, registrars, middle grade doctors (doctors with at least three years' experience as senior house officer or at a higher grade) and consultants. The WTE for medical staffing was 24.0. There were 11 paediatric consultants, which equated to 8.35 WTE. We were told this was a full complement of staff and there was only one bank locum who was covering maternity leave when we inspected the trust. Locums were sourced using an agency to cover at registrar level.
- The neonatal service had 24-hour availability from a consultant paediatrician and 24-hour resident cover from an experienced specialist trainee with a minimum of four years specialist training.
- We viewed recent medical rotas. There was a three-tier rota for children's services and this included registrars, middle grade doctors and consultants. Ten consultant paediatricians contributed to the 24-hour on-call rota and this equated to 7.5 WTE. At weekends, there was consultant cover within the hospital between 9.00am and 5.00pm and then on call between 5.00pm and 9.00am.
- Handovers between medical staff occurred daily at 8.30am, 5.00pm and 9.00pm during the week. At weekends, these took place at 9.00am and 9.00pm. We observed one session that was attended by two consultants, two registrars, three senior house officers (SHO) and six medical students. It was held in a separate room, away from patients and families. The handover was led by a senior consultant and was very clear with educational content and an emphasis on learning. One doctor, who was sitting at a computer, retrieved a baby's blood results and x-rays while the patient was being discussed to inform the handover and prevent any unnecessary delay. Each doctor showed a very good knowledge of every child in their care. One doctor highlighted the need to arrange an interpreter for a family whose first language was not English. When we followed this up later that day, we found action had been taken.

Major incident awareness and training

- The business unit had a major incident and escalation plan and children's services had its own tailored action plan. The plan set out a list of specific actions for the senior nurse or manager on duty. Staff we spoke with (at all levels) demonstrated awareness of the plan and members from the paediatric team had taken part in scenario testing as part of the move to the new emergency care centre.
- Business continuity plans were in place as part of the overall trust business continuity planning policy.

Are services for children and young people effective?

Good

We rated effective as good because:

The service 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 children's services participated in national audits that monitored patient outcomes when these were applicable.

Policies and guidelines were accessible to staff on the trust intranet however, paper copies were also held in clinical and ward areas. Policies we viewed online were in-date however; some of the corresponding paper copies were not.

Children and young people had access to pain relief if needed and staff used an evidence-based pain-scoring tool to assess the impact of pain. Non-pharmacological methods were also utilised including a 3D television to distract and calm children before, during and after the administration of treatment.

Nursing and medical staff were qualified and had the skills they needed to carry out their roles effectively and in line with best practice. 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 children's service reviewed and implemented NICE guidance and other evidenced-based best practice guidance. New guidelines were reviewed and ratified at unit Safecare meetings or at wider network meetings. The ward manager told us some guidance had been developed with a neighbouring trust, for example, kidney scans and sedation.
- Policies and guidelines were accessible on the trust intranet and paper copies were held centrally within each service area. When we reviewed paper copies we saw most, but not all, were current and up to date. For example, in SCBU, we found a number of paper neonatal guidelines, held in the guidelines folder on the unit, were out of date and did not match the online in-date guidelines. These included the jaundice guidelines (expired February 2014); excessive weight loss in breastfed infants (expired March 2012) and thyroid problems (expired February 2014). Patient pathways, based on paediatric clinical guidance, were also easily accessible and displayed at staff workstations.
- The trust had achieved stage one accreditation in the United Nations Children's Fund (UNICEF) Baby Friendly Initiative. Staff were unclear about plans to progress towards stage two. Nurses within the neonatal unit were trained to support breastfeeding mothers.
- Children's services participated in national audits such as diabetes, epilepsy and asthma. We also saw evidence of local audit activity to assess compliance with NICE quality standards. For example, the management of constipation in children and young people looked at the assessment, management and follow-up of children attending A&E and the Walk-in Centre.
- SCBU had recently signed up to deliver the Bliss Baby Charter, an accreditation scheme to ensure babies received the best neonatal care and treatment. Evidence provided to us by the trust showed the unit had completed the Bliss Audit Tool, the purpose of which was to allow hospitals to assess the quality of family-centred care they provide and identify areas for improvement. The unit met or partially met most of the criteria and a series of actions were identified to achieve compliance with the criteria that was not met.

Pain relief

- There was a paediatric pain assessment tool and analgesia guideline displayed at staff workstations across the service. This included a pain score, a faces scale, behaviour display examples of injury and suggested analgesia. It was split into four sections; 'no pain', 'hurts a bit' 'hurts more' and 'hurts worst'. A FLACC (face; legs; action; cry and console) chart was also used to assess and manage pain.
- Staff in SCBU did not use a specific pain assessment tool and instead used oral sucrose analgesia, administered pre-procedure, for new-born infants undergoing painful procedures. The use of sucrose as an analgesia is common practice across the UK and the rest of the world. The paediatric team told us they recognised that sucrose, 'non-nutritive' sucking, breastfeeding and physical comfort all had a role to play in providing relief from the pain associated with certain procedures.
- Other non-pharmacological methods were also used by staff across the service. The nursery nurse told us she used age appropriate play and activities as a means of helping to prepare children for procedures. We saw evidence of this in the day unit. There were also two 3D televisions, one in the short stay assessment unit and one in the day unit. Staff told us the interactive

television was an invaluable tool in calming and distracting children and young people. We spoke with a parent whose child was watching the television in the day unit. She told us it helped her daughter to relax and made the visit enjoyable. Her child was less stressed and anxious. Staff could undertake procedures such as taking blood in the same room as the television.
- We saw evidence of completed pain assessments in the care records we reviewed.

Nutrition and hydration

- Nursing staff told us they could order food for children and young people who were admitted to the short stay assessment unit and there were no problems accommodating children who had special dietary requirements. Fresh fruit was available throughout the day and parents were offered drinks and biscuits. Food was also provided for patients if they had experienced a particularly long stay in the day unit.
- We observed a healthcare assistant in the outpatient department serving cold drinks to children and parents in the waiting room before their appointment. One of the doctors we spoke with told us this was part of the daily routine.
- There were facilities available to support and encourage mothers of babies on the special care SCBU to breastfeed and breastmilk could be stored in the unit refrigerator and freezer.

Patient outcomes

- Clinical and patient outcomes were reviewed and monitored and appropriate actions plans created. Outcomes of audits were shared and discussed at monthly Safecare meetings.
- Children's services participated in national audits in order to monitor patient outcomes. For example, information from the National Neonatal Audit Programme and data from the national Commissioning for Quality and Innovation (CQUIN) about neonatal outcomes showed appropriate action was taken to improve the proportion of babies born at less than 34 weeks gestation receiving some of their mother's breast milk when discharged home.
- The trust's rate of multiple admissions for children aged one to 17 years was worse than the England average for asthma. Information provided to us by the trust suggested this could be due to the lack of an inpatient unit at the hospital. Patients were discharged with the arrangement they could be readmitted into the short stay assessment unit if they required further care. However, managers we spoke with also acknowledged further work could be done with the community children's nursing team to ensure continuity of care following discharge.
- We saw evidence of action because of clinical audits in relation to asthma. For example, in response to the College of Emergency Medicine moderate and severe asthma in children audit, paediatric nurses now triaged children and young people in A&E and a paediatric pro forma had been included in new A&E guidelines. Actions also included plans to undertake a re-audit locally to measure improvement.
- Results from the 2013/14 national paediatric diabetes audit showed the trust was worse than the England average for the HbA1c (average blood sugar) audit measure. The median HbA1c was 76 mmol/mol for the trust; slightly higher than the England average of 69 mmol/mol. This meant fewer children in Gateshead had better controlled diabetes. A score over 80 mmol/mol increased the risk of long-term complications for a child. In response to this and the National Paediatric Diabetes Peer Review, children's services developed a business case and action plan. Outcomes included the appointment of a psychologist and a band seven diabetes nurse to support and improve transition services for young people aged 16-19 years.
- The trust's rate of emergency readmissions for non-elective paediatrics was better than the England average for children under one year old and for those aged between one and 17 years old in 2014.
- Results from the CQC Children and Young People's Inpatient and Day Case Surgery Survey 2014 showed the trust performed better than other trusts in three of the five questions measuring the effectiveness of the service. Parents and carers of babies and children aged up to 15 said staff agreed a care plan with them, staff worked well together and all staff caring for and treating the child were aware of their medical history. The trust scored the same as other trusts in response to staff doing everything they could to ease the child's pain and caring for the child's individual or special needs.

Competent staff

- Staff were competent to carry out their roles and received appropriate professional development, including an annual appraisal. Staff we spoke with

confirmed they had received an appraisal from their immediate line manager. Revalidation was part of the appraisal process for medical staff and was co-ordinated by the medical director's office. Information provided to us by the trust showed 89% of staff within children's services had received an appraisal from their respective line manager.

- Band seven nursing staff who worked in SCBU had all achieved a post-graduate qualification as Advanced Neonatal Nurse Practitioners, as recommended by the British Association of Perinatal Medicine.
- All qualified children's nursing staff were trained in paediatric triage and minor injuries. Staff told us they worked closely with A&E nurses who supported them to fulfil all required competencies.
- All band seven neonatal nurses had completed Advanced Neonatal Nurse Practitioner training and the trust had a plan for developing their role within the unit to plan for gaps in the middle grade medical tier.
- Staff we spoke with from all clinical areas gave positive feedback about the individual support they received and the opportunities for training and development. Trainee medical staff 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 and neonatology. A student doctor told us she felt supported in her role and that this had been her best placement so far. There was always a registrar on-call or a consultant on duty if she needed to seek advice.
- Clinical supervision across the medical team appeared to be robust. A senior consultant told us they and a colleague took responsibility for peer supervision and review and all meetings were documented. Arrangements appeared to be less formal for nursing staff. We heard many examples of informal meetings and ongoing support however; staff we spoke with were less clear about formal supervision and 1-1 meetings with their line manager.

Multidisciplinary working

- Medical and nursing staff within the paediatric and neonatal services gave positive examples of multidisciplinary team (MDT) working. Medical and nursing staff worked closely together and with other allied healthcare professionals such as dieticians, speech and language therapists, health visitors and children's community nurses. Staff we spoke with also gave us positive examples of working with child and adolescent mental health services (CAMHS) and social services.
- Paediatricians delivered care in the community to meet the needs of children and young people. This was delivered in a coordinated way involving different teams and services. We saw evidence of good practice. This included giving advice to schools that were renewing their epilepsy guidelines and monthly multidisciplinary feeding clinics, which included staff from speech and language therapy, dietetics and children's community nursing.
- Staff from the community children's nursing team visited the paediatric emergency assessment and short stay units every Saturday and Sunday to offer support and assistance to facilitate a more effective discharge.
- We saw examples of joint working between paediatric services and A&E where representatives from each service attended regular weekly meetings. Nursing and medical staff also reported positive working relationships with obstetricians and midwives in the maternity unit.
- There were pathways in place to support 16-19 years olds receiving emergency care or receiving care in a non-paediatric service. For example, if a young person with complex needs was being cared for on an adult ward, a paediatric nurse would also be available to provide support and advice. A consultant also told us about working with adult services to support the transition of young people with diabetes. Joint appointments with adult services were held to support the young person through the transitional period.
- There were formal transfer arrangements in place for children and babies who required inpatient or specialist care at neighbouring hospitals and tertiary care centres. Staff we spoke with demonstrated their knowledge and understanding of the arrangements and told us they worked well in practice.
- We heard examples of co-ordinated planning and delivery of care. A consultant paediatrician we spoke with told us about working closely with a colleague from the RVI to provide care and treatment to twins who required immediate treatment. Treatment was planned and delivered effectively and began the following day.

Seven-day services

Services for children and young people

- There was a three-tier rota, which provided medical cover across seven days. Consultant cover was provided over a 24-hour period using an on-call rota system. At weekends, there was consultant cover in the hospital between 9.00am and 5.00pm and on-call cover between 5.00pm and 9.00am.
- The paediatric emergency assessment pod and short stay unit were accessible 24 hours a day, seven days a week.

Access to information

- Staff said they were readily able to access patient information and reports such as test results and x-rays
- Policies and guidelines were accessible on the trust intranet and staff we spoke with told us they had experienced no problems in accessing this information.

Consent

- The trust had a consent policy with a section specifically about children and young people.
- Staff were aware of and understood the Gillick competency guidelines and we were given examples of how this had been applied in practice. A consultant paediatrician told us she explained the treatment and possible options to her patients and provided information about what each entailed. She empowered her patients to make their own decisions. Nursing staff also told us they provided children with choices wherever possible and encouraged them to consent to their own treatment. For example, one nurse explained she always asked the child whether they would prefer an anaesthetic spray or cream before an injection as she understood children felt differently about each option.
- Nursing staff told us leaflets were sent to families before an appointment to provide information about what to expect.
- Training about the Mental Capacity Act 2005 (MCA) was included in the trust induction and was part of the mandatory training programme. Information provided to us by the trust stated children's services had recently appointed its own MCA champion from within the team.

Are services for children and young people caring?

Good

We rated caring as good because:

Children, young people and parents told us they received compassionate care with good emotional support from all staff. This included administrative staff, nurses and paediatricians and the wider multi-disciplinary team. There was a strong person-centred culture and staff worked in partnership with patients and their families. Parents felt fully informed and involved and we saw evidence staff empowered children and young people to be active participants in their own care. Staff also showed determination and creativity to overcome obstacles and deliver high quality, compassionate care.

Paediatricians and nurses went beyond the call of duty to ensure they met the needs of children and their families. We spoke with 13 families who provided examples of how they received supportive care centred on their personal needs. Parents we spoke with were consistently positive in their praise of the staff and the service. Most parents described the care they received as 'outstanding'.

Compassionate care

- Results from the CQC Children and Young People's Inpatient and Day Case Surgery Survey 2014 showed the trust scored the same as other trusts to questions about compassionate care. Parents and carers of babies and children aged up to seven years felt their child was given enough privacy when receiving care and treatment and was well looked after. Staff were friendly, listened to parents and treated them with dignity and respect.
- Throughout our inspection, we observed medical and nursing staff delivering compassionate and sensitive care that met the needs of children, young people and parents. For example, we spoke to a family in the short stay unit whose GP had referred the child to the emergency assessment pod due to a concern they were showing signs of diabetes. The multi-disciplinary team, who included the diabetes nurse, psychologist and dietician, quickly saw the child and a care plan was developed with the family and arrangements were made for the diabetic nurse to meet with the child

again, at home, following discharge. The child's parent described the whole experience as 'perfect' in relation to the care and support they received and told us staff were very kind and approachable.

- 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.
- A local patient survey of families whose babies received treatment in SCBU showed parents were unanimous in their responses. 100% of those surveyed found staff were friendly and approachable, felt they received adequate information; their baby was well cared for; they were involved in decisions about their baby's care; had someone to talk to about their worries and fears and had their baby's treatment explained to them in way they understood.
- Parents whose babies were receiving care and treatment on SCBU during our inspection repeated the outcomes from the survey. For example, one parent told us doctors always introduced themselves and explained all processes involved in caring for and treating their child. Another parent told us the unit was 'like a family' while two others said the care was 'outstanding'.
- Children's services participated in the NHS Friends and Family Test. Responses collated between April and July 2015 showed 96.7% of families said they would recommend the service. Feedback from families included comments such as 'lovely bright friendly team' and 'doctor explained to both me and my child, made us feel at ease'.

Understanding and involvement of patients and those close to them

- Results from the CQC Children and Young People's Inpatient and Day Case Surgery Survey 2014 showed the trust scored the same as other trusts to questions about understanding and involvement of children, young people and their families. Parents and carers of babies and children aged up to 15 years had confidence and trust in the members of staff treating their child. Parents also felt information was provided to them in a way they understood, were encouraged to be involved in decisions about their child's care and treatment and were kept informed about what was happening. The trust scored better than other trusts when parents were asked if a member of staff told them what would happen when their child left hospital.
- We received feedback from three parents about nursing staff on SCBU. They told us they received 'outstanding' support in relation to breastfeeding. Information leaflets were available and facilities were provided, including breast pumps, to enable them to care for their babies in a suitable environment.
- We spoke with a parent who described one of the consultant paediatricians as 'phenomenal'. His children were supposed to receive treatment at the Great North Children's Hospital in Newcastle however issues with capacity resulted in their transfer to Gateshead. Although the children required immediate inpatient care, the doctor and nursing staff all agreed to extend their working day to provide the care and treatment the children required. This enabled the children to return to their home each night. The doctor spoke directly to the children, asked them what they wanted to happen and gave them various treatment options for them to choose from and select. Information was presented in a child-friendly format and the children were encouraged to ask questions.
- The nursery nurse told us she supported children who had appointments outside of those provided within children's services. For example, children who required a scan or an x-ray within the radiology unit could become upset and distressed. Staff from the unit would call upon the nursery nurse for support and assistance in caring for the child.

Emotional support

- Results from the CQC Children and Young People's Inpatient and Day Case Surgery Survey 2014 showed the trust scored about the same as other trusts in response to questions about the emotional support they received. Parents felt members of staff communicated with their child in a way they could understand and were given information about who to talk to if they were worried about their child when they got home.
- Parents told us they felt staff understood the impact the condition and treatment had on their children. One parent told us staff constantly offered reassurances and support throughout the treatment process. They were

kept informed at every stage by medical and nursing staff and felt empowered to ask questions. They also felt very confident their children were receiving the best care possible.

- Support was available for children with long-term health conditions. The family of a child with diabetes told us about the care and support they received from the paediatric dietician, psychologist and diabetic nurse. They were very patient with the child and demonstrated their understanding of the impact the condition had on both him and his family. His mother told us the staff took their time to explain things in a way, which the child understood.
- We were told there was no dedicated counselling service for mothers of babies being cared for on SCBU however support was available from the nursery nurse.

Are services for children and young people responsive?

Good

We rated responsive as good because:

We found the service was very 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. Care and treatment was coordinated with other services and providers. There was a proactive approach to understanding and treating the needs of different groups of children and young people. This included children who were in vulnerable circumstances or had complex needs. There was a support structure in place to support young people transitioning to adult services. Complaints were reviewed and the service learned from them.

Service planning and delivery to meet the needs of local people

- The trust had recently been part of a reorganisation of children and young people's services across the region following a three-year review led by NHS South of Tyne and Wear. The review looked at the changing pattern of childhood illness, hospital admissions and challenges linked with the current workforce to provide a safe level of cover across the configuration of services. The outcome of the review led to the development of the paediatric emergency assessment pod and short stay unit and the closure of the inpatient unit. Although staff we spoke with told us they were still adjusting to the removal of the inpatient provision, they felt, overall, services had improved for children and young people.
- We saw evidence that demonstrated how children's services engaged with the trust, commissioners, the local authority and other providers to address the needs of the local population. For example, one of the community paediatric consultants was working with the CCG, speech and language therapists, the early year's assessment team and health visitors to commission a pilot aimed at developing an autism spectrum disorder (ASD) pathway for pre-school children. The paediatrician explained that the current model was too linear and did not allow for joined up working with other services involved with the child and family.
- Four of the consultant paediatricians worked in the community where services offered included children with special educational needs, neurodevelopment clinics and feeding clinics.

Meeting people's individual needs

- Results from the CQC Children and Young People's Inpatient and Day Case Surgery Survey 2014 showed the trust scored the same as other trusts to questions about meeting people's individual needs. Parents felt they had access to hot drinks facilities in the hospital however facilities for parents staying overnight was rated 6.12 out of 10. Staff we spoke with were aware of this and new comfortable recliner chairs were in all cubicles in the paediatric emergency assessment pod for families to use.
- The facilities and environment in paediatric emergency assessment pod and short stay unit were suitable for children and young people. Local children and young people were involved in the decoration of the department and their artwork displayed. There was a designated waiting area, which was accessible to children 24 hours. There were toys, books and a television. We found the environment was tailored towards younger children. Staff we spoke with told us they had identified a need to develop a designated area for older children and young people and were exploring ideas to develop this.

- Parents could access a family room. The purpose of the room was to accommodate families before discharge from SCBU and for families whose babies were not expected to go home. There was a personal car parking space plus a private entrance.
- Staff we spoke with told us there were no problems accessing interpreting services. The nursery nurse was trained in Makaton and British sign language (BSL) level one.
- Staff demonstrated their understanding of the cultural diversity of their local population. For example, staff we spoke explained the different dietary requirements of children and young people with different ethnic backgrounds. In addition, local Jewish leaders worked with the trust to create a 'Sabbath box', held in the paediatric emergency assessment pod, which included everything a family required if attending hospital on the Sabbath day. A Rabbi Governor on the Trust Board also delivered training to junior doctors about Jewish culture to meet the needs of the large Jewish community in Gateshead. In addition, a teacher from a local Jewish school visited SCBU regularly to offer support and guidance to staff and Jewish families using the service.
- Children's services provided information and leaflets in a child-friendly format. The nursery nurse had been instrumental in developing leaflets and photobooks about procedures. We reviewed a sample of these and saw they were tailored to meet the needs of all children, including those with special needs. Booklets in Makaton were also available. The information was presented in a way that would generate a discussion and prompt questions about what would happen at each stage in the treatment process.
- There were pathways to support children and young people who required psychiatric support. For example, we saw guidance developed by the local mental health trust to advise staff on the appropriate action should a child or young person present following an episode of self-harm or who was suffering from a mental health crisis. We spoke with staff who demonstrated their understanding of dealing with children who had mental health problems and could explain what appropriate action they would take.
- The service recognised that the needs of different age groups of children and young people varied. In support of young people aged 13-15 years, the service ran a teenage diabetes clinic once a week and tailored the environment to suit this age group. For example, appropriate age-related books and magazines plus movies were shown on the television.
- There was a support structure for young people transitioning to adult services. For example, although a young person would see the same consultant paediatrician, the appointment took place in an adult environment rather than in the children's outpatient department. Doctors told us each transition was different with each one tailored to meet the needs of the individual. For example, young people with complex needs would continue to attend appointments in the children's outpatient department. A new policy to support the transition of young people with learning disabilities was being developed. One of the consultant paediatricians explained some young people were ready to self-manage their diabetes as a certain age while others were not. Medical and nursing staff told us they took a multi-disciplinary team approach to the transition process while encouraging and supporting the young person to feel empowered by providing guidance and support.

Access and flow

- The children's day unit was open Monday to Friday from 8.00am to 5.00pm.
- Between 7.30am and 2.00am, a paediatric nurse triaged all children and young people who presented at the paediatric emergency assessment pod. Outside of those hours, an adult nurse performed this and could liaise with the paediatric nurse on night duty for any support and guidance. This was a recent development and the service was working well and staff felt confident and well supported by A&E nurses.
- To assist with the flow of patients, the medical team, led by a consultant paediatrician, held three handover/ patient reviews each weekday. There were daily ward rounds in the paediatric emergency assessment pod and SCBU where children and babies were reviewed regularly and this helped to facilitate a timely discharge.
- Parents and children who were waiting to attend outpatient appointments told us they were usually seen very quickly. The reception desk in the outpatient department had details of the clinics run that day displayed on a wipe-clean notice board, which included information about any waiting times.

- Information provided to us by the trust showed waiting times for the different outpatient clinics varied. For general paediatrics, the wait was between three and nine weeks and dependent upon the consultant. The epilepsy clinic was one week; bowel management was five weeks; eczema and nephrology were seven weeks and the allergy clinic was 13 weeks. Urgent referrals were actioned straight away and children would see a paediatrician in the day unit. Parents we spoke with during the inspection told us they never had to wait long for an appointment. One parent told us she would always choose Gateshead over other providers.
- If children or young people were transferred to neighbouring trusts, there were communication pathways in place to ensure that medical staff were aware of the treatment plan. Parents were also given written information when transfers were required to help reduce feelings of anxiety.

Learning from complaints and concerns

- Between 1 July 2014 and 20 June 2015, there were six complaints made about children's services. Of those, four related to inadequate clinical assessment, one related to lack of communication and one was a delay in referral to another service.
- Parents we spoke with told us they felt they could raise concerns if they felt they wanted to and told us they knew how to make a complaint
- Safecare governance meeting minutes showed consultant paediatricians and other attendees regularly discussed complaints. Daily nursing handover meetings also included a discussion of any complaints or concerns raised by children, young people and their families.
- Staff told us there had been lessons learned from complaints. For example, one parent complained about their child's stay in hospital, about the bed linen and lack of refreshments. As a result, amendments were made to the daily care record to ensure additional information was collected and specific actions taken.

Are services for children and young people well-led?

Good

We rated well-led as good because:

There was a governance framework in place and staff were aware of the vision and goals of the wider organisation. A new strategy for children's service was in development and had been circulated to staff for their comments and input.

The management team worked well together and staff told us they were visible and approachable. We found a positive, open and friendly culture across the service. Staff placed the child and the family at the centre of care delivery. This was seen as a priority and everyone's responsibility.

The trust engaged with children, young people and families and involved them in decisions regarding the service.

Vision and strategy for this service

- There was no current strategy for children and young people's services. The service had recently moved into the medical business unit following a restructure and reorganisation of directorates. and there was a vision and strategy in development. The service line manager told us the new strategy would feed in to the trust strategy and various stakeholders had been involved in its development. Its purpose was to ensure the sustainability and efficiency of the service as well as serving the needs of the patient population.
- Children's services had completed a strategy development plan as the foundation of the new strategy. We reviewed this document in its draft status. It included a vision statement, a SWOT analysis (strengths, weaknesses, opportunities and threats), service improvement plans and achievements. Senior leaders told us there was a team approach to the new strategy and the paediatric consultant team was currently reviewing it.
- Staff we spoke with were all very clear in their understanding of the trust organisational vision however, not everyone was aware of the development of the new children's service strategy.

Governance, risk management and quality measurement

- Children's services Safecare meetings took place every month and minutes distributed to all areas. Staff said they received the minutes by email. Paper copies were kept in files within PEAPod and the Children's Unit. Other communication forums included weekly meetings held with the service line manager, matron and

assistant director of medicine to discuss issues and risks, joint SCBU and paediatric team meetings plus monthly perinatal morbidity and mortality meetings were held.

- Every paediatric consultant had a specialist interest, which included looked after children, bowel management, epilepsy, eczema and eating disorders. The associated consultant at Safecare meetings shared updates to national guidance in relation to specialist areas. For example, the lead consultants for paediatric epilepsy and diabetes gave feedback on results from national audit and changes to practice.
- Children's services had a risk register. This was a standard agenda item at the monthly Safecare and at the Patient Risk Quality and Safety Committee meetings, attended by the service line manager. Information provided to us by the trust showed there were only two risks on the register. One identified the lack of a designated doctor for safeguarding children while the other was a financial risk in relation to the recent transfer of the inpatient unit, as there had been no agreement about a new financial tariff. Nursing staff were aware of the risk register and told us risks were discussed at ward meetings.
- SCBU worked closely with the Northern Neonatal Network and the service line manager represented the trust on the Neonatal Board. Data from the service was submitted to Badger Net, the network reporting system, which informed quarterly analysis reports about neonatal services across the region.
- Children's services participated in bi-annual Care Quality Assessment Framework (CQAF) accreditation. The assessment reviewed the workforce, patient safety, clinical care and patient experience. Staff said evidence was collected at ward level to ensure the team met the required standards and could evidence their learning. We were told the unit had recently passed its CQAF.
- We saw evidence of internal quality audits undertaken routinely across children's service to ensure safe and effective care.

Leadership of service

- There were clear lines of management and accountability across children's services. The service line manager and clinical lead reported directly to the interim associate director of the business unit and had line management responsibility for nursing and medical staff respectively. Staff told us they regularly saw the service line manager, matron and clinical lead and felt they were accessible and approachable. One member of staff described them as being 'very hands on'.
- We found the consultant body to be cohesive and proactive in decision-making, with innovative approaches to areas such as sub-specialisms and job planning.
- One of the consultant paediatricians told us managers were supportive during the reorganisation of children's services. They were proactive in ensuring staff were included at every stage and had the opportunity to contribute to the developments.
- Staff told us they felt well supported by their immediate line manager. They felt there was a clear management structure within the team and leaders and senior staff were very approachable. If there was any conflict within the service, they would go to their line manager and seek support.
- Staff told us they were aware of whom the senior management team of the trust were, but most did not see them regularly. Staff had mixed opinions about the visibility of the chief executive and his management team. Some felt they were not very visible while others felt they were both visible and approachable.

Culture within the service

- The culture within children's services was very positive, open and transparent. Staff said they felt valued for the work they did and felt comfortable talking to anyone, at any level, about any concerns they had. 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.
- Staff spoke positively about the care they provided for children, young people and parents. Everyone we spoke with, across the nursing and medical teams, demonstrated a very high level of commitment to their role, their patients and to the organisation. There was a strong focus on the health and wellbeing of staff.
- In 2014, the children's unit nursing team won the Chief Executive's 'Team of the Year' award in recognition of their strong team ethos, cohesive working and their outstanding contribution to service. The team also delivered a presentation celebrating their achievements at the Nursing and Midwifery conference.

- Records showed staff turnover was low. Many staff we spoke with had worked for the organisation for many years. Managers told us retention rates were good and the main reason for leaving was retirement or relocation. One of the student doctors told us this was the best trust she had worked in so far.

Public engagement

- Comment cards were available and on display in the outpatient department for parents and children to share any concerns or suggestions.
- Local children and young people contributed to the design of the environment in the paediatric emergency assessment pod and the outpatient department.
- The service recognised the challenges of meeting the needs of young people aged 16-19 years. Engagements meetings took place with the local Youth Council to ask young people about the services provided by the trust. Staff we spoke with told us this work was ongoing and we saw evidence an action plan was in place to support its progress.
- The paediatric diabetes team were actively involved in the Type 1 KZ patient support group. This group focused on giving children with diabetes a voice and there was a plan to expand this across the region.

Staff engagement

- Staff had taken part in the national NHS staff survey in 2014. The results were not available specifically for children and young people's services. The national staff survey showed that on a scale of one to five, with five representing highly engaged staff and one representing disengaged staff, the organisation scored 3.74, which was the same as the national average.
- The organisation distributed a weekly bulletin entitled 'QE Weekly'. Staff we spoke with told us they found this to be a useful and informative means of finding out what was happening across the wider organisation.
- Staff from all disciplines told us they felt very involved and encouraged to participate and contribute to new developments in the service.

Innovation, improvement and sustainability

- The children and young people's services team had sourced a safety thermometer tool that specifically met the requirements of the service. The ward manager explained the team felt frustrated as only a limited amount of data about children and young people could be recorded using the national tool. In addition to basic demographic information, the new tool enabled staff to capture information about a child's deterioration, infection or inflammation from intravenous devices and the monitoring of pain. The Safecare team had recently ratified the new tool and plans were in place to use it across the service.
- There had been concerns that families were using the short stay assessment unit inappropriately, as a substitute GP service. This had resulted in an increase in admissions. One of the paediatricians led the research and discovered surgeries had been recommending families visit the hospital due to the practice's inability to offer a timely appointment. The information was fed back to GPs and we were told the situation would be closely monitored. During our inspection, there was no data available as this work had only recently been undertaken.

End of life care

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

Information about the service

End of life care (EOLC) was delivered by nursing and medical staff throughout Gateshead Health NHS Foundation Trust, based at Queen Elizabeth Hospital and Dunston Hill Hospital. The specialist palliative care team (SPCT) provided support and advice for the care of patients with complex needs and symptom management issues at the end of life. The SPCT delivered a Monday to Friday 9am to 5pm service. The Marie Curie Hospice and St Oswald's Hospice provided advice out of hours.

The SPCT in the trust was located within St Bede's Unit and managed by the Medical Business Unit. The remit of the SPCT was to provide holistic assessment, advice and treatment of patients with complex palliative care needs and to resource other clinicians in the provision of good general palliative care through education and support.

St Bede's was a 10 bed dedicated in-patient palliative care unit. The unit had dedicated sessions from a consultant in elderly medicine, which allowed for close working. Palliative day care was also situated at Dunston Hill Hospital, which provided social day-care facilities.

We visited medicine and respiratory wards, emergency access unit, critical care plus accident and emergency where end of life care could be provided. We also visited the chapel, the hospital mortuary, viewing room and the EOLC team offices. We observed care being delivered by both SPCT nurses and ward staff. We spoke with five relatives and three patients. We spoke with members of the SPCT including the clinical matron, community consultant and specialist community nurses. In addition we spoke with ward nurses, doctors, healthcare assistants, allied health professionals, bereavement office staff, porters and a hospital based discharge facilitator. We looked at the records of patients receiving end of life care and 39 DNACPR (do not attempt cardiopulmonary resuscitation) forms.

End of life care

Summary of findings

Overall we rated end of life care as good because:

The hospital SPCT provided face-to-face support five days a week, with the hospice providing out-of-hours cover. There was visible clinical leadership resulting in a well-developed, strong, motivated team. The teams worked well together to ensure that end of life policies were based on individual need and that all people were fully involved in every part of the end of life pathway.

Palliative care link nurses championed good end of life care on the wards. Ward staff spoke about the importance of making sure they understood the preference of patients and relatives in the last stage of life.

The staff throughout the hospital knew how to make referrals and patients were appropriately referred to and assessed by the SPCT in a timely manner, therefore individual needs were met. Staff had access to specialist advice and support 24 hours a day from a consultant on-call team for end of life care.

Medicines and equipment were provided in line with guidelines for end of life care. There were infection, prevention and control measures.

Staff cared for patients with dignity, respect and compassion. There was access to facilities to support patient's different spiritual and religious beliefs. The chaplaincy and bereavement service supported families' emotional needs when people were at the end of life, and continued to provide support afterwards.

Do not attempt cardio-pulmonary resuscitation (DNACPR) forms were appropriately completed by the medical staff. Decisions had either been discussed with the patient themselves or, in cases when patients did not have capacity to consent to end of life care, decisions were made in accordance with the patient's best interests, with the inclusion of relevant professionals and those close to the patient.

Are end of life care services safe?

Good

We rated safe as good because:

We found there was a culture where staff were encouraged by management to report incidents.

There were systems to manage medicines and infection, prevention and control.

There were enough trained clinical, nursing and support staff with an appropriate skill mix meaning patients received safe end of life care. The trust had adult safeguarding procedures, supported by mandatory staff training. Staff knew how to report and escalate concerns about patients who were at risk of neglect and abuse.

Incidents

- Staff said they were encouraged to report incidents, near misses and any incidents that had caused actual harm using the trust electronic incident reporting system.
- We saw evidence of the EOLC team addressing DNACPR non-completion issues around discharge and medication linked to patients coming into the hospital, going back home or out to the community. For example staff told us as part of the handover in the Emergency Care Centre staff liaised with paramedics around patients DNACPR's.
- The trust provided data about incidents reported for six months with summaries of action taken to mitigate the risk of reoccurrence. We viewed two incidents, which had been reported both were investigated with actions and learning identified.
- Between August 2014 and July 2015 EOLC did not report any never events which are defined as serious, largely preventable patient safety incidents, which should not occur if the available, preventable measures have been implemented.
- Staff had some understanding about the duty of candour regulations which came into force in November 2014; they understood their responsibilities to be open and transparent. They gave us an example of when they had used the duty of candour to explain treatment options and outcomes to a patient when the prognosis had not been as expected

End of life care

Cleanliness, infection control and hygiene

- The wards, mortuary and viewing areas we visited were visibly clean, bright and well maintained. In all clinical areas the surfaces and floors were covered in easy to clean materials allowing hygiene to be maintained.
- Cleaning records were easily accessible and up to date. We saw appropriate hand washing facilities were available.
- We saw staff had access to personal protective equipment (PPE), such as gloves and aprons and were seen to be using these.
- Mortuary protocols were reviewed and we saw that relevant infection control risks were managed with clear reporting procedures which staff working in this area were aware of.
- Each ward and department had a daily and weekly cleaning regime carried out by domestic services and the ward housekeepers.
- Infection prevention and control inspections were carried out on the wards by matrons, including monitoring the environment and equipment checks.
- There were multiple bottles of toiletries including shampoo within a cupboard in the bathroom at St Bede's; rather than single use items to reduce the risk of cross infection.

Environment and equipment

- Staff told us that equipment was accessible within a few hours for patients at the end of life who were being discharged home through the fast track route.
- The mortuary was secure to prevent inadvertent or inappropriate admission to the area. Fridges were lockable to reduce the risk of unauthorised access and the potential for cross infection.
- In response to the National Patient Safety Agency (16th December 2010) entitled: "Safer Ambulatory syringe drivers NPSA 2010/RRR019" alert. The trust Medical Equipment Library had already commenced renewing the ambulatory pumps in 2009 with the recommended syringe pumps, and this was completed by 2010 ensuring compliance with the guidance to remove all other syringe pumps. Initial training at this point was to train the trainer and this took place for all palliative care link nurses from each ward.
- However, with the newly appointed specialist palliative care team (Consultants and Nursing) it was considered that this had not been a full training roll out for all qualified staff across the trust. It was agreed to be re launched and monitored as a key priority work-stream.
- All staff who attended annual palliative care training received advice and initial training on syringe pumps. To mitigate risks a new action plan was drawn up to re visit training and competence to further support use of these syringes across the whole trust.
- A multidisciplinary EOLC group reviewed the Kings Fund 'Enhancing the Healing Environment (EHE) programme 2008-2010' recommendations for improving facilities in the trust and in the palliative care unit. Action taken at St Bede's included use of art work to enhance the environment and involvement of local partners, the Emergency Care Centre had single rooms allowing privacy during difficult conversations in addition to the quiet room on Ward 1 and in the chaplaincy department.
- The mortuary was well equipped and capacity was adequate. We saw specialist equipment including bariatric trolleys. We looked at records for equipment checks and saw these were updated regularly.
- The temperature of the mortuary fridges was recorded on a daily basis and the fridges were alarmed with alerts directly to the estates department should the temperature fall outside of the normal range.

Medicines

- Newly qualified nurses completed safe Medicate, an e-learning tool for assessing and developing competence for drug calculations.
- The choice of medications at the end of life had been aligned to local community guidelines to support safe and consistent practice between care providers.
- St Bede's staff carried out weekly controlled drugs checks and this was monitored through the trust's Care Quality Accreditation Framework which ensured compliance was met. Records showed that there were no administration drug errors at St Bede's from August 2014 to August 2015.
- Medicine administration records for individual patients receiving EOLC were completed correctly on the wards. We noted that controlled drugs (CD) were handled appropriately and stored securely demonstrating

compliance with relevant legislation. CDs were regularly checked by staff working on the wards we visited. We audited the contents of the CD cupboard against the CD register on two wards and found these were correct.
- Anticipatory end of life care medication (medicine that patients may need to make them more comfortable) was appropriately prescribed. The SPCT worked closely with medical staff on the wards to support the prescription of anticipatory medicines.
- We spoke with staff on the wards and the SPCT team who told us the system for prescribing anticipatory drugs was effective and staff were confident patients would receive the appropriate medication even at short notice.
- There was a plan for SPC nurses to be independent nurse practitioners which would enable them to prescribe medication for patients without the need to wait for a doctor's prescription.

Records

- There was a trust wide electronic record system that enabled sharing of patient information within the team and with other health care professionals.
- Patients' healthcare records were stored in a secure way that promoted confidentiality.
- We saw paper records located in patients' rooms. These included medicine administration records, syringe driver administration and care records. The paper records we looked at had been completed according to trust policy.
- We saw quarterly clinical record keeping audits. The last one completed in June 2015 showed areas covered clinical information, nutrition, falls, manual handling and medicine and results showed most areas were accurately completed.
- Information governance training was part of the annual mandatory requirement for all staff and 83% of the SPCT were up to date with this against a trust target of 100%.

Safeguarding

- Staff were aware of safeguarding processes and would refer to the trust safeguarding lead in the first instance. Staff could give examples of what constituted a safeguarding concern and how they could raise an alert.
- SPC staff mandatory training completion for safeguarding adults' level one was 90% against a trust target of 90%. Completion of safeguarding children level 2 training was 100%.
- There was a safeguarding link nurse at St Bede's to ensure relevant information was cascaded to the team. Support was also provided by the trust's lead nurse for safeguarding adults.
- Patients and relatives we spoke with did not highlight any concerns about aspects of safeguarding. They said they were well looked after and they felt safe on the unit.

Mandatory training

- Mandatory training was undertaken by all staff providing end of life care. Training data showed 90% of SPC staff were compliant with training requirements in relation to consent, infection control and managing violence and aggression; 84% of staff had attended training in fire safety, resuscitation and patient handling.
- 50% of SPC staff had attended training in dementia, against a trust target of 75%.
- End of life training was mandatory for all staff groups across the trust and was 100%.
- Staff told us that they completed face to face and on line mandatory training. Staff said they were up to date with training and time was given for staff to complete training.

Assessing and responding to patient risk

- The EOLC team used an early warning score (NEWS) which identified if escalation of care was necessary. Staff told us that they also used the trust's electronic observation system and escalation processes for any patients who deteriorated.
- Ward staff told us the SPCT team had a visible presence on the wards. Any changes to patient's conditions generated a visit by the SPCT. We saw patient's daily notes by nursing, medical and therapy staff with updates on any changes clearly recorded.
- The EOLC team held a weekly team meeting to discuss ongoing patient care.
- The EOLC team at St Bede's had access to 24/7 medical support and out of hours through the I-Bleep system for any patients who may be acutely unwell or needing review, including access to specialist advice and support from specialist teams across the acute site.
- Staff told us that the trust acute response team provided support both in and out of hours.

Nursing staffing

End of life care

- We found staffing levels were sufficient to ensure that EOL patients received safe care and treatment.
- The nurse staffing at St Bede's was displayed on 'time to care' boards, which showed planned and actual staffing figures. The nursing team on St Bede's currently fell just below full establishment. However challenges were recognized and any concerns escalated to ensure staffing was in line with recommended levels.
- Specialist palliative care was provided from 8am to 5pm five days a week. Access to specialist support from a consultant and advice was provided by the Marie Curie Hospice, St Oswald's Hospice and staff at St Bede's out of hours.

Medical staffing

- The department currently had a consultant vacancy post which had been advertised.
- The palliative care consultants worked across the acute hospital, the community and with Marie Curie Hospice, St Oswald's Hospice allowing for improved continuity and management of patients who were using more than one of the services.
- The palliative medicine consultants were able to demonstrate continued professional development in line with the requirements of revalidation by the General Medical Council.

Major incident awareness and training

- Major incident and winter management plans were in place. Senior staff had access to action plans and we saw that these included managers working clinically as appropriate, staff covering different areas and prioritisation of patient need.
- Specialist support was available from the SPCT when required and out of hours specialist advice could be sought by telephone.
- Staff told us St Bede's was part of the medical business unit and followed plans and procedures which were in place in relation to major incidents and business continuity.

Are end of life care services effective?

Good

We rated effective as good because:

End of life services were delivered according to up to date evidence and guidance. The service participated in national audits such as National Care of the Dying audit and was currently completing the 2015 audit.

In the 2013/2014 National Care of the Dying audit (NCDAH) the trust performed better than the England average for nine of the ten clinical indicators. The review of the number of assessments undertaken in the last 24 hours of a patient's life was worse than the national average. The trust achieved four of the seven organisation indicators. Areas not achieved were access to information relating to death and dying, continuing education, training and audit and access to specialist support for care in the last hours or days of life.

Do not attempt cardio-pulmonary resuscitation forms were appropriately completed by the medical staff. Decisions had either been discussed with the patient themselves or, in cases when patients did not have capacity to consent to end of life care, decisions were made in accordance with the patient's best interests, with the inclusion of relevant professionals and those close to the patient.

There was guidance for staff on symptom management including the need for pre-emptive prescribing of medication at the end of life. Patient nutrition and hydration needs were met.

Evidence-based care and treatment

- EOLC followed guidance produced by the National Institute of Clinical Excellence (NICE) including End of Life Care for Adults (NICE QS13) and Opioids in Palliative Care (NICE CG140).
- Implementation of the five priorities of Care for the Dying person was a priority for the trust. The trust had responded to the Neuberger review that set out recommendations regarding the Liverpool Care Pathway (LPC). An action plan was written post the Neuberger Review and approved at the End of Life steering group. The LCP was withdrawn in July 2014; this included the release of further good practice guidance for staff to highlight the 5 priorities of care. The trust was part of the regional initiative led by the end of life clinical network to develop a document for caring for patients in the last few days of life. This document was piloted in August-October 2014 and rolled out from April 2015

End of life care

- The trust has been proactive since the Neuberger review of the LCP to audit care provided in the last few days of life. Since 2013 twice yearly audits have been in place with clear action plans approved by the EOL steering groups. These audits have shown encouraging results with clear improvement following each action plan.
- In January 2015 an audit of patients who were identified as end of life (<3 months life expectancy) and made known to the discharge liaison team was carried out. The months reviewed were September 2014 – December 2014. Out of 48 Patients, 6 (13%) passed away at QE prior to their discharge, the main reason for this was the patients deteriorated very rapidly and would not survive transfer. A delay with fast-tack funding and subsequent arrangement of care packages over a weekend was also identified. These results were discussed at the end of life steering group and also raised at the locality end of life group

Pain relief

- There was guidance available for staff on symptom management including the need for pre-emptive prescribing of medication at the end of life.
- An audit in January 2015 showed a significant improvement in pre-emptive prescribing (92% of all patients audited). This was felt to be due to the presence of the SPCT as well as guidance released to all staff.
- Staff told us they could contact the SPCT for advice about appropriate pain relief if required.
- Appropriate medication was available in ward areas, and there were examples that anticipatory prescribing was being managed effectively.
- Staff told us there were adequate stocks of appropriate medicines for end of life care and that these were available as needed both during the day and out of hours.

Nutrition and hydration

- Following the withdrawal of the LCP, specific nursing care plans for care in the last few days of life had been developed covering nutrition and hydration.
- All patients had a Nutritional Risk Score (NRS) assessment on admission to the unit. This was a five-step screening tool to identify adults who were malnourished, at risk of malnutrition, or obese.
- We saw the trust had taken into account the General Medical Council guidance for supporting nutrition and hydration in end of life care. Staff told us about the prompt cards which also emphasized this.
- We observed SPCT staff visiting patients and discussing care including nutrition and hydration options with the patient.
- Staff told us that patients were offered a food choice at mealtimes. They were not required to pre order and this was appropriate due to the patient's appetites changing frequently.
- Staff were able to provide patients with hot and cold snacks outside usual meal times

Patient outcomes

- In the 2013/2014 National Care of the Dying audit (NCDAH) the trust performed better than the England average for nine of the ten clinical indicators. The review of the number of assessments undertaken in the last 24 hours of a patient's life was worse than the national average. The trust achieved four of the seven organisation indicators. Areas not achieved were access to information relating to death and dying, continuing education, training and audit and access to specialist support for care in the last hours or days of life.
- A patient's preferred place of care and death are collected at the weekly St Bede's MDT meeting and communicated to the community team on discharge. The team worked individually with the heart failure nurses to address end of life care for their patient group and implemented advanced care planning whereby preferred place of care was addressed. However trust wide, recording of preferred place of care was recognised as a challenging area of practice and this was demonstrated also through the ongoing care in the last few days of life audit, the team had highlighted this as a priority for the coming year. This will also be addressed through the roll out of the Caring for the Dying patient document.
- Between April 2014 and June 2015 there were 301 cancer patients and 43 non-cancer patients referred to the SPCT compared to 224 and 27 in April 2013 – March 2014.

Competent staff

- Staff told us they had received an annual appraisal and records confirmed this

- The SPCT delivered training to staff as part of their mandatory training. For example, training was delivered to ward staff around the last few days of life as well advance care planning
- All staff had training in equality and diversity as part of their induction. Guidance was available on wards, in the chapel and multi faith room and on the intranet to support staff in providing care in accordance with peoples religious and cultural preferences.
- Staff had completed advanced communication and breaking bad news modules through the local university as part of their degree qualification.

Multidisciplinary working

- The SPCT was multi-disciplinary (MDT) and comprised of staff from Gateshead trust and South Tyneside community team, integrating palliative care across primary and secondary healthcare settings including care homes. The MDT took place weekly. The aim of the MDT was to ensure a coordinated approach to providing active and holistic care/assessment to patients with any advanced, progressive illness with the aim of achieving the best quality of life for patients and their families.
- The MDT worked closely with other cancer MDT's although this had been a challenge for every MDT due to staff numbers and increasing referrals.

Seven-day services

- The SPCT worked 9am to 5pm and out of hours specialist palliative care advice was provided to Gateshead by the Marie Curie/St. Oswald's advice line. Details of this service was distributed to local contact points and advertised by the SPCT.
- The service recognised the need to provide a seven-day palliative care service. This was an urgent priority of the Clinical Commissioning Group and the End of Life Locality group who were looking at models of EOLC in other areas.

Access to information

- Guidance relating to EOLC could be accessed by ward staff.
- In St Bede's, on discharge, it was standard practice to inform GPs about a patient in the last year of their life.
- An electronic shared care record was an aim of the team and the locality group to ensure continuity of care in end of life. This had been identified by the locality group as a priority work stream.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- We viewed DNACPR forms and saw evidence of clear recording of the patients' capacity. We saw evidence that the decision had been discussed with the patient's relatives and this had been recorded. We viewed 39 DNACPR forms when visiting the wards and found on 33 occasions these were recorded appropriately with discussions with the patient and relatives recorded where appropriate. Forms were kept in the front of patient notes, had clearly documented decisions with reasoning and clinical information and had been signed by a consultant.
- Where DNACPR forms were in place we saw that either people were involved in discussion about the decision where their capacity was clear or that an assessment of their capacity had been recorded in their medical notes.
- The trust resuscitation group audited DNACPR forms yearly. A further audit was carried out in March 2015 to examine the documentation of discussions around DNACPR following the 'Tracey's Judgment' (The Court of Appeal handed down a judgement regarding the duty of clinicians to consult patients when making a DNACPR decision). The results demonstrated that for the majority of DNACPR decisions there was documentation in clinical notes of discussions with patients/families. However, the audit found that discussions could have been tentatively broached earlier in the patient's admission. The reasons for these discussion not occurring or being broached later in the patient's admission was lack of time, junior doctors lacking confidence and clinical deterioration that occurred out of hours. The action arising out of this audit was to train and educate junior doctors about how to discuss clinical deterioration with patients and families.
- We viewed assessment documents for patients identified as being at end of life. We saw prompts for guidance for staff to follow in relation to best interest decisions for patients who did not have capacity to make decisions about care and treatment, including in relation to nutrition and hydration.
- The SPCT had completed consent and Mental Capacity Act training and this was repeated annually in mandatory training. In addition, St Bede's staff received trained in Deciding Right, which was a local initiative bringing together consent, Mental Capacity Act and Advance Care planning

End of life care

- Consent training was provided as part of the induction process, which included how to assess capacity and the fundamentals of obtaining consent.

Are end of life care services caring?

Good

We rated caring as good because:

Staff on the wards we visited and the SPCT treated end of life care patients with compassion and kindness. Patient privacy and dignity was respected.

The service proactively engaged with representatives from different community groups to ensure that individual religious and cultural needs were met. Patient and relatives comments were very positive and the trust was in the top 20% of trusts in 25 of the 34 indicators in the Cancer Patient Experience Survey.

St Bede's Unit had a dedicated chaplain and access to chaplaincy volunteers, who understood issues relating to end of life care. The volunteers showed compassion and respect.

Patients were given the opportunity to discuss their wishes for their future with staff. This included decisions regarding: CPR, preferred place of care at the end of life, decisions to refuse treatment and emergency health care plans.

The team acknowledged the importance of patient experience and had worked with another provider to introduce the 'Family's Voice' Diary Multi-Centre Research Project. The diary was used to improve communication between family and health professionals.The trust recently implemented the 'Family Voice' collecting feedback from the family of patients cared for at the end of life which were very positive.

Compassionate care

- We saw a short video which had been produced in-house by trust staff with its aim of sensitizing staff to compassionate care. The trust told us this development has been instrumental in raising awareness of the simple gestures which make a big difference when caring for someone in the last days of life. We were told the video had been adopted by the North East region for use in training packages in other specialist palliative care services.
- The trust was in the top 20% of trusts for 25 of the 34 indicators in the Cancer Patient Experience Survey, and in the middle 60% of trusts for the other nine indicators.
- The trust had implemented the 'Family Voice'. Family members were invited to fill in a diary, prompted by six questions about their relatives care. The diary was left by the bedside and checked regularly by staff in order to act on comments in the diary. Family members completed this in 'real-time' and healthcare professionals were able to offer support quickly if a concern was identified. The EOLC team said they had received positive comments from family members.
- Free parking across the trust site was available for families with patients staying at the St Bede's Unit, which relieved some of the pressure for relatives and carers.
- Staff were able to demonstrate compassion, respect and an understanding of preserving the dignity and privacy of patients following death. Mortuary staff told us there was always a member of staff on call out of hours. This service was available for families who requested to visit during an evening or a weekend.
- The service followed the policy for Care after Death. This was supported by a checklist to ensure the last offices were met. An audit of Last Offices was completed quarterly and the matrons shared learning with staff.
- The bereavement office co-ordinated all aspects of support for the family. It was intended to be the point of reference for families so they could contact them to arrange a visit to the mortuary, chaplain availability, and also to be able to collect the death certificate. This part of care was also audited and action taken to improve the service.
- A retrospective bereavement survey was conducted annually with bereaved relatives to assess their opinions about the care their relatives received during their admission. Issues raised through this were taken to matrons linked to the specific area. Recent results were due to go through the Bereavement Group and End of Life Steering Group.
- We saw a dedicated chaplain for St Bede's Unit as well as access to chaplaincy volunteers who demonstrated a good understanding of the issues relating to end of life care and showed compassion and respect. We spoke

with the chaplain who told us there were over 100 chaplaincy volunteers. The recruitment of a chaplaincy volunteer involved an interview, disclosure and barring service (DBS) checks and reference checks prior to them starting in their role.
- Ward staff were aware of patients who were receiving end of life care. They were able to discuss their needs and the support that they required. They showed a good understanding and demonstrated compassion and respect.
- During initial and pre assessments, the needs of the patient were identified and their wishes acknowledged and responded to.

Understanding and involvement of patients and those close to them

- St Bede's operated an open visiting policy for patient's friends, relatives and carers.
- The trust provided an appropriate and caring service to the large Jewish population in Gateshead. The trust proactively engaged with representatives from this community to ensure that they were meeting their individual needs. Additionally, seminars were delivered by this community to the trust and its staff to raise cultural awareness.
- The trust followed national recommendations in appointing an organ donation committee including specialist nurse in organ donation (SNOD), clinical lead in organ donation (CLOD) and a non-executive director as chair of the committee. There was an organ donation policy in place (which at the time of inspection was under review) and the trust was proud to support solid organ, corneal and tissue donation to fulfil people's wishes both in their lifetime and in the event of their death.
- The organ donation team was working closely with local, regional teams and national organ donation initiatives to increase awareness of organ donation and train multi-disciplinary team members to improve the rate of consent for organ donation. Progress had been made by including organ donation as a part of checklists during end of life care in the Critical Care Department (CCD) and Accident and Emergency.
- Staff training days had been organised for CCD nursing staff, as well as trainees and consultants. The CCD has included the SNOD at the midday multi-disciplinary huddle. Organ donation funds had been utilised to buy furniture for the relatives room in the Accident and Emergency Department and to organise staff away days. The trust aimed to be front runners in encouraging ethical organ donation practice.
- In Gateshead medical staff had prioritised referring 100% of appropriate patients to be considered for organ donation. At the time of the inspection, 100% of potential donation after circulatory and/or brain death patients was referred to the organ donation team.
- All patients admitted to St Bede's Unit were given the opportunity to discuss their wishes for their future with staff. Within this discussion, there was opportunity to discuss and document their decisions regarding CPR, preferred place of care at the end of life, decisions to refuse treatment and emergency health care plans. At the weekly MDT meeting in St Bede's the team was prompted to consider discussing these issues with patients.
- We saw that clinical staff spoke with patients about their care so that they could understand and be involved in decisions being made.
- There was evidence of patients and/or their relatives being involved in the development of their care plans. We saw advance wishes were discussed with patients and their relatives and recorded within the care planning documents.
- Information was available offering advice for relatives with guidance on viewing arrangements, how to register a death, organ and tissue donation, funeral arrangements and a list of advice and support organisations and how to contact them.

Emotional support

- Staff told us bereavement-counselling services were offered for relatives.
- A chaplain was able to provide advice in relation to other ethnicities but that usually the patient or their family advised of preferences in relation to the patient's spiritual needs.
- The service used a general anxiety disorder tool (GADs) to assess patients' needs in relation to their level of anxiety and to provide appropriate support depending on the results.
- Throughout our inspection, we saw that staff were responsive to the emotional needs of patients and their visitors.

End of life care

- The rooms at St Bede's were private with en-suite facilities where family members could stay with the patient and had the opportunity to bring along special mementos.
- A consultant clinical psychologist was available to provide emotional support.
- For patients who had young children, there was support from a children's support social worker accessed through Marie Curie Hospice. At the time of our visit we saw this service being accessed and fully utilised.
- Complimentary therapy and art therapy was available to all patients and carers in St Bede's and for patients being cared for in the acute hospital.
- The Specialist Palliative Care team developed the 'Priorities of care in the last days of life' prompt card. It was designed to fit into the back of staff ID badges for easy reference. Included on the card was a reminder to offer emotional and spiritual support and the extension number of the chaplaincy team for quick referral.

Emotional Support for staff – clinical supervision

- The trust provide emotional support for staff as they recognised this was an important aspect in caring and provided staff with an outlet facilitating them to maintain their ability to continue caring for patients and their families.
- The SPCT provided staff group reflective practice sessions and group debriefs for wards, teams and staff groups (nursing and medical). The team also provided ad hoc one-to-one support for staff.
- The team supported the following areas; weekly ward round within the tertiary gynae-oncology centre using this as a supportive method to the team with complex cases, ward 11 and the chemotherapy day unit clinical supervision sessions.

Are end of life care services responsive?

Good

We rated responsive as good because:

The service effectively planned, designed and delivered services to meet the needs of a diverse population.

Staff facilitated patient access to end of life care. Fast track discharges were managed by the SPCT efficiently and in the patient's best interest. Staff supported patients who had complex needs. We saw evidence of how staff met the holistic needs of palliative and end of life care patients.

Referrals to St Bede's and to the specialist palliative care team were managed through agreed referral criteria and where required referrals could be managed within four hours.

There were systems to encourage patients and those close to them to provide feedback about their care.

Service planning and delivery to meet the needs of local people

- Across the locality, all key providers met regularly as part of the Locality End of Life group to look at service planning and how to meet the needs of local people.
- The England Strategic Clinical Network Population Based Needs Assessment looked specifically at the demand for specialist palliative care. The report had been used by the locality and trust EOLC group to discuss commissioning of specialist palliative care consultants and beds on the St Bede's Unit. This resulted in approval for the employment of a new palliative care consultant

Meeting people's individual needs

- Records showed that patient's preferred place of death was discussed. Staff told us that rapid discharge was available and that they received support from other agencies in order to achieve this for patients.
- We saw evidence of how staff were meeting the holistic needs of palliative and end of life care patients. This was a core priority of the End of Life Steering group. Records showed a holistic assessment of all patients accessing specialist palliative care (holistic admission pro-forma and distress thermometer). The service introduced caring for the dying patient document which emphasised holistic needs. Cancer nurse specialists completed holistic assessments for all their patients at specific points in their journey.
- Advance care planning was available for all patients accessing specialist palliative care. The principle of advance care planning was delivered to all staff through

education provided by the SPCT. Other specialities such as the heart failure team had been trained in this area and had implemented advance care plans in their daily practice.

- The EOLC team supported the cancer of unknown primary (CUP) pathway and developed a close working relationship with the acute oncology nurse consultant and joint visits and assessments were made. The Macmillan specialist palliative care nurse was a core member of the CUP MDT, providing communication paths to patient decisions in EOLC care.
- Staff with experience in end of life care cared for patients and we saw that members of the EOLC had attended specialist training, for example dementia awareness.
- Staff across the trust could access support from specialist teams for, example dementia services, safeguarding team and best interest assessors.

Access and flow

- Referrals to St Bede's and to the SPCT were managed through agreed referral criteria and the pro forma was available to staff on the intranet. Referrals could be managed within 4 hours.
- The SPCT aimed to see patients in hospital within 48 hours of referral.The SPCT had introduced rapid discharge for patients who wished to be cared for in their own home. Over the last 24 months the number of patients that were identified as end of life and had a rapid discharge organised had increased. On average a total number of 16 patients per month since the start of January 2015 had a rapid discharge organised from the trust.
- The SPCT worked closely with Gateshead equipment service in the rapid provision of equipment, with Marie Curie to source a care package if a patient wished to return home and commissioners regarding the approval of appropriate levels of care.

Learning from complaints and concerns

- Information was available in the hospital to inform patients and relatives about how to make a complaint.
- Staff told us that they received more compliments than concerns but that complaints were discussed at team meetings.
- For end of life and palliative care complaints and concerns, the trust's policy on complaints was followed. The end of life steering group was made aware of complaints around end of life care through the service evaluation group to evaluate what lessons have been learnt.
- The bereavement officer also offered 'Being Open' meetings for families who have struggled with medical events leading to bereavement to discuss issues with healthcare professionals involved. The SPCT were involved to discuss issues with families through these meetings where appropriate to individual cases.

Are end of life care services well-led?

Good

We rated well-led as good because:

We saw a flexible and adaptable service that responded effectively to national initiatives and local demand in a timely manner.

Staff on the wards shared the visions and values that SPCT promoted. Leadership within the end of life specialist palliative care team was clear. The executive team involved themselves in developing the end of life care strategy with the support of clinical staff.

Clinical governance arrangements provided assurance to the Trust Board that safety was being well managed in respect of end of life care. There was good public and staff engagement and examples of innovative practice. There was an open and transparent culture and staff reported being proud of the service, the team and their job.

The trust and staff were committed to caring for patients in a timely and appropriate manner in their preferred place of death.

Vision and strategy for this service

- The trust had delivered a number of transformational changes to the service. These included the move of St Bede's Unit to the acute site leading to an innovative, proactive palliative care unit. The service had recruited two palliative care consultants and another was being advertised and a successful Macmillan bid for an end of life care facilitator and hospital based Macmillan nurse specialist.

- St Bede's Unit had a mission statement that was in line with the trust values and the core values of good end of life care.
- The EOLC team vision during the next few years identified priorities for EOLC in partnership with the community teams; this included a 24/7 seven day palliative care service, the refurbishment of St Bede's unit to have a more homely feel, the movement and service development of the Specialist Palliative Care Day Care on site in the Queen Elizabeth Hospital (currently based at Dunston Hill Hospital) and the delivery of a comprehensive end of life care education strategy.
- There was a commitment by the trust and this was underpinned by staff that patients were cared for in a timely and appropriate manner in their preferred place of death.

Governance, risk management and quality measurement

- Team meetings were held on a weekly basis and a standard agenda included new risks. The team liaised with the patient safety team and the senior clinical matron.
- Patient safety and quality was addressed at the hospital care directorate meetings which were held on a monthly basis.
- The end of life steering group reported into the Patient Quality Risk and Safety Committee of the Trust Board with yearly reports.
- Following the withdrawal of the Liverpool Care Pathway, the roles and responsibilities of all staff including the senior physician were clarified through communication to all staff. This was then audited as part of the twice a year last few days of life audit.
- The end of life steering group complied with the audit standards of the trust. Trust protocols showed EOLC participated in all relevant audits and shared findings to make improvements to patient care. Audits were a key part of the delivery and monitoring of good end of life care for the trust. The End of Life steering group ensured audits were monitored through a report back process and that appropriate actions were taken (for example audit of the use of a pilot caring for the dying document).
- The trust had undertaken a piece of work to ensure the appropriate coding of specialist palliative care patients. This had led to increasing identification of those patients.
- The risk register was managed and discussed at team brief and board meetings.

Leadership of service

- There was a dedicated Head of Service (Head of Cancer and Palliative Care/Lead Nurse for Cancer) that supported the team strategically working with the business unit's service level managers. This role directly managed the end of life care facilitator and Macmillan nurse role.
- This post was line managed by the Director of Nursing Midwifery and Quality and this ensured direct dialogue in relation to end of life care so that important issues were communicated to the Board.
- The Nursing Director was the executive lead for end of life and monthly meetings with the team ensured it remained a key priority.
- The Board had further engaged with the work of the end of life steering group through a number of presentations to the Board.
- The palliative care consultant was the clinical lead on end of life care and the lead for service improvement was the service line manager for medicine.

Culture within the service

- Staff spoke highly of the way teams worked together and the support being good across all wards and departments.
- Staff felt supported by the team and that debriefs took place following patients' deaths particularly for any deaths of younger patients.
- Staff told us that they had been acknowledged by the board in relation to the good work that they did.
- A staff member told us that one of the best things about working on the unit was that they could spend more time with patients. Staff told us that the HCA's were 'undeniably brilliant' and they definitely wanted to make a difference. Staff told us they are able to support others and promote their skills.
- Senior staff were supportive including the matron who often visited the unit. Monthly ward meetings were held. Staff reported being proud of the service, the team and their job.

End of life care

Staff and public engagement

- The trust had implemented and completed a range of surveys. This included a survey of the views of staff on the use of the LCP and a recent survey of staff's use of the palliative care team. A presentation to members of the public on the LCP had taken place.
- The local community were very supportive in relation to fundraising for EOLC.
- Patient views were sought during the development of St Bede's with regards to the environment.
- The views of bereaved relatives on end of life care were initially conducted as a pilot survey. This was now sent to all bereaved relatives.
- Service of Light at St Bede's unit and development of Friends of St Bede's was formed. This involved partnership working between the St Bede's unit staff and the chaplaincy team.

Innovation, improvement and sustainability

- A Celebration Day was held every year for families to attend to celebrate people's lives and an opportunity to meet up with other families. This invitation was sent out to all families who wished to be kept on the mailing and contact lists. This involved families who had contact with the Queen Elizabeth Hospital from twenty years ago.
- Artists visited St Bede's and provided recreational therapy with patients. Art work had also been created including door signs for each room. Feedback received from patients indicated that room names rather than numbers were preferred. Therefore all rooms were named after local castles.
- St Bede's Palliative Care Day Unit was located at Dunston Hill Hospital and worked in partnership with Coping with Cancer. It provided social activities, outings and complimentary therapies for palliative care patients. It also provided a confidential Bereavement Support Group (BLOSSOM) for Gateshead residents that have been bereaved.
- The SPCT had clear work streams with aims going forward. However, it was acknowledged that the demand on the service continued to rise to address the needs of all long term condition patients. Workforce planning was therefore a key factor to enable sustainability.

Outpatients and diagnostic imaging

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

Information about the service

The Clinical Support and Screening Department managed outpatients and diagnostic imaging (x-ray) departments and they provided outpatient appointments across 16 specialties with up to 200 clinics per week. Screening and diagnostic services including radiology (where staff carried out x-rays and other related studies), therapy, and pathology for the people of Gateshead and further afield including the north east of England, Cumbria and Lancashire.

The trust provided outpatient services at Queen Elizabeth Hospital between 8am and 8pm Monday to Friday with some added clinics held to reduce waiting lists on Saturdays. The other sites were open between 9am and 5pm.

Pathology (laboratory testing) services had been joined from three local acute trusts into a single integrated service opened on the Queen Elizabeth Hospital site in July 2015, which, would process over five million samples in its first year.

Diagnostic imaging services offered various x-ray and scanning facilities.

About 81% of all outpatient appointments took place at Queen Elizabeth Hospital. The remainder were held at Trinity Square, Metro Riverside, Blaydon Primary Care Centre, Bensham Hospital, and Washington. Average attendance numbers across all sites were around 26,038 each month. We inspected services at Queen Elizabeth Hospital, Bensham Hospital and Metro Riverside and did not visit the other sites due to lower numbers of patients due to attend there during our inspection.

We spoke with 14 patients and two volunteers, 41 members of staff and looked at 10 patient records.

Outpatients and diagnostic imaging

Summary of findings

We rated the Gateshead Health NHS Foundation Trust outpatient and diagnostic imaging as good because:

Patients were happy with the care they received and found it to be caring and compassionate. Staff worked within nationally agreed guidance to ensure that patients received the most appropriate care and treatment. Trust policies protected patients from the risk of harm by making sure they met any individual support needs. Staff demonstrated understanding of these policies and followed them.

Communication was effective between senior management and outpatient staff, and there was good overall leadership of staff to provide good patient outcomes in the outpatients department. The outpatients department had well organised systems for organising clinics. The diagnostic imaging department was well led, proactive and all staff worked as a team towards continuous improvement for good patient care.

The departments learned from complaints and incidents, and developed systems to stop them happening again. Overall, the trust delivered services to respond to patient needs and ensure that departments worked efficiently.

However, the service did not meet national targets for urgent appointment waiting times. The service had a high percentage of clinics cancelled.

Are outpatient and diagnostic imaging services safe?

Good

We rated safe as good because:

The department used an electronic system to report incidents. All the staff we spoke knew how to use the system if they needed to. Managers and governance leads investigated incidents and shared lessons learned with staff.

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

Staff knew the various policies to protect patients and people with individual support needs. Staff asked patients for their consent before treating them. Staff were clear about who could decide on behalf of patients when they lacked, or had changes in, mental capacity.

Medical records were stored electronically and transported securely. Records showed patient notes were ready for patients attending clinics 99% of the time.

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

Incidents

- The departments had robust systems to report and learn from incidents and to reduce the risk of harm to patients.
- The trust used an electronic programme to record incidents and near misses. Staff we spoke with knew how to use the programme and said they knew how to report incidents. Staff could give examples of incidents that had occurred and investigations that had resulted in positive changes in practice.
- There had been one never event and 74 incidents, of which 2 were classed as serious incidents, reported in the 12 month period from May 2014 to April 2015.

Themes included appointment cancellations, issues around a new radiology information system (RIS), delays due to staff shortages, increases in demand and equipment breakdowns.

- The never event which involved wrong site surgery in radiology was investigated fully by the department, medical staff, business unit manager. Staff carried out and presented root cause analysis at the Safecare meeting where they identified several reasons for the error and made some changes immediately. The whole team then focused on the World Health Organisation (WHO) "5 steps to safer surgery" checklist before procedures began and made sure all the interventional radiology multidisciplinary team (MDT) and the patient were involved. The team carried out a further risk assessment following the changes and the risk of recurrence was significantly reduced.
- There had been five radiological incidents reported under ionising radiation medical exposure regulations (IR(Me)R) in the previous year. These were all low level and included one incident of imaging the incorrect body part, two incidents of equipment faults and one incident where more images were taken than the clinician had requested. There was evidence staff had checked these, taken actions, and produced action plans following learning. The radiation protection advisor had reported that the frequency and severity of incidents were within national norms for a trust of this size.
- Consultants and reporting radiographers discussed radiology discrepancy incidents by case review. Staff took the opportunity to learn, work as a wider team and liaised with the specialty medical teams across the trust.
- Staff understood their responsibilities of the recently introduced Duty of Candour regulations and all staff described an open and honest culture. We saw evidence of telephone call logs and letters to patients offering an apology and information about incidents and complaints.
- Staff had reported one information governance incident when a patient had received another patient's letter in their envelope. Staff thought this was an occasional occurrence and had devised a new way of working to help reduce the risk of this happening again. Staff preparing letters for posting used a separate room with no distractions and carried out no other duties while completing the task.

Cleanliness, infection control and hygiene

- Domestic services staff carried out daily and weekly cleaning regimes and followed an equipment cleaning schedule. Nursing staff adhered to a standard operating procedure for setting up and clearing each clinic.
- The business unit matron carried out regular hand hygiene, clean equipment, standard precautions, and uniform policy checks. They measured compliance (that staff were following policies) and uploaded results from all departments to the "Better care Safecare" dashboard that showed consistently high compliance rates at 93% or above. They gave information to staff at meetings and collated data for the Infection prevention team, departmental managers and outpatient's department infection control link nurse.
- The senior nursing team carried out an internal nursing and midwifery care quality accreditation framework (CQAF) assessment and observations were reported on patient safety and reducing harm from infection. Results were rated green for cleanliness.
- Personal protective equipment (PPE) such as gloves and aprons was used correctly and available for use in the departments. Once used it was disposed of safely and correctly. We saw PPE being worn when treating patients and during cleaning or decontamination of equipment or areas. All areas had stocks of hand gel and paper towels.
- We saw, and patients reported, that staff washed their hands regularly before attending to each patient.
- Patient waiting areas and private changing rooms were clean and tidy. The trust provided single sex and disabled toilets and these areas were clean.
- We saw that staff ensured treatment rooms and equipment in outpatients were cleaned regularly. Diagnostic imaging equipment was cleaned and checked regularly. Staff cleaned and decontaminated rooms and equipment used for diagnostic imaging after use.

Environment and equipment

- The executive team carried out annual environmental audits. Staff reported concerns to the estates department and developed action plans to address areas for improvement.
- Equipment in the departments was calibrated, maintained and the medical electronics department managed maintenance contracts.
- All areas were clean, well-kept and patient areas were spacious and bright. Staff ensured that consulting,

treatment and testing rooms were well stocked. The department did not label clean equipment but all staff followed the standard operating procedure for cleanliness and infection control.

- We found that resuscitation trolleys for adults and equipment including suction and oxygen lines were clean. Staff checked and cleaned them daily and most checklists were signed and found to be up to date. Staff ensured they were locked and tagged and staff made regular checks of contents and their expiry dates. No drugs or equipment had exceeded expiry dates. We found one paediatric (for babies and children) resuscitation trolley in radiology that was dirty, dusty and staff had not completed or signed the checklist for several months. We reported this to the matron who, with input from nursing staff and managers, decided that, since children's procedures were now undertaken in the accident and emergency diagnostic imaging rooms, it was no longer needed in the department. Staff removed it the same day and included paediatric equipment into the adult trolley.
- Reception areas were open plan and appeared spacious but they were situated on a main thoroughfare and congestion built up at busy times. There was enough seating in the clinical areas and chairs were in good condition.
- We saw, and staff confirmed that, there was enough equipment to meet the needs of patients within the outpatients and diagnostic imaging departments. Staff told us they were encouraged by senior management to raise any immediate concerns to ensure they were rectified quickly or escalated to the department manager.
- Managers told us capacity had reached its limit for the number of clinics that could take place each session and some medical teams had requested extra examination rooms to carry out improved clinical pathways and improve productivity. Staff organised some clinics to move to other areas to ease capacity problems.
- We saw there were clear signs about radiological hazards in the diagnostic imaging department.
- Staff wore dosimeters (small badges to measure radiation) and lead aprons in diagnostic imaging areas to ensure they were not exposed to high levels of radiation and Radiation Protection Supervisors (RPS) carried out dosimeter audits to collate and check results. Results were all within the safe range.
- Staff carried out, quality assurance (QA) checks in diagnostic imaging for all x-ray equipment. These were mandatory (must do) checks based on the ionising regulations 1999 and the ionising radiation (medical exposure) regulations (IR(ME)R) 2000. These protected patients against unnecessary exposure to harmful radiation.
- RPSs carried out risk assessments with ongoing safety indicators for all radiological equipment and its use by staff. These were easily accessible to all diagnostic imaging staff.
- Staff in diagnostic imaging demonstrated safe working methods to record patient doses for radiation.
- The design of the environment within diagnostic imaging kept people safe. Waiting and clinical areas were clean. There were radiation warning signs outside any areas that were used for diagnostic imaging. Imaging treatment room no entry signs were clearly visible and in use throughout the departments at the time of our inspection.

Medicines

- We checked the storage of medicines and found staff managed them well. No controlled drugs were stored in the main outpatients departments. Small supplies of regularly prescribed medicines were stored in locked cupboards and where needed, locked fridges. We saw the record charts for the fridges that showed that staff carried out temperature checks daily and that temperatures stayed within the safe range. All medicines we checked were in date.
- Nursing staff followed a standard operating procedure for the safe use and security of prescription pads.
- The CQAF assessment included a check on storage and security of medicines, injectable drugs, and prescription pads. This had previously highlighted a need to keep injectables more securely and the nursing team had completed the action.
- Medicines management training figures were 91% for registered nurses across the outpatients and diagnostic imaging departments.
- In the diagnostic imaging and breast screening departments, some patients having interventional procedures would need sedation and pain relief and these included controlled drugs. The consultant

radiologist carrying out the procedure prescribed the medicines and the specialist nurses administered them. All medication used was documented and controlled drugs books were kept with patients during procedures.
- Patient group directions (written instructions for the supply or administration of medicines) for radiological contrasts and drugs used in MRI and CT had been completed and reviewed.

Records

- Records in the outpatient department were a mixture of paper based and electronic. Diagnostic imaging department records were digitised and available for doctors across the trust.
- Records contained patient-specific information about the patient's previous medical history, presenting condition, personal information such as name, address and date of birth, medical, nursing, and allied healthcare professional interventions.
- Staff managed records and their preparation for clinics in outpatients and 99.2% of all full patient notes were available in clinic. Staff had written a standard operating procedure (SOP) for preparation and supply of patient records to clinics. Referral letters and discharge summaries were stored electronically and provided back up when patients' notes were unavailable. Staff agreed that a doctor would always see a patient in clinic as long as there was some information about them in paper or electronic form and they could create temporary notes for the appointment that they merged with main records when they became available.
- Records were stored securely at outpatient reception and were carried to and from the clinic areas by trust volunteers as patients checked in. They were then stored in lockable drawers at each clinic suite. This ensured records were safe and confidential until the point of need.
- We reviewed 11 patient records which were completed with no obvious omissions.
- Outpatients and diagnostic imaging staff completed risk assessments including early warning score (EWS), pre-assessment for procedures and pain assessments. Nurses recorded these in patient records and escalated any concerns to medical staff in clinics.
- Patient information, pathology reports, diagnostic images and reports were stored electronically and available to doctors through Picture Archiving and Communications System (PACS), Radiology Information System (RIS) and Integrated Clinical Environment (ICE) systems. Staff used these systems to automatically record appointments, cancellations, procedure requests and rejections, examinations marked as complete and a record of the radiology activity undertaken.

Safeguarding

- All staff we spoke to understood safeguarding policies and procedures and knew how to report a concern. They knew they could ask for support if they needed it or they had a query.
- There was a designated safeguarding lead for the outpatients department and the business unit matron was a member of the trust safeguarding committee.
- Information provided by the trust showed that 85% of applicable staff in outpatients and 69% in diagnostic imaging had undergone safeguarding adults level 1 and safeguarding children level two training as part of their mandatory training. The trust target was 100% for the year and our inspection occurred part way through the year so more staff were due to complete their training in the remaining months.

Mandatory training

- Mandatory training was delivered in study days and some e-learning modules had been introduced this year. Staff had begun to use e-learning as an accepted method of learning. Modules included patient handling, resuscitation and the deteriorating patient, risk management, incident reporting and safeguarding adults and children.
- Managers in the outpatients and diagnostic imaging departments made sure staff attended training. The training and development department produced and distributed monthly reports on mandatory training and departmental managers checked compliance regularly to make sure that all staff were up to date with reviews.
- Department managers told us that staff were allowed time to attend mandatory training.
- Mandatory training compliance for outpatients ranged between 91% and 93% for all staff groups.
- In diagnostic imaging compliance varied between staff groups. Administration staff, advanced practitioners, and nurses had achieved 100% compliance and radiographers were 92% compliant. Only 43% of radiology department assistants had completed their

mandatory training. The service line manager explained that this group had been severely short staffed but compliance was improving rapidly as new staff were recruited and appointed.

Assessing and responding to patient risk

- There were emergency assistance call bells in all patient areas, including consultation rooms, treatment rooms, and diagnostic imaging areas. Staff confirmed that, when emergency call bells were activated, they were answered immediately.
- Staff knew actions to take if a patient's condition deteriorated while in each department and explained how they could call for help, call the paediatric and adult cardiac arrest teams and how to transfer a patient to the Accident and Emergency Department. There were enough resuscitation trolleys and defibrillators across outpatients and diagnostic imaging departments.
- The staff followed the radiation protection policy and procedures in the diagnostic imaging department and ensured that roles and responsibilities of all staff including clinical leads, medical physics expert and specialist safety advisor were clear and the risks to patients from exposure to harmful substances were managed and minimised.
- The Radiation Protection Advisor (RPA) report from September 2015 highlighted that all radiology equipment had been risk-assessed to ensure the safety of staff and patients. Specific testing and reporting had taken place during the previous 12 months on 86 pieces of equipment including radiographic tubes and generators, ultrasound, CT and image intensifiers. The RPA had reminded managers that follow up on any issues raised as an outcome of this testing was essential.
- The health and safety manager had developed and introduced a risk review for new optical radiation equipment entering service within the trust.
- Diagnostic imaging policies and procedures were written in line with the Ionising Radiation (Medical Exposure) 2000 regulations. IR(ME)R and the most recent medical physics expert report from September 2015 gave advice about commissioning new x-ray and CT equipment, improved audit response times for investigation of incidents and a full trust review of IR(Me)R and employer procedures. Staff produced plans to address all of these points with full and on-going support of the RPA.
- Named and certified radiation protection supervisors (RPS) provided advice when needed to ensure patient safety. The trust had radiation protection supervisors (and liaised with the radiation protection advisor (RPA).
- Arrangements had been agreed for radiation risks and incidents defined within the comprehensive local rules. Local rules are the way diagnostics and diagnostic imaging work to national guidance and vary depending on the setting. Staff ensured policies and processes were written and agreed to identify and deal with risks. This met with (IR(ME)R 2000).
- Staff asked patients if they were or may be pregnant in the privacy of the x-ray room therefore preserving the privacy and dignity of the patient. This met with the radiation protection requirements and identified risks to an unborn foetus. We saw staff follow different procedures for patients who were pregnant and those who were not. For example patients who were pregnant underwent extra checks.
- Outpatients and diagnostic imaging used early warning scores to check for and manage patient risk. Nursing staff assessed patients and gave scores to manage and treat patients.
- The outpatients and diagnostic imaging departments utilised risk assessments for patient management including; the World Health Organisation (WHO) checklist for invasive procedures. Diagnostic imaging, screening, and endoscopy departments used the WHO safer surgical checklist for all interventional procedures. We found no evidence of audit of compliance or quality of checklists.

Nursing and allied health professional staffing

- We looked at the staffing levels in each of the outpatient areas. There was one nursing assistant vacancy across the whole outpatients department and managers told us that staff retention was high. All department managers told us that staff were flexible to ensure they provided cover for each clinic and department. There were no departments with significant vacancies to affect the way they could function. Staff told us there were enough staff to meet service and patient needs and they had time to give to patients.
- Managers told us they could adjust the number of staff covering clinics to help those that were busy or where patients had greater needs. Managers compiled rotas based upon activity within the departments.

Outpatients and diagnostic imaging

- Within the diagnostic imaging department, there were nine vacancies for three radiographers and six radiography assistants were being recruited. Vacancies remained open for 11 staff including qualified radiographers and eight clerical staff.
- Within pathology there had been significant staff attrition when three large trust services amalgamated into one large service based at Queen Elizabeth Hospital, Gateshead. The manager reported they had carried out significant workforce planning to mitigate risks and although there were now fewer staff overall, there was a good skill mix and staffing numbers.
- There were five full time radiology specialist nurses, led by an advanced practitioner nurse. They worked across the department in a multidisciplinary style for CT and ultrasound procedures and took a major pre-assessment role, assisting with procedures and caring for patients pre, peri and post-operatively when undergoing interventional procedures.
- There was liaison across outpatient services and across sites for staffing with areas supporting each other where possible.
- Managers told us staff sickness rates in outpatients were consistently low. The rate for long term absence in July 2015 was 0.8%. The short term absence rate was 1.65% and the combined rate was 2.45%.
- The diagnostic imaging staff absence rate including long term sickness was 3.6% (just above the national average of 3.4%) and maternity leave for three staff had caused some staffing difficulties in ultrasound. The manager had organised increased staffing of the service gap by agency sonographers (staff trained and qualified to carry out ultrasound scans). This included providing 7 day service cover where possible. They had recruited new staff and identified existing staff interested in sonographer training.
- Physiotherapy staff reported that staff vacancies were currently a cause for concern. They had just recruited two senior staff and 5 more vacancies were unfilled. This had created a big impact and the team had lost some extensive skills and knowledge. Managers were using locums to fill temporary gaps.

Medical staffing

- Medical staffing was provided to the outpatient department by the various specialties which ran clinics. Medical staff undertaking clinics were of all grades; there were usually consultants on duty to support lower grade staff when clinics were running. Some specialist trainee doctors had their own caseloads and would deliver outpatients clinics when consultants were away. Staff would adjust clinic formats accordingly.
- There was a national shortage of radiologists and the trust had three vacancies, which they had not been able to recruit to in the previous 12 months. The department used the services of a locum consultant for approximately one week a month to support waiting lists. There were 9.5 whole time equivalent consultant radiologists. At the time of our inspection, there were enough staff to provide a safe service for patients, and managers used NHS Waiting List Initiative (WLI) work to manage staffing shortfall. The clinical director reported that the current situation was fragile regarding waiting and reporting times.
- Diagnostic imaging reporting was regularly outsourced to meet reporting time targets. There was a service level agreement and contract written for this and radiologists undertook quality checks in line with the departmental discrepancy policy.

Major incident awareness and training

- There was a major incident policy and staff understood their roles in case of an incident. Outpatients and diagnostic imaging staff took part in table top exercises and events to test the major incident plan.
- There were business continuity plans to make sure that specific departments could continue to provide the best and safest service in case of a major incident. Staff understood these and could explain how they put them into practice.

Are outpatient and diagnostic imaging services effective?

Not sufficient evidence to rate

We are unable to provide a rating for hospital outpatient and diagnostic imaging services. However: Care and treatment was evidence based and patient outcomes met national targets and guidelines.

The staff in the departments were competent and the multidisciplinary team met weekly and included both medical and non-medical staff.

Outpatients and diagnostic imaging

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

Evidence-based care and treatment

- We saw reviews against IR(ME)R regulations and learning shared with staff through team meetings and training.
- The trust had a radiation safety policy, which met with national guidance and legislation. The purpose of the policy was to set down the responsibilities and duties of designated committees and individuals. This was to ensure the work with Ionising Radiation undertaken in the trust was safe.
- Radiation protection supervisors for each modality led on the development, implementation, monitoring, and review of the policy and procedures to comply with Ionising Radiation (Medical Exposure) 2000 regulations IR(Me)R.
- Senior staff ensured that National Institute for Health and Care Excellence (NICE) guidance was fed-back to departments. Staff we spoke with understood NICE and other specialist guidance that affected their practice. Specialties were responsible for compliance with NICE guidelines, Public Health England directives, and specialty specific guidance such as Royal Colleges at national, regional, and local levels. All policies and guidelines were stored on the trust intranet. As staff received new guidance and directives, the department managers ensured clinical practice was updated.
- There were identified lead nurses within the department who had a responsibility to share changes in practice with the outpatient's team. An education lead nurse took responsibility for ensuring staff undertook the relevant training to enable them to support the specialist clinics.
- Procedures were followed to ensure the diagnostic imaging department were following NICE guidance to prevent contrast induced acute kidney injury and evidence based documentation was completed before, during and after interventional procedures which included NEWS (national early warning system) assessments.
- The diagnostic imaging department carried out quality control checks on images to ensure the service met expected standards.

Pain relief

- Outpatient's department nursing staff administered simple pain relief medication and they kept records to show medication given to each patient.
- Patients we spoke with had not needed pain relief during their attendance at the outpatient departments.
- Diagnostic imaging and breast screening staff carried out pre-assessment checks on patients before carrying out interventional procedures. Staff assessed pain relief for patients undergoing procedures such as biopsies (removal of a small piece of tissue for testing).

Nutrition and hydration

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

Patient outcomes

- Staff carried out audits throughout the outpatients department. Audits included themes on patient access, Mental Capacity Act and consent forms, use of clinic rooms, and health records including patient assessments in line with NICE guidance. Where audits produced results different from what was expected or needed, managers reported results and made changes to procedures accordingly.
- All diagnostic images were quality checked by radiographers before the patient left the department. Staff followed national audit requirements and quality standards for radiology activity and compliance levels were consistently high.
- The diagnostic imaging department key performance indicators included waiting times in various modalities for both in and out patients as well as general practitioner (GP or family doctor) patients and all met national standards.
- The diagnostic imaging department took part in the Royal College of Radiologists (RCR) National Audits including reporting and census audits in last 12 months. Staff submitted interventional radiology outcomes to a national data base. There was also representation at the Network Clinical Radiology Advisory Group (CRAG) to share and compare service delivery with other radiology

services. Staff audited all CT colonography imaging (x-ray of the colon with dye to show a clearer picture) within the National Bowel Cancer Screening Programme.
- The Radiology department was part of all major pathways in the trust. Examples included the stroke and theatres pathway, which staff developed through meetings involving specialist staff.

Competent staff

- In outpatients 98% of staff had undertaken formal appraisals, diagnostic imaging 92% of radiographers but only 43% of radiology department assistants had received a formal appraisal. All other diagnostic imaging staff had received appraisals. In all departments, staff were encouraged to discuss development needs at appraisal and as opportunities arose.
- Managers had created two new reporting radiographer posts and three trainee sonographer positions to train existing staff and improve skills. These posts were introduced to improve ultrasound capacity, plain x-ray reporting levels and in response to the national shortage of radiologists.
- Staff in radiology and outpatients completed trust and local induction which was specific to their roles.
- Senior staff checked and documented staff competencies and medical devices training in all departments. Staff undertook preceptorship, mentoring, clinical peer support and one to one supervision meetings. Managers supported staff to carry out continuous professional development activities, complete mandatory training, appraisal and diagnostic imaging staff completed specific modality training and competencies. Radiation protection supervisors undertook annual training updates.
- The local RPA had developed a presentation for e-learning training support around radiation safety awareness for radiation workers and referrers.
- Nominated key staff led on specialist information and guidance on areas such as radiation protection, education, infection control, safeguarding, and the Mental Capacity Act.
- Students were welcomed in all departments and information from students showed they felt supported.
- The trust carried out medical revalidation for all consultants.

Multidisciplinary working

- There was evidence of multidisciplinary team (MDT) working in the outpatients and diagnostic imaging department. For example, nurses and medical staff ran joint clinics and staff communicated with other departments such as diagnostic imaging and community staff about patients.
- Specialist nurses ran clinics alongside consultant-led clinics.
- We saw the departments had links with other departments and organisations involved in patient journeys such as GPs, support services and therapies.
- Clinical and non-clinical staff worked within the outpatients department. Staff worked in partnership with staff from other teams and disciplines, including radiographers, physiotherapists, nurses, receptionists, and consultant surgeons.
- Staff worked towards common goals, asked questions, and supported each other to provide the best care and experience for the patient.
- Managers and senior staff in all outpatient and diagnostic imaging departments held regular staff meetings. All members of the MDT attended and staff reported they were a good method to communicate important information to the whole team.
- Staff attended specialty MDT meetings from 12 specialist clinical areas and outpatients department including nurses, consultant leads and radiologists. In addition, medical staff could contact a duty radiologist any time to discuss issues and to provide support to other doctors and staff throughout the trust.
- Doctors liaised with staff at other trusts and could refer patients with complex or specialist needs to regional centres such as oncology services.

Seven-day services

- Outpatient managers had not fully developed seven day working within the outpatients setting as they had judged there was currently no demand for this service. The majority of staff were all employed with seven-day working terms and conditions. The department did support the delivery of outpatient's clinics over a six-day service including Saturday and evenings when demand occurred. Such demand was mostly for extra capacity to support waiting list initiatives requested by specialties to help address shortfalls in capacity.
- Diagnostic imaging provided services seven days a week. The trust provided a 24 hours a day, seven days a

week service for emergency plain x-ray imaging, emergency CT, out of hours portable images and emergency theatre imaging. Staff provided radiology outpatient services from Monday to Friday although there were occasional Saturday clinics to ensure the trust met their waiting list targets.

- The diagnostic imaging department provided general radiography, CT, MRI, ultrasound scanning and fluoroscopy (study of moving body structures) services for outpatients and inpatients every day. There was a rota to cover evenings and weekends so inpatients and emergency care patients could use diagnostic imaging services when they needed to.
- The trust introduced seven day working for routine imaging and outpatients into CT from September 2015. Managers had secured funding for more staff from an approved business case following a full capacity and demand analysis. The service used two CT scanners from 8am to 8pm Monday to Friday and one CT scanner on Saturday and Sunday from 8am to 4pm. The service was being supported by a CT van until a new scanner could be installed.
- MRI was providing a seven-day service with the support of locum staff. Managers had submitted a business case requesting funding for more staff. This service was running from 8am to 8pm seven days a week.

Access to information

- Staff could find all patient information such as diagnostic imaging records and reports, medical records and referral letters through electronic records. Staff followed procedures if patient records were not available at the time of appointment.
- Diagnostic imaging departments used picture archive communication system (PACS) to store and share images, radiation dose information and patient reports. Staff undertook training to use these systems and could find patient information quickly and easily. Staff used systems to check outstanding reports and staff could prioritise reporting and meet internal and regulator standards. There were no breaches of standards for reporting times.
- The diagnostic imaging department kept an electronic list of approved referrers and practitioners. Internal and external staff were vetted against the protocol for the type of requests they were authorised to make.
- There were systems to flag up urgent unexpected findings to GPs and medical staff. This met the Royal College of Radiologist guidelines.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- Nursing, diagnostic imaging, therapy, and medical staff knew how to obtain consent from patients. They could describe to us the various ways they would do so. Staff told us they usually obtained verbal consent from patients for simple procedures such as plain x-rays and phlebotomy (taking blood samples for testing).
- Staff obtained consent for any interventional radiology in writing according to the pre-assessment policy before attending the diagnostic imaging department. Staff checked and confirmed consent at the time of the procedure following trust policy.
- There was a trust policy to ensure that staff were meeting their responsibilities under the Mental Capacity Act and Deprivation of Liberty Safeguards. Staff completed this training as part of the trust mandatory training programme.
- Patients told us that staff were good at explaining what was happening to them before asking for consent to carry out procedures or examinations.

Are outpatient and diagnostic imaging services caring?

Good

We rated caring as good because:

Patients told us, and we saw that staff treated them kindly, and in a caring and compassionate way at every stage of their journey. They gave patients enough time for explanations about their care and encouraged them to ask questions.

Staff respected patients' privacy, dignity, and confidentiality at all times.

There were services to provide emotional support for patients and their families. Staff involved patients by discussing and planning their treatment. Patients could make informed decisions about the treatment they received.

Compassionate care

Outpatients and diagnostic imaging

- Staff in outpatient and diagnostic imaging were caring and compassionate to patients. We watched positive interactions with patients. Staff approached patients and introduced themselves, smiling and putting patients at ease.
- The department did not display clinic specialty names to maintain patient privacy and confidentiality.
- Staff respected patients' privacy and dignity. Consultation and treatment rooms had solid doors and patients could get changed before seeing a clinician. Staff knocked on doors before entering and closed doors when patients were in treatment areas.
- Patient treatment areas in physiotherapy services had curtains to separate patient bays. Staff reported this was not ideal for patient privacy. Staff told us they had requested rooms that were more private but thought that nothing was available.
- We spoke with 12 patients and 5 people close to them and all said that staff were friendly with a caring attitude. There were no negative aspects highlighted to us.
- Results from the national Friends and Family test showed that during July 2015, 91% of patients would recommend the trust to others (slightly worse than the England average of 92%). 5% of patients or those close to them would not recommend it (worse than the England average of 3%).

Understanding and involvement of patients and those close to them

- Patients received an appointment confirmation letter and all relevant patient information specific to their appointment for both NHS e-booking and paper GP referrals.
- Patients told us they were involved in their treatment and care. Those close to patients said nursing and medical staff kept them informed and involved. All those we spoke with told us they knew why they were attending an appointment and agreed with their care and plans for future treatment.
- Outpatients and diagnostic imaging staff involved patients in their treatment and care. We saw staff explaining treatment.
- Staff told us they would invite families into the consulting room as long as the patient was agreeable.

Emotional support

- Patients told us 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. Medical, nursing and allied health professionals provided support for individuals and their carers to cope emotionally with their conditions, treatments and outcomes. The outpatient teams supported patients within the department. Specialist nurses worked throughout the department in all specialist areas including acute oncology, respiratory, and gastroenterology. These specialist staff provided support and care to patients and those close to them throughout their visit.

Are outpatient and diagnostic imaging services responsive?

Requires improvement

We rated responsive as requires improvement because:

The trust had not achieved the national two week cancer waiting times for a first outpatient appointment in a number of specialties for the fourth consecutive time which the trust had identified as a governance concern. Action plans and escalation meetings were in place. The under-performing tumour sites that were subject to the escalation process were upper gastro intestinal, gynaecology and urology. Also the percentage of cancelled clinics was 11.5% which was almost double the average (6%) for Trusts in England.

However:

Several clinics and related services were organised so patients only had to make one visit for investigations and consultation. Staff made sure services could meet patients' individual needs, such as dementia, learning or physical disabilities, or whose first language was not English.

The department recorded concerns and complaints, which they reviewed and acted on to improve patient experience. The trust provided cancer screening services for patients in the North East, North Cumbria and Lancashire.

Routine appointments were booked within acceptable timescales.

Outpatients and diagnostic imaging

Service planning and delivery to meet the needs of local people

- The outpatient department flexed capacity and staffing to meet demand. Managers met with doctors to organise extra clinics.
- Service line managers held weekly meetings to plan for the weeks ahead. They discussed each clinic taking place, previous performance for appointments and over runs and highlighted concerns such as patient numbers or cancellations.
- The diagnostic imaging department used written instructions to deal with urgent referrals and arranged extra scanning sessions to meet patient and service needs.
- The breast screening service offered one-stop clinic appointments to enable patients to attend on one day for consultation and investigations.
- The trust was responsible for community abdominal aortic aneurysm (AAA) screening for the North East, North Cumbria and Lancashire. AAA screening teams travelled to community venues to carry out and promote the screening programme to men across these regions.
- Managers told us the trust were exploring options to move more outpatient sessions from the hospital to community to bring care closer to the patient's home. Managers had carefully measured capacity and had decided clinic space could be used at one of the existing satellite sites.
- Physiotherapy services provided a service to individual patients as well as a gym for groups of between 10 and 20 patients at Bensham Hospital five days a week and evening sessions twice a week. All patients were seen within set timescales. Staff had developed a database to manage patient referrals to the service.
- Pathology staff provided a Point of Care Team (POCT) which was clinical pathology accredited for five different blood tests. POCT staff trained staff on the wards to use the system; take blood samples and use the analysis equipment on the ward.

Access and flow

- The previous 12 months' appointments showed the outpatient departments booked 447,568 appointments with a new to review ratio of 1:3.4 (the number of new appointments compared to the number of reviews) for all appointments which was higher (worse) than the England average.
- According to information supplied by the trust, the percentage of appointments cancelled by the trust was consistently high with an average over the previous four months of 11.5% which was much worse than the England average of 6%. The main reasons given for cancellations were annual leave, on-call changes, and sickness. Outpatient staff booked review appointments regularly for 12 months, two years, or even five years in advance and because they were unable to trust the booking system to hold future appointments in a waiting list, clinics would be cancelled before those appointments arose.
- The 'did not attend' (DNA) rate for the trust was 6% which was slightly better than the England average of 7%. There were written trust policies for managing DNAs and an appointment reminder and confirmation service had reduced DNAs by 1 to 2%. This system also enabled the booking team to use empty clinic appointments more efficiently and invite other patients to attend. Staff reported that since the beginning of this system the number of empty appointment slots had reduced by 79%. The trust had received positive messages from patients about the appointment reminder calls.
- The trust had not achieved the 2 week cancer waiting times for a first outpatient appointment in a number of specialties for the fourth consecutive quarter. Action plans and escalation meetings were in place. The under-performing tumour sites that were subject to the escalation process were Upper GI, Gynaecology and Urology. The trust had identified this as a governance concern.
- Many more patients than expected had used the "NHS Choose and Book" option to request an appointment at Gateshead. Service line managers recognised they were reactive rather than proactive and had organised plans already for other specialties they anticipated would have higher demand. They had told the clinical commissioning group (CCG) about capacity issues. The outpatient service line manager met with waiting list managers and performance leads weekly to check performance against these targets and had highlighted issues with human resources to request extra staffing to deal with increased capacity and demand.

Outpatients and diagnostic imaging

- The percentage of Non-admitted patients seen within 18 weeks of referral over the previous 12 months was 97% and higher (better) than the England operational standard of 95%. The percentage of patients with incomplete care pathways who started their consultant-led treatment ranged between 92.5% and 96%. The operational standard in England is 92%. For September 2015 the referral to treatment times (incomplete pathway standard) was achieved with a rate of 92.9%. The specialities showing performance below 92% was cardiology, plastics and gastroenterology. Action plans were being developed and escalation meetings held to improve the position.
- The trust was performing consistently similar to or slightly worse than the England average for the percentage of people waiting less than 62 days from urgent GP referral to first definitive treatment for all cancers. 82% of patients were seen within 62 days for Quarter 1 of 2014/15 but this rose rapidly to better than average at 87% in Quarter 2.
- Turnaround times for urgent radiology reports were 60 minutes for general scans and 30 minutes for suspected stroke patients. Management of routine radiology reports ensured completion within national target times and staff checked records to ensure reporting compliance for images nearing the end of the time allowance.
- The percentage of patients waiting for over 30 minutes to see a clinician in outpatients was 5% and for over an hour was 0.9%. Staff followed the trust protocol for delays and we heard staff tell patients about delays and the reasons for them. Outpatient staff audited patient waits from the time patients booked in at reception.
- In diagnostic imaging, staff told us they did not measure waiting times for patients following their arrival at the department. Staff did record the arrival time of every patient and explained any unexpected delays to individuals.
- The bookings team checked referral letters and radiology requests within 24 hours of receipt and forwarded to consultants for triage, for return within 5 days. Staff entered radiology requests onto the integrated clinical environment system (ICE) and sonographers or radiologists triaged them.
- The trust had introduced a new paper-free way to work with referral letters where staff scanned all letters and sent an electronic version to consultants for triage. At the time of our inspection 80% of consultants were using it for all referrals. Managers had introduced paper-free referrals as mandatory practice across all specialties during our inspection.
- The trust used the NHS e-Referral Service (previously known as Choose & Book) and had sustained a performance of approximately 70% referral rate. This service allowed GP practices to offer patients a choice of appointment. The remaining 30% of referrals were received as a paper copy. Once triaged staff contacted these patients by telephone to offer them a choice of appointment. The booking clerks would make a minimum of three attempts to contact the patients, one of which would be out of hours between 5pm and 8pm.
- Diagnostic imaging waiting times for all departments and from all urgent and non-urgent referrals met national targets of 99%. Two target breaches had occurred for ultrasound and two for MRI scanning. Managers had set out temporary and long-term measures and closely checked targets to ensure no new breaches occurred. However, the ultrasound department had experienced severe staff shortages in 2015 due to multiple staff taking maternity leave and one episode of long-term sickness which led to patients waiting longer than targets allowed. The department had recruited two sonographer posts and identified staff interested in commencing sonographer training. Managers had bought in a fully managed service with equipment, staff and reporting facilities to support the department until recruitment was complete. Managers were certain the capacity problems would be resolved quickly following these staff appointments.
- Staff carried out a continuous review of planned diagnostic imaging sessions regarding demand and 7-day working arrangements. They organised extra imaging sessions to provide more urgent diagnostic imaging requests as necessary.
- In the diagnostic imaging department, reporting times for urgent and non-urgent procedures consistently met or were better than national and trust targets for all scans and x-rays for inpatients and outpatients. A manager checked the number of images waiting for reports on a continual basis and took action when needed to ensure they did not exceed reporting time targets. Reporting was regularly outsourced and if targets were in danger of being breached they would send a reminder or request the images be released so internal staff could report them immediately.

- Patients who cancelled diagnostic imaging appointments were re-booked to attend within the national target of 6 weeks of their original appointment date.
- The pathology service tested up to 10,000 samples every day through up to 7,000 different processes. Staff carried out performance checking for reporting turnaround times and the service benchmarked itself against other centres. An example of the standard achieved was that 94.35% of histopathology samples were tested and results provided within one week and 99.95% within two weeks.

Meeting people's individual needs

- In several areas chairs were fixed together and to the floor so seating could not be rearranged to suit individual needs.
- Clinics were organised to meet patients' needs. Teams worked together and specialist clinics were organised so all investigations and consultations happened on the same day. Doctors, nurses and therapists worked together to carry out joint assessment and treatment.
- Staff could use private areas to hold confidential conversations with patients if necessary and receptionists told staff quickly if patients had difficulties with speaking, listening or understanding.
- Staff within the main outpatient department had been assessed in a CQAF audit with an area dedicated to the 6 C's (An NHS England initiative around Compassion in Practice; Care, Compassion, Competence, Communication, Courage, and Commitment.)
- Breast and bowel screening services offered a one-stop-shop approach to appointments where all investigations and consultations were carried out on the same day and patients left with a diagnosis and treatment plan. Patients we spoke with liked this approach. The service also offered interventional radiology treatments on the same day of a referral if they were needed.
- Staff told us they were ordering bariatric furniture and equipment (for people who were larger or heavier and could not use standard furniture) but we found some items that were already in use. A search for a new CT scanner included finding one with a bariatric table that could hold larger and heavier patients.
- Staff could identify patients with complex individual needs such as those with learning difficulties or physical disabilities using an alert system through the patient administration system (PAS) to offer specialist support, which led to improved timely reviews by specialist teams. The learning disability specialist nurse received a weekly report of patients with special needs who would be attending the department.
- Staff knew how to support people living with dementia and had completed the trust training programme. They understood the condition and how to be able to help patients experiencing dementia. However, they had to rely on referrers or those accompanying patients to tell them if a patient needed extra support.
- Departments could help patients in wheelchairs or who needed specialist equipment. There was enough space to manoeuvre and position a person using a wheelchair in a safe and sociable manner. There was a hoist for patients who needed help with mobility.
- Staff offered patients good quality, up to date information. Staff displayed information on notice boards and provided patients with information leaflets.
- There had been a recent introduction of a virtual trauma clinic, where staff contacted patients by telephone to tell them if they would need to attend a clinic or not. The team aimed to improve the service for patients as well as reduce the number of those who did not attend their appointments (DNAs). Managers had commenced an audit on time saved and had identified direct benefits to patients. They would audit the results after 6 and 12 months of its use
- The bookings teams organised interpreter services for patients who did not speak or understand English. Staff told us they did not have trouble in booking interpreters. However, booking staff had to rely on GPs and hospital referrers ensuring the trust knew about a patient's individual needs.

Learning from complaints and concerns

- Staff in all departments told us they received very few complaints. They could identify patterns and themes from patient concerns and shared the lessons learned with the outpatient team.
- Most complaints that were made were about clinical decisions and a few were about appointments. Staff had sent a complaints evaluation questionnaire to patients who had raised a complaint or concern and the data

had been analysed and recorded. We saw evidence of staff responding to complaints and concerns and action plans that departments had written following investigations into practice.

- Staff understood the local complaints procedure and were confident in dealing with concerns and complaints as they arose. Managers and staff told us they discussed complaints, comments, and concerns at local team meetings, agreed actions, and shared any learning throughout the team.
- There was a patient advice and liaison service (PALS) open every weekday between 9am and 5pm. We saw patients using the service throughout our inspection to ask for information or advice. Staff listened to patients, were courteous and understanding.
- None of the patients we spoke with had ever wanted or needed to make a formal complaint. Some had raised concerns during their visit about waiting times within the department and a lack of disabled parking spaces close to the building, due to estates works being carried out. They told us that staff had listened and dealt with their concerns and, where possible, action taken to address the concern. Overall they were happy with the experience they received from the departments.
- The trust provided its complaints policy on the trust web site.
- Staff managed complaints in diagnostic imaging and showed us logs of actions they had taken to address concerns, complaints, and their outcomes.

Are outpatient and diagnostic imaging services well-led?

Good

We rated well-led as good because:

Trust staff and managers had a vision for the future of the departments and knew the risks and challenges the service faced. Staff we spoke with generally felt supported by their line managers, who encouraged them to develop and improve their practice.

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

Vision and strategy for this service

- Staff told us managers involved them in strategic planning. Managers were working in partnership with the medical and surgical business units to produce an outpatient's strategy to meet the needs of the specialties as well as local people. Radiology staff had produced a departmental strategy for the future delivery of diagnostic services.
- We saw business plans for all services and departments within outpatients and radiology. These included strategies for dealing with winter pressures and staff had contributed as teams towards these documents.
- The trust vision was displayed in staff areas and teams had worked together to agree local ideas about providing the best possible service for patients.

Governance, risk management and quality measurement

- Staff reported on risk, incidents, and complaints. They discussed incidents at departmental meetings, led by the service line manager and clinical directors attended to discuss trends and serious incidents.
- Service line managers held and controlled risk registers and staff could influence what risks were included. The "Safecare" forum met monthly to discuss risks and disseminate learning across the organisation through directorate and service line manager meetings, and staff emails.
- Diagnostic imaging staff carried out risk management as a team with modality (specialist diagnostic imaging services for example CT and MRI) leads, radiology risk assessors, and radiology protection specialists. The radiation protection advisor provided support and guidance in all aspects of risk assessment.
- Staff held monthly peer management meetings where staff raised, discussed and actioned risks identified within the department and agreed higher level risks they would forward to the patient safety manager.
- The organisation checked up to date NICE guidance to make sure they put any relevant guidance into practice; in diagnostic imaging, this included radiology related stroke thrombolysis and non-thrombolysis imaging times. Gastroenterology doctors were following NICE guidance on Infliximab (a drug used to treat Crohn's disease) and had carried out a compliance audit.
- The operational board measured and checked performance against national targets where managers

presented finance, performance, and operational performance dashboards. Service line managers, matrons, clinical leads, finance and Safecare teams attended and key risks were fed up to the executive team.

Leadership of service

- Staff found the local managers of the service to be approachable and supportive. Most staff we spoke with told us they were content in their role and many staff had worked at the hospital for many years. Staff felt they could approach managers with concerns but some medical staff in diagnostic imaging did not always feel listened to, or confident action would be taken. We saw good, positive, and friendly interactions between staff and local managers.
- Staff felt line managers communicated well with them and kept them up to date about the day-to-day running of the departments.
- Diagnostic imaging department leadership was positive and proactive. Staff told us they knew what was expected of them and of the department that managers had planned some positive changes and some had already taken place.
- Staff told us they completed annual appraisals and were encouraged to manage their personal development. Staff could access training and development provided by the trust and the trust would fund justifiable external training courses.
- Staff told us they knew the executive team, they listened to new ideas for change and sent out regular messages to staff.

Culture within the service

- Staff were proud to work at the hospital. They were passionate about their patients and felt they did a good job. They were encouraged to report incidents and complaints and felt their managers would look into these consistently and fairly.
- Staff told us they felt there was a culture of staff development and support for each other. Staff were open to ideas, willing to change and could question practice within their teams and suggest changes.
- Outpatients and diagnostic imaging staff told us there was a good working relationship between all levels of staff. We saw there was a positive, friendly, but professional working relationship between consultants, nurses, allied health professionals, and support staff.

Public engagement

- The trust recruited and vetted volunteers following trust policies and procedures. Volunteers provided support to patients and staff throughout outpatient areas, transporting patient records from reception to each clinic area and showed patients and relatives to waiting areas.
- Volunteers were involved in the service by giving their opinions and suggestions.
- Staff gave patients and those close to them information, and they could voice their opinions through various forums including patient focus groups for example hospital user group, respiratory, screening, diabetes, rheumatology user groups.
- The trust involved patients from charitable organisations in deciding how to use funds raised by them.
- Diagnostic imaging staff had undertaken a staff and patient questionnaire to review the MRI service staffing to consider extending the outpatient service to include weekends. Results showed that patients had answered positively about the offer of weekend scanning appointments.

Staff engagement

- Staff told us they took part in team meetings and were confident to talk about ideas and sharing of good news as well as issues occurring in the previous days or planning for anticipated problems.
- Each staff team had produced a “Compact” where they had worked together to link trust vision and strategy with everyday working and staff attitudes and links were made between staff induction, working practice, and appraisals.
- Physiotherapy staff reported that the head of nursing sent staff a personal letter when FFT results were good.

Innovation, improvement and sustainability

- Pathology services had achieved the national external quality assurance scheme (NEQAS) accreditation for cellular pathology and were recognised as a national centre for excellence.
- The pathology service were developing mobile phone “apps” to provide help, a better service to patients and providers of care. There were four projects underway: to give information to the point of care testing (POCT) team about where quality standards on wards had reduced or

where staff training was necessary, to monitor in-patient results with online help and information for staff so that if results became critical this would be flagged with the lab or the clinician, provide doctors in the community with a sample tracking service with a same day text-back service, provide a text message for patients to let them know if they needed to contact their GP for their results or if they were normal that this would be unnecessary.

- Prescribing pharmacists were carrying out a pilot to work alongside junior doctors and nursing teams within some outpatient's clinics to support with prescribing and transcribing to speed up the way drugs were prescribed and delivered for patients. This was already proving beneficial and managers planned to introduce this throughout the departments in the year ahead.
- The phlebotomy team provided direct support to the acute response team for deteriorating patients and the hospital at night team in a trial for a system used to monitor and analyse patients' vital signs with any calls for intravenous cannulation and taking blood for testing.
- Physiotherapists were working in the emergency care centre to support frail patients with mobility aids.

Outstanding practice and areas for improvement

Outstanding practice

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

Areas for improvement

Action the hospital MUST take to improve

Action the hospital MUST take to improve

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

Action the hospital SHOULD take to improve

Action the hospital SHOULD take to improve

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

Outstanding practice and areas for improvement

- Continue to implement and strengthen governance processes in response to recommendations following an external independent review including strengthening the board assurance framework, clinical engagement and management of performance and risk.
- Review version control arrangements for the updating of paper copies of polices and care pathways held in clinical areas to ensure staff are using policies which are in date and reflect the latest best practice guidelines..
- Ensure cause for concern-safeguarding forms identify if a child is, or is not, subject to a child protection plan to enable swift and appropriate action.

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