

# The Newcastle upon Tyne Hospitals NHS Foundation Trust

## Freeman 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

Outstanding 

Medical care (including older people's care)

Outstanding 

Surgery

Outstanding 

Critical care

Outstanding 

Services for children and young people

Outstanding 

End of life care

Good 

Outpatients and diagnostic imaging

Good 

# Summary of findings

## Letter from the Chief Inspector of Hospitals

We inspected the trust from 19 to 22 January 2016 and undertook an unannounced inspection on 5 February 2016. We carried out this inspection as part of Care Quality Commission's (CQC) comprehensive inspection programme.

We included the following locations as part of the inspection:

- Freeman Hospital incorporating The Northern Centre for Cancer Care
- Centre for Ageing and Vitality

We inspected the following core services:

- Medical Care
- Surgery
- Critical Care
- Services for Children and Young People
- End of Life Care
- Outpatients & Diagnostic Imaging

Overall, we rated the Freeman Hospital as outstanding.

Our key findings were as follows:

- The trust had infection prevention and control policies, which were accessible, and used by staff. Patients received care in a clean, hygienic and suitably maintained environment.
- 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.
- 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.
- Patient outcome measures showed the trust performed mostly within or better than national averages when compared with other hospitals. Stroke pathways and long-term cancer outcomes were particularly effective. Death rates were within expected levels.
- There were clearly defined and embedded systems and processes to ensure staffing levels were safe. The trust had challenges due to national shortages however; it was actively addressing this through a range of initiatives including the development of new and enhanced roles, and overseas recruitment. There were particular challenges in the provision of consultant to patient ratios and pharmacy cover in critical care.
- The trust was meeting its waiting time targets for urgent and routine appointments.
- The diagnostic imaging department inpatient and emergency image reporting turnaround times did not meet nationally recognised best practice standards or trust targets
- 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.
- Information written in clinical notes about the care patients received in the Emergency Department and on some wards was minimal.
- Feedback from patients, those close to them and stakeholders was consistently positive about the way staff treated people. There were many examples of exceptional care where staff at all levels went the extra mile to meet patient needs.

# Summary of findings

- The trust used innovative and pioneering approaches to deliver care and treatment. This included new evidence-based techniques and technologies. Staff were actively encouraged to participate in benchmarking, peer review, accreditation and research.
- The trust worked hard to ensure it met the needs of local people and considered their opinions when trying to make improvements or develop services. It was clear that the opinion of patients and relatives was a top priority and highly valued.
- There was a proactive approach to understanding the needs of different patients. This included patients who were in vulnerable circumstances and those who had complex needs.
- There were strong governance structures and a systematic approach to considering risk and quality management. Senior and local site management was visible to staff. Staff were proud to work in the organisation and spoke highly of the quality of care provided.
- There were consistently high levels of constructive engagement with patients and staff, including all equality groups.

We saw several areas of outstanding practice including:

- There was an integrated model of care between the Specialist Palliative Care Team and the Cardiothoracic Transplant Team. The teams worked alongside patients with advanced disease including those waiting for transplant and those with ventricular assist devices.
- A sleep checklist was developed for patients in critical care to optimise sleep. This included measures such as environmental factors, noise, temperature and light in patient areas.
- Hydrotherapy rehabilitation after critical illness had been developed for patients who were ventilated which enabled them to move their limbs supported by water. This gave psychological support to patients and helped them engage with their rehabilitation programme.
- Radiology facilities were adapted to meet the needs of patients with dementia or learning difficulties. This included distraction aids and mood lighting to help patients relax.
- The trust Falls and Syncope Service was the largest of its kind in Europe and undertook research and treatment for patients presenting with a range of problems such as balance disorders, dizziness, low blood pressure, balance problems or unspecified lack of co-ordination and falls.
- The Northern Centre for Cancer Care (NCCC) in partnership with Macmillan was providing chemotherapy in three community health centres enabling access for non-complex treatments closer to home. Chemotherapy nurses from the NCCC ran this service.
- The perioperative care team at the Freeman were national leaders in pre-operative assessment, cardiopulmonary exercise testing after major intra-abdominal surgery (including shared decision making in the pre-operative counselling process).
- The pancreatic service had developed a remote care service to assist clinicians in outlying hospitals to manage their patients. This was to avoid transferring ill patients to Newcastle when they could be managed at their base hospital. This service was coordinated by a nurse specialist and saved patients being unnecessarily transferred to Newcastle. It also ensured that those patients who may require specialist care were transferred at the correct time.

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

Importantly, the trust MUST:

# Summary of findings

- Ensure that care documentation in the Emergency Care Department and on some wards are fully completed to reflect accurately the treatment, care and support given to patients, and is subject to clinical audit.

In addition the trust SHOULD:

- Ensure processes are in place to meet national best practice guidelines for diagnostic imaging reporting turnaround times for inpatients and patients attending the Emergency Care Department.
- Ensure that all groups of staff complete mandatory training in line with trust policy particularly safeguarding and resuscitation training. Ensure that all staff are up to date with their annual appraisals.
- Ensure that the departmental risk register in End of Life Care accurately reflects the current clinical and non-clinical risks faced by the service.
- Ensure that all housekeeping staff who undertake mattress contamination audits are aware of the trust policy relating to mattress cleanliness and the criteria for when to condemn a mattress.
- Ensure staff follow the systems and processes for the safe storage of medicine and the recording and checking of resuscitation equipment.
- Ensure that the storage of patient records is safe to avoid potential breaches of confidentiality.
- Ensure that arrangements are robust to enable patients to transfer safely with continuity of syringe drivers in place from hospital to the community to avoid the risk of breakthrough pain being encountered.
- Ensure that the Care for the Dying Patient documentation is fully implemented and embedded across acute hospital sites.
- Ensure that processes are developed to identify if patients achieved their wish for their preferred place of death.

**Professor Sir Mike Richards**  
**Chief Inspector of Hospitals**

# Summary of findings

## Our judgements about each of the main services

### Service

**Medical care  
(including  
older  
people's  
care)**

**Outstanding**



### Why have we given this rating?

We rated medical care (including older people's care) as outstanding overall because:

There was a good record of accomplishment in safety with no never events and measures implemented to address serious incidents. Staff understood their responsibilities to raise concerns and report incidents. Senior staff managed staffing shortfalls proactively. Patient outcomes were better than targets recorded in local and national audit data. There was very good evidence of effective 24/7 multi-disciplinary team working.

There was a strong and visible patient-centred focus shown by both clinical and non-clinical staff. Patients had individual care plans and felt safe. Staff considered physical, emotional and social aspects of patient's wellbeing. Patients and staff would recommend the service as a place to receive care.

The service was responsive to the internal and external demands placed upon it. Staff made reasonable adjustments in response to individual patient needs and to accommodate vulnerable patient groups.

Managers led the service well with an open and honest culture. Governance arrangements were set up to effectively identify, manage and plan service improvements, efficiencies and to implement actions to mitigate risks affecting service provision. The service was innovative, with strong well-established partner relations.

### Surgery

**Outstanding**



Overall we rated surgery as outstanding because:

Surgical services showed a proactive approach to identifying and developing improvements in safety, full investigations were undertaken. Staff understood the process for reporting and investigating incidents, actions were identified and communicated widely to support improvement.

Staffing levels and skill mix were planned, implemented and reviewed to keep patients safe. Staff shortages were responded to quickly.

We found that surgical outcomes for patients were mostly similar or better than expected when compared with other similar services.

# Summary of findings

There was a holistic approach to assessing, planning and delivery of care with safe use of innovative and pioneering approaches encouraged. Patients were supported and treated with dignity and respect. Feedback from patients, relatives and stakeholders was consistently positive. The complaints process was well embedded, thorough and managed in a way that ensured good investigations and outcomes were achieved. Leaders had an inspiring shared purpose and strived to deliver and motivate staff to succeed.

## Critical care

Outstanding



Overall we rated critical care as outstanding because: During our inspection, patients and staff consistently shared good experiences; it was evident that critical care had a good and safe reputation. The service demonstrated a balance between getting the basics right and innovation. There were excellent examples of sustained innovative practice. The teams in critical care services were very well led. The service was consultant-led and we observed good relationships with nurses and the multi-disciplinary team. A genuine culture of listening, learning and improvement was evident amongst all staff. Governance arrangements were clear. Critical care was represented at board and trust level and information was shared with perioperative and cardiothoracic services. Patients and their families had access to an established range of support services. It was clear that patients were at the centre of decisions. The critical care unit performed well or above national averages in governance and performance areas. Patient outcomes were the same as or better than the national averages and care and treatment was planned and delivered in line with current evidence based guidance and standards.

## Services for children and young people

Outstanding



Overall, we rated services for children, young people and families as outstanding because: Managers and staff created a strong, visible, person-centred culture and were highly motivated and inspired to offer the best possible care to children and young people, including meeting their emotional needs. Staff were very passionate about their role and, in some cases, went beyond the call of duty to provide care and support to families. Staffing levels were appropriate.

# Summary of findings

Families were very positive about the service they received. They described staff as being very caring, compassionate, understanding and supportive. Services were flexible, provided choice and ensured continuity of care.

The care and treatment of children and young people achieved good outcomes and promoted a good quality of life. Staff proactively collected and monitored this data and used the information to improve the care they delivered.

The culture was open and transparent with a clear focus on putting children and young people at the centre of their care.

Staff protected children and young people from avoidable harm and abuse. Managers and staff discussed incidents daily, and took appropriate action to prevent them from happening again.

Staff were very positive about working for the trust and we saw some excellent examples of leadership. There was a clear management structure and managers were visible and involved in the day-to-day running of services. The trust provided opportunities for training and development and staff were well trained and highly motivated to offer the best possible care to children and young people.

## End of life care

Good



Overall end of life care was rated as good with well-led rated as requires improvement because:

The Caring for the Dying Patient document to replace the Liverpool Care pathway, although fully embedded in the community had only been piloted on a small number of wards in the acute hospitals. Interim guidance was available for ward staff and plans were in place to roll out training for the new documentation across all wards but there were no formal timescales to specify this at the time of inspection.

Although risks were identified in the End of Life and Palliative Care update reports to the Board, there was no end of life care risk register used to identify and monitor risks.

Whilst ward staff were engaged in the provision of end of life care there appeared to be a lack of understanding of the strategies and priorities for end of life care by ward staff. The trust had taken steps to engage with staff to increase awareness of the strategy.

# Summary of findings

Although there was some audit for monitoring if, patients achieved their wish for their preferred place of death this was limited and was not routinely identified. The trust acknowledged that future audits would include this.

The Specialist Palliative Care Team and End of Life Care Team were highly visible and accessible and ward staff had a clear referral process in place for patients. The results of the End of Life Care Dying in Hospitals Audit 2016 showed that the trust met all clinical audit indicators and seven of the eight organisational indicators.

Patients received compassionate care and their privacy and dignity was respected. The chaplaincy and mortuary staff demonstrated examples of outstanding care provided to patients and their families.

Nursing staff told us that they had sufficient staff to prioritise good quality end of life care when needed and that they had the processes in place to escalate staffing concerns should they arise.

## Outpatients and diagnostic imaging

Good



Overall we rated 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.

There were sufficient staff of all specialties and grades to provide a good standard of care in all departments.

There was good leadership of staff to provide good patient outcomes in the outpatients and diagnostic imaging departments. There were well-organised systems for organising clinics.

The departments learned from complaints and incidents, and developed systems to stop them happening again.

However, diagnostic imaging reporting turnaround times for inpatients and A&E patients did not match national best practice guidance.



# Freeman Hospital

## Detailed findings

### Services we looked at

Medical care (including older people's care); Surgery; Critical care; Services for children and young people; End of life care; Outpatients & Diagnostic Imaging

# Detailed findings

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## Background to Freeman Hospital

The Freeman Hospital is a 1025 bed tertiary referral centre in Newcastle upon Tyne. The Freeman was opened in 1977, when services from several hospitals across the city and elsewhere in the North East were relocated into one centre.

In 2011, the UK's first Institute of Transplantation was completed at the Freeman Hospital. The Freeman provides a full range of cardiothoracic surgery for adults and children, which are provided under one roof.

The Northern Centre for Cancer Care opened in 2009. The centre provides a full range of specialist cancer care for patients, and is the first in the UK to offer leading edge radiotherapy technology.

The Freeman offers in-patient care for those requiring general, specialist medical and surgical services and critical care. There is a wide range of outpatient and diagnostic facilities.

## Our inspection team

Our inspection team was led by:

**Chair:** Ellen Armistead, Care Quality Commission

**Head of Hospital Inspections:** Amanda Stanford, Care Quality Commission

The team included: CQC inspectors and a variety of specialists including: medical, surgical and obstetric

consultants, a dentist, junior doctors, a paediatric doctor, senior managers, a paediatric nurse, nurses, midwives, a palliative care nurse specialist, a health visitor, physiotherapists and occupational therapists and experts by experience who had experience of using services.

## How we carried out this inspection

Prior to the announced inspection, we reviewed a range of information that we held and asked other organisations to share with us what they knew about the hospital. These included the Clinical Commissioning Group (CCG), Monitor, NHS England, Health Education

England (HEE), the General Medical Council (GMC), the Nursing and Midwifery Council (NMC), Royal Colleges, Overview and Scrutiny Committee and the local Healthwatch.

We held a listening event on 13 January 2016 in Newcastle to hear people's views about care and

# Detailed findings

treatment received at the trust. 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 and in the community, including nurses and midwives, junior doctors, consultants, allied health professionals, including: physiotherapists; occupational therapists and administrative and support staff. We also spoke with staff individually as requested. We talked with patients and

staff from all the ward areas, outpatient services and community sites. We observed how people were being cared for, talked with carers and/or family members, and reviewed patients' personal care and treatment records.

We carried out the announced inspection visit from 19 – 22 January 2016 and undertook an unannounced inspection on 5 February 2016.

## Facts and data about Freeman Hospital

- There were 834,122 outpatient appointments at the Freeman Hospital in the year before our inspection they provided outpatient services with up to 2,700 clinics per week across all sites and a range of specialties.
- Between July 2014 and June 2015, children's and young people had 385 spells.
- The medical services, which provide almost 500 in-patient beds, reported in excess of 78,000 admissions from July 2014 – June 2015.
- During 2014/2015, the trust carried out over 400 transplants.

## Our ratings for this hospital

Our ratings for this hospital are:

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

# Detailed findings

## Notes

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

# Medical care (including older people's care)

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

## Information about the service

The Newcastle upon Tyne Hospitals NHS Foundation Trust ("the trust") has been providing care to the communities in the North of England for over 250 years. The trust provides acute and specialist medical services across Newcastle upon Tyne from six main sites.

The medical directorate which provides 680 in-patient beds reported in excess of 78,000 admissions from July 2014 – June 2015 across the range of services offered, namely immunology, stroke medicine, diabetes, endocrinology, general medicine, respiratory care, gastroenterology, urology and renal, dermatology, hepatology, rheumatology, neurology, cardiology, infectious diseases, haematology, oncology and older people's medicine.

With more than half of directorate beds across its specialist medical in-patient wards, the Freeman Hospital ("the FH") situated in the north of Newcastle accounted for 38,500 of these admissions (inclusive of Northern Centre for Cancer Care – "NCCC"). The FH offers in-patient care for those requiring general and specialist medical services in urology, renal haemodialysis, rheumatology, older person's medicine, cardiology, respiratory care, gastric and liver conditions and transplantation. NCCC provides haematology and oncology services.

It is the aspiration of the medical directorate to deliver services, which are characterised by excellence in clinical outcomes, which are managed efficiently and effectively and in doing so ensure comprehensive patient

satisfaction. In the NCCC and Clinical Haematology, they aim to continue to deliver excellent haematology, oncology and bone marrow transplant services across the North of England.

During our inspection, we spent time at the FH and NCCC visiting wards (excluding oncology services), the investigation unit, the emergency assessment suite, the institute of transplantation (IOT) and the endoscopy unit. We spoke with 68 members of staff (including managers, doctors, nurses, therapists, pharmacists and non-clinical staff). Where appropriate we considered care and medication records (including electronically stored information) and completed some 29 reviews. Our team met with 37 patients, relatives, observed shift handovers, multi-disciplinary team meetings (MDT), and care being delivered at various times during the visit.

# Medical care (including older people's care)

## Summary of findings

We rated medical care (including older people's care) as outstanding overall because:

- There was a good record of accomplishment in safety with no never events and measures implemented to address serious incidents. Staff understood their responsibilities to raise concerns and report incidents. Senior staff managed staffing shortfalls proactively.
- Staff delivered evidence based care with good patient outcomes recorded in local and national audit data. There was very good evidence of joint and effective 24/7 multi-disciplinary team working.
- There was a strong and visible patient-centred focus shown by both clinical and non-clinical staff. Patients had individual care plans and felt safe. Staff considered physical, emotional and social aspects of wellbeing. Patients and staff would recommend the service as a place to receive care.
- The service was responsive to the internal and external demands placed upon it. Staff made reasonable adjustments in response to individual patient needs and to accommodate vulnerable patient groups.
- Managers led the service well with an open and honest culture. Governance arrangements were set up to effectively identify, manage and plan service improvements, efficiencies and to implement actions to mitigate risks affecting upon service provision. The service was innovative, with strong well-established partner relations.

## Are medical care services safe?

Good



We rated safe as good because:

- Staff reported never events and serious incidents in accordance with national guidelines. Staff reported incidents without hesitation.
- Safety thermometer data showed performance consistently better than national targets and the service showed steps taken to address particular concerns surrounding pressure ulcer care and falls. There was an inconsistent approach in data display but this was accessible on the wards.
- All ward areas were visibly clean and well maintained. Staff were aware of infection prevention and control (IPC) measures and isolation of patients where necessary was appropriate. The service evidenced good compliance with various IPC audits.
- Staff had an awareness of safeguarding procedures.
- There was very good use of the National Early Warning Score (NEWS) surrounding escalation of care.
- The service identified nurse staffing as an issue however proactively managed ward staffing levels. To reinforce Safer Nursing Care Tool (SNCT) findings, senior staff used professional judgment and referred to 'red flags' when addressing ward staffing acuity. Senior staff managed escalation efficiently by offering existing staff additional or extended shift patterns, moving staff from better-staffed areas and accessing the nurse bank. The service temporarily closed beds when safe staffing levels could not be achieved.
- We noted particularly low fill rates on two medical wards but these were mitigated with additional staff. We identified no patient safety issues on these wards and there was no correlation between incidents and low staffing fill rates at this location.

However

- Staff were not given protected time to complete some aspects of their mandatory training causing conflict with working shifts and ward duties.
- We observed some loose strip medications not securely stored

# Medical care (including older people's care)

- Although record keeping was overall good, some handwritten notes were illegible. Staff administered medications in accordance with guidelines but some resuscitation trolley medications were not securely stored.

## Incidents

- The service reported incidents through the trust electronic reporting system.
- Between June to September 2015, there were 2,627 medical care incidents reported, of which 1,075 originated from FH.
- From the 2,627 total, four (0.15%) had a severity classification of 'catastrophic' and 33 (1.3%) were reported as 'major'. The most common incident type within these categories related to patient accidents (including falls, sharps, moving and handling) accounting for 13 of the 37 (35.1%).
- The FH reported 2 'catastrophic' and 15 'major' reports in the same period. We reviewed five incident investigation reports/root cause analysis (RCA) documents and these were comprehensive and of good quality. Actions were identified and plans were on going at the time of our inspection.
- In accordance with the Serious Incident Framework 2015, the medical directorate reported 38 serious incidents (SIs) which met the reporting criteria set by NHS England during August 2014 and July 2015. Of these, the majority, 22 (58%) were slips, trips and falls, pressure ulcers (PUs) meeting the serious incident criteria accounted for six (16%) of the total. These trends correlated with figures published by the trust in the Directorate Clinical Governance Meeting – Monthly Reporting Template for September and October 2015.
- Staff were confident in reporting incidents and provided us with examples of incidents that they would report. This included any incidences of falls, pressure ulcers, near misses and medication errors. Staff graded incidents according to a scale of level of harm ranging from no harm/insignificant to major/catastrophic events.
- The trust had developed a bespoke incident investigation/RCA template specifically for falls and pressure ulcers which were reviewed and were fit for purpose
- Staff we spoke with explained that they sometimes received feedback on incident outcomes by e-mail, at team meetings, and through informal supervision to inform learning and improvements in care.
- Staff reported all PUs irrespective of grade or classification. The tissue viability nurses (TVNs) responded to the incidents within 24 hours. This avoided misclassification and ensured accurate reporting. Staff reported an increase in the availability of pressure relieving equipment because of proactive reporting of such incidents.
- Staff we spoke to knew of the Duty of Candour requirements. Junior staff understood that this involved being 'open and honest' with patients. Ward managers were aware of the Duty of Candour and some staff explained to us that they had been involved in investigating and responding to patients and families under this duty.
- The service shared learning from incidents and when things went wrong. We saw evidence of good reflection on action in cardiology however in some other wards staff informed us they were becoming more reliant upon e-mail to cascade information. Heads of Units, Ward Managers and Matrons also discussed incidents at their regular meetings. The trust also held training events, which highlighted themes and trends in patient safety such as the Pressure Ulcer Study Day in November each year.
- Each unit (stroke, gastroenterology, endocrine, general medicine, and respiratory) held and minuted regular mortality and morbidity (M&M) meetings. The medical and nursing attendees discussed individual care and issues were identified and action taken. Feedback from these meetings was shared with staff during safety briefings and direct contact with those concerned.

## Safety thermometer

- In 2014/15, the trust was consistently better than the national target of 95% for harm free care throughout the whole year.
- Between September 2014 and September 2015, there were 159 pressure ulcers, 20 falls and 47 CUTIs (urine infections in patients with a catheter) in the service. There were no clear trends in the data over this period to show sustained worsening or improvement in this performance.
- In the six months from July to December 2015, the tissue viability nurses recorded 88 trust acquired categorised

# Medical care (including older people's care)

PUs across all wards at the FH. Thirteen (14.8%) we recorded as category 1, 73 (83%) as category 2 and two (2.2%) as category 3. There were none reported in category 4.

- From October to December 2015, the 'No Falls on My Patch' data provided by the trust recorded 140 falls at the FH, 97% classified as 'insignificant' or 'minor'.
- Venous-thromboembolism (VTE) Risk Assessment Audit results produced for the Directorate Clinical Governance Meeting in September and October 2015 showed increasing compliance at the FH from 87% to 92.4%. Of 29 records reviewed, we noted staff completed 25 VTE risk assessments, two were pending and two could not be located. Of the 25 completed, all except two were completed within the first 24 hours of admission. This would accord with compliance of 86.2%. We also observed in all patients who required VTE treatment, staff prescribed the relevant prophylaxis.
- Of 29 records reviewed, staff completed 27 pressure ulcer risk assessments using the Braden Scale (tool used to predict pressure sore risk) within 6 hours of admission.
- Of 29 records reviewed, 28 patients had a multifactorial falls risk assessment on admission and included in their care plan where appropriate. Staff had not signed two falls risk assessments and one was not reviewed after a significant change in the patient's condition.
- The trust had developed a 'Strategy for the Prevention of Slips, Trips and Falls' and had a Falls and Syncope Service (FASS) which included a consultant, a falls prevention co-ordinator and a nurse practitioner. The team worked closely with other services, in particular with older people's medicine, cardiology and neurology. The service was available to all in-patients identified as being at risk and referral to the service triggered a specialist falls assessment within an hour.
- All wards we visited displayed safety thermometer data however, the quality was variable and the most up-to-date information was not always evident. Some wards provided a user-friendly explanation of what the data showed which was helpful to patients and relatives.

## Cleanliness, infection control and hygiene

- All wards we visited were visibly clean and tidy.

- Therapy rooms had cleaning rotas and all the equipment was visibly clean. We observed clinical waste been disposed of appropriately. Commodes had green stickers placed on them to indicate the time and date they had been cleaned.
- Most wards we visited displayed the number of cases of Methicillin Resistant Staphylococcus Aureus (MRSA) and Clostridium Difficile (C. difficile) along with hand hygiene and environmental cleanliness audit data, however, in some instances there were no dates attached to confirm when these were completed.
- The wards we visited displayed posters at the entrance asking visitors not to visit the ward if they had been unwell. This was in order to reduce the spread of infection.
- We observed that personal protective equipment (PPE) such as disposable gloves and gowns were available to staff. We saw these were used appropriately, when staff were interacting with patients.
- We observed patients requiring isolation nursing cared for in side rooms. Staff displayed appropriate signage advising staff and visitors not to enter without appropriate protective clothing. Staff used appropriate protection when entering the room and disposing of the same appropriately when they left.
- We observed staff carrying out hand washing prior to and after patient contact. Staff adhered to the "5 Moments for Hand Hygiene" and "Bare below the Elbow" protocols.
- Staff used clinical waste and sharps disposal appropriately on the wards we visited.
- The trust provided us with sight of results from a rolling annual cleanliness audit, completed at various times throughout 2015 by senior members of the nursing, catering, estates and hotel services team. Wards audited in July and September 2015 (32, 33, 34, 36, MSU) recorded scores between 89% - 97% with only minor estates related deficits highlighted. In the January 2016 environmental cleanliness audit, the service recorded a compliance rate of 98.4%.
- In the Matron's monthly check for December 2015, medicine scored 100% in the cleanliness audit, which covered all aspects of the ward environment such as hand hygiene equipment, clinical areas, patient areas day rooms, toilets and bathrooms, linen storage and clinical waste disposal.
- The trust also used the Clinical Assurance Toolkit Scorecard (CAT) which measures performance against



# Medical care (including older people's care)

key criteria such as environmental cleanliness, hand hygiene, infection prevention and control (IPC) practice and encompasses the matron's monthly check. The same also audits staff knowledge of IPC against key criteria. In December 2015, medicine recorded 100% against hand hygiene opportunity, hand hygiene technique, 98.4% under IPC practice and 97.6% for environmental cleanliness. The service recorded IPC knowledge at 85.7% for the same period.

- The CAT programme also monitored urinary catheter care, invasive device insertion and invasive device care. In December 2015, medicine scores were 100%, 100% and 99% respectively.
- The service monitored staff knowledge surrounding ANTT and IPC to support competence in infection control procedures. The service scored consistently above 80% from August to December 2015.
- Most wards we visited had side rooms to isolate patients and many of these had en-suite bathroom facilities.
- The trust had seen a year on year reduction in MRSA bacteraemia with only five reported cases in 2014/15.
- Between October 2014 and May 2015 the trust carried out an audit to see how many patients suspected of having influenza were appropriately isolated. The trust set a standard of 90%. The audit included data from the medicine wards and showed only 53% of patients were appropriately isolated on a positive influenza test. The audit made recommendations for improvement, including training for staff and increasing the number of isolation beds available. The audit did not include a formal action plan to monitor compliance and progress against these recommendations.
- Following a C. difficile outbreak on ward 48 at RVI in April 2015, the trust carried out an audit of antimicrobial prescribing on the ward. This checked prescribing against five local standards. This identified some areas of good practice (for example, there were no serious errors in prescribing) and some areas for improvement (for example, 26% of prescriptions were not found to be fully compliant with local guidelines). Staff presented the results of the audit to the wider gastroenterology M&M meeting identifying a need for a review of antibiotic prescribing.
- At the end of October 2015, the Directorate Clinical Governance Meeting Report confirmed cumulative year to date figures for hospital acquired infections to be MRSA bacteraemia at two cases, Methicillin Sensitive

Staphylococcus Aureus (MSSA) bacteraemia at nine cases and E. coli infections at 26 cases. As of end of December 2015, the service reported 36 C. difficile cases (against target of 77 for year-end).

- The trust had a HCAI Prevention and Control Strategy underpinned by national guidelines and IPC policies to manage and monitor infection essential for patient and staff safety.
- IPC training was mandatory within the trust and staff accessed IPC staff for advice and guidance when required.
- Disinfection facilities in the endoscopy suite were good.

## Environment and equipment

- The service designed wards in such a way to make optimum use of space to deliver patient care.
- Patient led assessments of the care environment (PLACE) see local people go into hospitals as part of teams to assess how the environment supports patient's privacy and dignity, food, cleanliness and general building maintenance. The 2014/15 Review of the Year provided an overview of the 2014 PLACE scores in which the service was involved. Overall, the trust performed better than national average in the four domains of cleanliness, food and hydration, condition, appearance and maintenance and privacy, dignity and wellbeing.
- Ward 14 had a further PLACE assessment carried out in February 2015 and received generally positive comments. Auditors wanted to see improvement in general signage on the ward.
- Matron's monthly check in December 2015 reviewed key ward equipment across the service. Medicine scored 100% in meeting key criteria for patient bed space, equipment (bed-side entertainment television/phone), oxygen and suction points, patient medicines lockers, patient chairs, beds/trolleys, hoists, mattress and cushion checks, thermometers and drip stands and sharps disposal. ECG machines and resuscitation trolley checks scored 95.8%, notes trollies, monitoring equipment and commodes scored 93.8% and locked medicine fridges recorded 85.7% compliance.
- We checked the resuscitation trollies on all the wards we visited and these contained correct stock. Two trollies we checked did not have their medication drawer secured with a tamper proof seal. This meant that there was a risk that medications were accessible. We saw that each resuscitation trolley had a log

# Medical care (including older people's care)

attached to it for staff to complete on a daily basis. The majority of daily checks were complete, however almost all trollies had at least one check missing within the 14 days prior to our inspection.

- Staff told us the medical devices department coordinated the monitoring of equipment and calibration checks where necessary. All equipment we checked had safety-testing stickers in date.
- Endoscopy equipment was up-to-date and in good condition.
- Staff provided patients at risk of developing pressure sores using the Braden Score with appropriate pressure relieving support surfaces such as mattresses and cushions.
- For those patients who were admitted into hospital with pressure sores or developed skin damaged whilst in hospital, access to higher specification mattresses were available through TVN or equipment stores.

## Medicines

- We checked the storage of medications on the wards we visited. We found that medications overall were stored securely in appropriately locked rooms and fridges.
- Staff appropriately stored medications requiring refrigeration. We saw staff completed daily checks to monitor fridge temperatures however, checklists on all wards showed some omissions.
- We checked the storage of controlled drugs. Staff stored and locked away controlled drugs appropriately and recorded dispensing in a controlled drugs book.
- The trust had an electronic chemotherapy system to support the safe prescribing of chemotherapy. In accordance with policy, only appropriately trained staff prescribed and administered intrathecal drugs. Staff collected these medications directly from pharmacy to minimise the need for ward storage. Ward 33 and 36 had good support from a clinical pharmacist who managed the electronic system who was able to add amend regimens as needed.
- On ward 33, we found some loose medicine foil strips in the treatment room. Such loose strips albeit labelled correctly may increase the risk of accidentally selecting the wrong medicine.
- Staff coordinated and managed discharge medications very well and dispensed these in a timely manner.
- We reviewed 14 electronic prescription charts. The name of the prescribing physician and the date

prescribed appeared on screen. All prescription charts had patient allergies recorded. Ten of the charts showed antibiotic prescribing and review in accordance with guidelines.

## Records

- We observed differing practices for the storage of records on the wards we visited. On some wards, records were stored at the nurse base station or in the junior doctor's room. On the majority of wards we visited records were stored in portable cabinets located outside bays and clinic rooms.
- We reviewed 29 sets of medical records (both paper and electronic format). Overall, the records were up-to-date however, it was not always clear, due to illegible written entries, who the name/grade of the clinician/nurse/ other healthcare professional was that made the note. Senior medical staff documented daily reviews along with a clear diagnosis and treatment plan. Staff recorded discussions following MDT meetings detailing on-going treatment, input from therapies, discharge plans and dialogue with family.
- Some staff were uncertain if notes audits had taken place.
- We found nursing records to be up-to-date with evidence of regular care review. We found all appropriate risk assessments, in particular surrounding falls and pressure ulcers completed in a timely manner. Review of risk assessments was not always well documented and appeared to be inconsistent.
- All nursing notes included a core care plan identifying care needs however these were not always individualised to identify specific patient care needs.

## Safeguarding

- The trust had a designated lead for safeguarding supported by a team from child protection, adults at risk, mental capacity, learning disabilities and midwifery.
- All staff we spoke with knew how to raise safeguarding concerns through the correct channels. Staff provided us with examples of when they had contacted the safeguarding team for support and said they received timely and appropriate advice.
- At the time of our inspection, data provided by the trust showed that staff on the medical wards at the FH had achieved on average 86% compliance with safeguarding

# Medical care (including older people's care)

adult's level 1 training and 57% compliance with safeguarding adults level two training. This was against a trust target of 95%. The service was potentially not updating staff on current safeguarding themes.

- A safeguarding vulnerable adult's leaflet was available for healthcare professionals on the wards we visited. This provided contact details for the safeguarding service and guidance on how to recognise abuse.

## Mandatory training

- On average, at the time of our inspection and part-way through the training calendar, staff on the medical wards at the FH had achieved on average 86% compliance with mandatory training modules. This was against a trust target of 95%.
- Mandatory training modules included a range of topics, such as moving and handling, infection prevention and control, safeguarding, and falls awareness.
- Ward managers informed us they received an e-mail to alert them when staff needed to complete the mandatory training sessions. This was then cascaded to the staff member accordingly. Some ward managers also kept an internal ward level list of key mandatory training dates.
- Staff that we spoke with understood they were up to date with mandatory training requirements in the current year. Staff accessed some mandatory training modules using the trust electronic learning system. This allowed staff to monitor training due dates when they logged onto the system. Staff told us that the system did not provide e-mail updates to alert them as to when training was overdue.
- Staff explained they completed the majority of their mandatory training around daily work commitments and that they did not always receive protected time to complete training. Some nursing staff told us that they had needed to cancel attendance at face-to-face training sessions due to staff shortages within the service.
- We saw that some ward managers kept a list of when staff needed to complete mandatory training.

## Assessing and responding to patient risk

- The trust took part in the National Audit of Inpatient Falls. This showed that the number of falls per 1000 patient days was in line with national averages, with the rates of falls resulting in harm being lower than the national average.

- Staff on the medical wards at the FH had achieved on average 95% compliance with falls training meeting the trust target of 95%.
- The service recorded falls prevalence on the risk register. The service had identified steps to reduce falls by additional training, seeking additional staff for 1:1 nursing for high-risk patients and access to equipment such as ultra-low beds, fall sensors and footwear assessment for patients.
- The trust used the Roving Elders Hospital Interface Team (REHIT) who proactively case search older persons within the trust through the emergency department to the assessment suite and then onto wards to ensure they receive an early comprehensive multi-disciplinary assessment. The team assess every medical boarder and older patients identified as needing extra care and support during hospitalisation, to reduce stay and plan for a supported discharge with community support to prevent unnecessary re-admission.
- All the staff we spoke with knew how to identify and respond if a patient was deteriorating. Staff told us they used the National Early Warning Score (NEWS) observation chart as a trigger to escalate concerns. Staff told us they could also record nursing concerns on the NEWS observation charts allowing clinical opinion alongside recorded observations.
- A number of senior clinicians across the medical specialisms confirmed NEWS worked very well in identifying and escalating care for a patient who was deteriorating.
- Staff we spoke with knew how to escalate concerns out of hours. The trust used a hospital at night team to support medical cover. Staff provided us with examples of when they had contacted the hospital at night team for support and said that they received timely and appropriate advice.
- The FH provided level two (those requiring more intense monitoring) and level three (those requiring advanced respiratory monitoring/organ support) care on site.

## Nursing staffing

- The service had used the 'Safer Nursing Care Tool' (SNCT) to measure patient dependency and determine the number of staff required to care for those patients. Senior nursing staff informed us they used their own internal professional judgment to reinforce SNCT findings and determine staffing numbers/skill mix required for the medical wards.

# Medical care (including older people's care)

- The management team had identified nurse staffing as an issue within the medical directorate and this appeared on the services risk register. All wards visited confirmed they had vacancies.
- Staff displayed planned and actual staffing numbers on boards on each ward.
- The service had an overall vacancy rate of 9.6% and there were widespread issues with staff shortages. Staff told us most areas tried to cover gaps with their own staff, by requesting assistance from other wards and the Matron or requested staff from the nurse bank.
- Nursing staff broadly followed NICE guidance and staff had an awareness of 'red flag' indicators to trigger escalation steps.
- At the time of our inspection, trust data as of September 2015 showed that there were some nurse and other clinical staffing vacancies across medical wards at the FH. In total, data showed 45.69 whole-time equivalent (WTE) nurses down on establishment levels. The majority of these vacancies were in older persons medicine wards (15.35 WTE).
- Data also showed a shortfall of 16.8 WTE on establishment for other clinical staff such as health care assistants. These vacancies were evenly spread across all wards.
- Nurse staffing had been further compromised by turnover rate of 167 WTE and staff sickness averaging 5.6% respectively.
- Nursing Fill Rate Trends from October – December 2015 showed the majority of medical wards at FH falling short for daytime registered nurses with figures in the region of 80-90%. Wards 13 and 18 were significantly lower at 62.4% and 63.6% respectively. These wards had significantly higher unregistered nursing fill rates for the same period at 160.6% and 162.2% respectively. These low fill rates were mitigated with additional staff and this had no evidenced impact on patient safety. We found no correlation between patient safety incidents and fill rates on these wards.
- Night time registered nurse fill rates for the same period were better, with the majority of the wards at the FH exceeding 95%.
- Unregistered nurse fill rates for both day and night time at the FH was variable but most wards recording figures in excess of 100%.
- The trust provided us with data on the use of bank nursing staff between April 2014 and March 2015. At the FH, this showed that the average use of bank staff during this period was 7.6%. The ward with the lowest usage of bank staff was across the cardiology speciality and the highest was ward 18 (19.9%). Agency staff were only utilised when a patient required 1:1 care and where existing staff and resource could not meet this need.
- Despite nurse staffing shortfalls, we obtained consistent evidence in all wards to confirm that there was a process in place for managing staffing levels and should there be a need to escalate due to a change in patient need. All staff confirmed patients were safe and not at risk.
- Staff on ward 24 informed us, when short staffed, "we simply get more". Senior staff managed this very well and they never had any problems.
- British Thoracic Society Guidelines confirm patients receiving non-invasive ventilation (NIV) require 1:2 staffing in the first 24 hours. Ward 29 confirmed an average number of patients requiring NIV to be approximately 1-2 at any given time. Staff allocated patients requiring this level of intensity to areas of the ward that provided the safest staffing ratio. The ward manager escalated staffing threshold levels to the patient services coordinators (PSC's).
- Ward 32 had four beds closed since November 2015 due to nurse staffing levels. The ward had particular challenges in managing both in-patients and outpatients and required help most days to meet workload. Positive recruitment had seen some vacancies filled. There were concerns raised to us about increased patient safety incidents because of staffing levels. Between July - September 2015 prior to the bed closure, there was no increase in numbers of incidents reported (June - 25, July - 19, August - 29 and September - 20).
- Ward 16 confirmed they attracted newly qualified staff for their vacancies however had difficulty in retaining. Senior staff were analysing reasons for this.
- We were able to view staff rotas from a number of wards, which confirmed actual numbers of staff on duty for given shifts. We were able to view historic rotas showing where additional staff had been requested to compliment shortfalls where need demanded.
- Service managers closed beds for short periods due to unsatisfactory staffing levels.
- The service was actively recruiting nursing staff by way of social media advertisements and pool interviews. The service had filled a number of vacancies.

## Medical staffing

# Medical care (including older people's care)

- The medical staffing skill mix showed the trust had a higher proportion of consultants and a lower proportion of juniors than the national average. Consultant staff made up 44% (national average 34%), middle career doctors (with at least 3 years in a chosen specialty) were 3%, registrars were 40%, and junior doctors were 13% (national average 22%).
- The trust performed within expectations for all questions on the 2015 General Medical Council (GMC) National Training Survey.
- The clinical directors confirmed there were no issues overall in medical staffing with current vacancies in older persons medicine. During the winter months, the service ensured extra consultants were available out-of-hours and at weekends. To assist, the service also appointed additional middle grade medical staff.
- The trust provided us with data on the use of medical locum staff between April 2014 and March 2015. At the FH, this showed that the average use of medical locums was around 6.3%. Some of the lowest usage was in older person's medicine and in musculoskeletal services (MSU) with general medicine seeing the greatest usage of locum staff.
- The service was actively involved in local, national and international audit activity and followed recognised guidance, which provided a strong evidence base for care and treatment.
- The patient outcomes from the stroke, heart failure, diabetes and myocardial infarction (heart attack) audits were all above national average. The trust performed better than expected with fewer numbers of deaths in cancer indicators.
- Patients were comfortable on the wards and food standard was adequate.
- Staff had access to a number of internal and external learning opportunities with many wards developing their own specialism specific competencies. Ward based learning opportunities were good.
- We found very good, robust and effective 24/7 MDT working. Medical/nursing handover and senior staff support was good. The service had strong senior physician and nursing staff presence out-of-hours and at weekends.
- Staff had an awareness of consent and capacity issues relating to Mental Capacity Act and Deprivation of Liberty Safeguards. Staff completed relevant documentation well.

## Major incident awareness and training

- We saw that the trust had appropriate policies in place with regard to business continuity and major incident planning. These policies identified key persons within the service, the nature of the actions to be taken and key contact information to assist staff in dealing with a major incident.
- Some staff we spoke with were not clear on their specific role in the event of a major incident but were aware on how to access the major incident policy for guidance on the trust intranet.
- Service managers and senior staff considered seasonal demands when planning medical beds within the trust. Staff at FH accessed contingency beds at RVI to assist with winter pressures.

However

- Some junior qualified nursing staff found it difficult to meet their full developmental needs due to working demands, financial restraint and restricted access to higher-level qualifications.
- Appraisal rates, in particular with junior registered nursing staff, were below expected targets.

## Evidence-based care and treatment

- Staff referred to a number NICE Guidelines/Quality Standards, Royal College, Society and best practice guidelines in support of their provision of care and treatment. Local policies, which were accessible on the ward and on the trust intranet site reflected up-to-date clinical guidelines.
- We reviewed a number of clinical guidelines on the intranet (acute kidney injury, peritonitis and neurogenic sepsis), all were current, identified author/owner and all had review dates.
- The service was actively involved in local, national and international audit programmes collating evidence to

## Are medical care services effective?

Outstanding



We rated effective as outstanding because:



# Medical care (including older people's care)

monitor and improve care and treatment. The service compiled an Annual Clinical Audit Report of activity that specified a range of completed, planned and on-going evidence-based reviews.

- In accordance with NICE Quality Standards, the service was involved in data collection activity for heart failure, diabetes, acute coronary syndromes, falls and fragility fracture audit programme (including hip fractures), gastrointestinal bleeding and renal registry.
- Services had developed a number of evidence based condition specific care pathways to standardise and improve patient care and service flow. In ambulatory care, there were pathways for low risk pulmonary embolism, anaemia, headaches, low risk upper gastrointestinal (GI) haemorrhage and high INR treatment.
- The service had reflected upon National Audit Report findings and developed action plans to support evidence-based care and treatment. For example, staff in respiratory medicine reviewed current evidence around exercise plans, muscle strength testing and pulmonary rehabilitation. In cardiology, action plans were in place monitor cardiac rhythm management devices for sick sinus syndrome. There were also action plans for diabetic foot care and dementia performance.
- Senior staff recorded and monitored a number of local quality measures. The Matron's monthly audits and CAT measured care planning and delivery against recognised standards and best practice guidelines.

## Pain relief

- Patients received pain relief as prescribed and where appropriate on an as required basis.
- Patients confirmed that staff recognised when they were uncomfortable and were proactive in enquiring if pain relief was required.
- In the endoscopy suite, staff provided patients with sedation and/or throat spray to minimise discomfort of the procedure.
- The CQC National Survey of In-Patients recorded a score of 8.2 out of 10 under the care and treatment category that was better than other similar trusts. Specifically, the trust scored 8.6 out of 10 for pain management, which was similar to other Trusts.
- Staff accessed the trust specialist pain team when needed.

## Nutrition and hydration

- Of 29 records reviewed, we observed only one patient did not receive a nutritional/malnutrition (MUST) risk assessment. Staff implemented care plans for those patients who required support and assistance with eating and drinking.
- Staff told us that they could access support from the speech and language therapy service (SALT).
- We observed nutrition and hydration recorded on fluid/food and FOCUS charts which summarised periodic intake during the course of the day. The completion and accuracy of these charts was variable on the wards we visited.
- The service had taken part in a trust wide audit and GAP analysis of patient's nutritional needs. This identified areas of compliance and non-compliance with trust policies on nutrition and hydration. The audit in October 2015 showed that the service had a nutritional care plan in place for 92.5% of the patients audited. It also identified that -wide, scores were at a four year high for staff knowledge and documentation in dealing with nutritional issues, whilst scores for assurance and observed practice were also above the average for this period.
- The GAP analysis identified some trust wide compliance issues with staff not adhering to nutritional policies. Senior staff identified this and put action plans in place to improve compliance.
- Patients had protected meal times. Staff allowed family members to attend during meal times where patients required help or support in eating or drinking.
- Staff used red jugs to identify patients at risk of dehydration or who required additional assistance with drinking.
- We received variable comments from patients regarding food quality and menu choice with most confirming the same to be of an adequate standard. There were various menu options for individual dietary requirement such as halal.
- We observed ward managers, staff nurses and health care assistants feeding patients. Where encouragement was required this was given in a non-disparaging way and at a relaxed pace. Staff updated care plans when a patient refused to eat. Overall, patients confirmed their enjoyment of the food provided.
- Staff provided patients on older person's wards with a choice of sweet and savoury afternoon snacks.

## Patient outcomes

# Medical care (including older people's care)

- The stroke service performed well in the Sentinel Stroke National Audit Programme (SSNAP) with a level B at trust level and at team level, a C overall (where A is the best and E is the worst) rating during July – September 2015.
  - The trust performed well in the 2013/14 Heart Failure Audit. It scored better than the England average in nine of the 11 areas considered. The audit did highlight that proportionally fewer patients received an echocardiogram when compared to the national average (38% compared to 91%).
  - The trust performed better than the England average in each of the three indicators in the 2013-14 Myocardial Ischaemia National Audit Project (MINAP) and showed an improvement on the previous year.
  - The majority of indicators in the National Diabetes Audit 2015 were better than the England average. 88.6% of patients reported their satisfaction with the service compared to a national average of 84.3%.
  - The trust performed better than expected with fewer numbers of deaths in 16 of the 20 cancer by type indicators (Summary Hospital Level Mortality Indicators provided by Health and Social Care Information Centre (HSCIC SHMI) covering the period October 2014 – September 2015). Of the remaining four, the trust performed as expected in three and worse than expected in only one area.
  - Regionally, the trust was the only service, which had a lower number of deaths than expected for cancer diagnoses (North East Quality Observatory 2014/15).
  - Patients from the FH took part in the national clinical audit of biological therapies to treat inflammatory bowel disease (IBD) in September 2015. The report identified good practice at the FH with all patients having had their patient outcome measures completed at the start of treatment and 15 of the 18 patients with Crohn's disease achieving remission.
  - The FH Endoscopy Unit had Joint Advisory Group (JAG) Accreditation recognising competence in delivery of endoscopy services against independently recognised standards.
- Competent staff**
- Nursing staff told us that they had received information and support from the trust about Nursing and Midwifery Council (NMC) revalidation.
  - Staff confirmed to us learning needs and development opportunities came up regularly through informal and formal discussions. These often translated into the opportunity to attend ward-based training, Trust-wide training sessions or external courses in conjunction with academic partners.
  - Staff identified learning and training needs during annual appraisal and 1:1 sessions. Appraisal rates at FH between April – October 2015 were variable from ward to ward and across different staff groups, averaging 74.4%. Overall, consultants and Band 7-8 nurses had appraisals completed during this period. Lower banded registered nurses (5-6) and non-registered staff (2-4) had considerably less appraisals completed during this period.
  - At the trust-wide focus groups, senior nurses informed us their managers supported further/higher/post-graduate level study. Many senior staff told us they had accessed additional training and development in their job roles. A physiotherapist in the Falls and Syncope Service (FASS) had been supported to complete a doctorate and matrons completed masters degrees.
  - The band 5-6 nurse focus groups indicated to us support for such study varied across the specialisms with a number feeling frustrated at being unable to secure time or funding for courses, which they felt, would support learning needs. They understood this to be due to financial and staffing pressures.
  - Medical and nursing staff acknowledged mentoring and clinical supervision on the wards was very good.
  - The trust had developed an integrated stroke clinical and research service whereby all stroke physicians and stroke specialist nursing staff were research active.
  - Staff on the stroke unit accessed additional training, completing specific stroke training competencies (STAR training). Staff worked well with the clinical education team.
  - Many specialist areas had developed local ward based competencies for newly qualified nursing staff. Ward 38 utilised the clinical nurse educator who was supportive in training and education.
  - The trust TVN's were visible and provided training to staff. The training was cascaded by clinical educators, 1:1 support, on an individual patient referral basis when reviewed and by way of the link nurse programme.
  - At the time of our inspection, 91% of staff had undergone equality and diversity training to help ensure that they delivered tailored care. This was against a trust target of 95%.

# Medical care (including older people's care)

- Junior medical staff informed us access to formal and informal training was good with many having been involved in M&M reviews, incident reviews, clinical governance group, audits and safeguarding concerns. During busy periods some medical staff found it difficult to attend elements of training and in cardiology, the regular departmental training sessions were intermittent.

## Multidisciplinary working

- We observed multidisciplinary working (MDT) throughout our visit to the FH.
- MDT involvement in the assessment, planning and delivery of patient care was apparent on all wards and we observed interactions between various different teams and services. Records reviewed showed evidence of this input from the MDT.
- MDT working in the Institute of Transplantation (IOT) was fundamental to the efficient running of the service. IOT specialist nurses had strong and effective working relationships across the MDT such as the interventional radiologist, surgeons, urologists, nephrologists, nurses and patient services coordinators. This allowed for prompt actions when an organ became available.
- The MDT meeting on ward 13 was very well attended by nursing/medical staff, therapists, pharmacists and medical social workers. Staff discussed each individual patient, their current medical condition, where internal referrals were required, any concerns and discharge plans. The MDT had an in-depth knowledge of each individual patient, his or her family and everyone contributed.
- The MDT process continued seamlessly throughout the stroke care pathway from acute admission to rehabilitation services at the Centre for Ageing and Vitality.
- There were clear internal referral pathways to therapy and psychiatric services. Additionally, staff confirmed external referral to community services also flowed well and community services would attend MDT meetings.

## Seven-day services

- The service supported the commitment to the trusts 24/7 strategy.

- There was consultant presence out-of-hours (OOH) up to 10pm in general medicine however frequently outside this window. The hospital at night service was available every day OOH from 9pm to 9am although the cardiology block was not covered by this service.
- Non-resident on-call consultant level cover was available in all specialisms, diabetes (1:5), endocrinology (1:4), gastroenterology (1:8), and stroke medicine (1:5), hepatology (1:6). In haematology and oncology, two consultants from each area were on-call from home overnight (9pm to 9am).
- Daily consultant ward rounds occurred seven days a week with additional review of any patients causing concern as required.
- A senior grade physician was present 24/7 and many specialist units within medical services provided senior grade physician cover OOH.
- The Institute of Transplantation provided a 24/7 service for donor patients across the region and farther afield.
- The trust operated a hospital at night service seven days a week to assist in out of hours and weekend medical cover. Advanced nurse practitioners led the service and took calls from wards where patients required medical support. The advanced nurse practitioners triaged calls and assessed the level of input required.
- Diagnostic testing and reporting was available at all times subject to the needs of the patient.
- Endoscopy facilities were available OOH, staff performed these procedures in theatre as opposed to the endoscopy suite. The physician gastroenterologist was on-call 7 days a week for emergency endoscopies.
- Staff told us that physiotherapy support was available seven days a week on some wards. Occupational therapy and speech and language therapy was available Monday to Friday.

## Access to information

- Staff we spoke with raised no concerns about being able to access patient information in a timely manner.
- Observation of nursing handover was thorough with detailed handover sheets providing key care summaries for each patient.
- Medical handovers at shift changes was comprehensive with detailed and relevant information shared. Medical handovers ran succinctly and timely prior to post-take ward rounds. Although invited to attend, senior nurses did so intermittently due to pressures and workload on their wards.



# Medical care (including older people's care)

- Staff moved patients to specialist wards following initial assessment. Staff handed over relevant patient information to the receiving ward prior to the transfer.
- Medical staff informed us they received investigation results promptly.
- Staff informed us discharge-planning considerations commenced on admission.
- Staff informed GP's of discharge in writing by way of a discharge summary, which tended to follow the patient on the day of discharge. The service had successfully piloted discharge summaries sent electronically with plans to roll this out further.
- Staff identified what community services or on-going care needs would be required for the patient on discharge. Staff involved the patient, their family and the service providers in discharge planning.
- If GP's had any queries or concerns regarding on-going patient care needs on discharge they would call into the service where they would be able to speak to a relevant member of staff. Staff informed us that this would not always be the consultant and was subject to the query raised.

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

- We observed staff asking patients for their consent prior to delivering care and procedures.
- We saw that the trust had an appropriate policy informing staff about the consent process. This included reference to obtaining consent where patients may have capacity issues and included guidance on the Mental Capacity Act.
- At the time of our inspection, data provided by the trust showed that only 46% of staff within medicine had completed the mandatory Mental Capacity Act training, against a trust target of 95%.
- Staff we spoke with knew of the Mental Capacity Act and DoLS. Staff provided us with examples of DoLS, explaining steps taken to identify and support patients who may not have the capacity to consent. Staff accessed the Safeguard Team if concerned about a patient.
- We saw that the trust had an appropriate policy in place advising staff about the use of DoLS. This contained relevant guidance and information for staff to assist in considering the DoLS process.

- We reviewed 11 sets of records on ward 16 where staff had completed MCA/DoLS documentation satisfactorily and in accordance with recognised practice.
- The service had access to trust specialist nurses with particular expertise in dealing with vulnerable groups such as learning disabilities and those living with dementia.

## Are medical care services caring?

Outstanding



We rated caring as outstanding because:

- There was a very strong, visible patient centred approach to holistic care delivery from all clinical staff across all disciplines.
- This ethos and spirit permeated throughout the service with patients consistently describing the care they received as "excellent". Staff put patients first and were determined to meet all elements of their care needs.
- This desire to deliver exceptional care was not limited to clinicians and we observed examples of true compassion and kindness from housekeeping and estates staff.
- Staff considered physical, emotional and social elements of wellbeing without exception. Patients felt included and integrated into care decisions and treatment plans with staff taking time to get to know what was important to each of them individually. Patients described feeling part of a family.
- We obtained evidence from a number of carers and family members who felt fully involved in care planning and they described how staff went the extra mile. Family members also described a feeling of being cared for and this had positive outcomes for everyone concerned.
- There was a good response rate in the NHS Friends and Family Test, nearly all patients at the Freeman Hospital would recommend the service and the trust performed well the CQC In-Patient Survey.
- All patients had individual care plans relevant to their particular care needs.

## Compassionate care

- The Freeman Hospital had a response rate to the NHS Friends and Family Test (FFT) in line with national averages (32.1% compared with 33.7%).

# Medical care (including older people's care)

- Between August 2014 and July 2015, the trust scored higher than the England average on the Family and Friends Test (FFT). In July 2015, 98% of patients responded that they would recommend the trust. This was broadly mirrored on the majority of the medical wards with only ward 13 not reaching at least 90% in one month.
  - The trust performed better than other trusts for four of the 12 questions on the CQC Inpatient Survey, with no responses being worse than the England average.
  - In Quarter 1 - Staff Family and Friends Test 2015/16, 95% of staff would recommend the trust to friends or family if they needed care or treatment.
  - Staff members had been nominated and won 'Personal Touch' (a trust recognition scheme for outstanding care) awards.
  - We observed nursing, medical, therapy and non-clinical staff interacting with patients in a genuine caring manner. This included addressing patients by name, actively listening, recognising each individual, and coming to the patient's level when they were in beds and chairs. There was no evidence of any discrimination.
  - Of the 37 patients and relatives we spoke to, the consensus was care received was consistently good which many described as "excellent" and "first class". Patients felt safe and commented that staff "will do anything for you". Patients and relatives told us that nurses responded to requests and 'buzzers' quickly.
  - Patients explained to us that staff maintained their privacy and dignity and always informed them of any care delivery or procedure in advance.
  - On ward 31 (renal haemodialysis), many patients had been regular attenders for a number of years. All patients commented how they had built up a real rapport with all members of staff and felt as though they were part of a family. One elderly relative commented that staff cared for him as much as they did his wife. He told us staff made him comfortable and housekeeping staff offered his wife some food and a drink when she visited for a long period.
  - On ward 18, patients described their consultant as "excellent". They confirmed he made time to talk and answer questions on a one-to-one basis checking they understood. We observed good communication between medical staff and patients. One patient commented staff always discussed care options and staff agreed treatment plans before going ahead.
  - A patient nominated a member of the domestic and housekeeping team for an outstanding care award.
  - We observed a member of estates staff halting his work when a patient called for assistance. He reassured the patient, went to the nursing station and got a member of staff to assist.
  - At the listening event, we heard from a patient who had spent considerable time at the Freeman Hospital recovering from a stroke. Staff at another hospital informed him and his wife of the possibility of an unfavourable outcome and they expected the worst. He believed that but for the care given to him from all staff, especially the therapists, he would not have been able to walk and talk again.
  - The ward 33 patient satisfaction survey in July 2015 highlighted extremely good results in the care delivery.
  - The majority of the wards we visited had set visiting times (2pm to 4pm and 6pm to 8pm), however we observed staff speaking with relatives to accommodate alternate visiting where this was necessary. Staff allowed visiting outside these hours if requested.
  - Staff enjoyed telling us of positive feedback received from patients and family members and most wards we visited displayed 'thank you' cards.
- ## Understanding and involvement of patients and those close to them
- The trust performed better than other trusts on the CQC Inpatient Survey question 'were you involved as much as you wanted to be in decisions about your care and treatment'.
  - All patients had a care plan and of those reviewed, all were appropriately individualised to the needs of the patient.
  - Patients and relatives informed us they felt involved in care options, decision making and planned treatment. One patient informed us she knew exactly where she was on her "care pathway".
  - A patient on ward 24 informed us they had a lot of tests and procedures completed. The whole team kept the family informed and when the patient was well enough, a consultant spent considerable time with them going through any questions and concerns.
  - Two family members on ward 13 commented how they felt part of the plans leading up to their relatives discharge by getting involved in MDT meetings and learning aspects of care delivery to provide support at home.

# Medical care (including older people's care)

- Three relatives on ward 29 commented how they felt staff really considered and recognised things that were important to them and the patient. One relative commented how staff ensured her husband's mobile phone was charged so he had contact with his family whom he was concerned about. One patient was concerned his wife would miss her own hospital appointment however; staff ensured she attended and escorted her back to the ward to continue with her visit. One relative stated staff acknowledged his concerns about his father's safety immediately and he was reassured.
- On ward 18, staff had developed a 'family involvement in care' leaflet inviting relatives to speak to staff about care and any concerns.
- The service had entered its third year 'memorial service' for bereaved families who came together to remember loved ones with the same being attended by staff and relatives of patients previously on ward 33.
- On ward 38, staff stressed the significance of patient involvement and family support in care pre and post-transplant. Staff spent considerable time with family members to help them understand the lifelong commitment.
- Staff informed us patients could manage their own medications if deemed safe to do so. Patients on the respiratory unit were able to administer their own intravenous (IV) antibiotics after completing a competency assessment.
- Management staff told us that two medical matrons were involved in a working group with carers to help encourage and facilitate partnerships in hospital care. Staff developed this following a concern raised by a carer who felt they could not adequately input into the care of a relative with dementia.

## Emotional support

- Staff explained to us, when caring for a patient they took into account all aspects of their particular needs from physical deficit to emotional and social elements that may affect their holistic well-being.
- Staff empathised with patients who were frightened and concerned about their health and being in hospital.
- On Ward 16, a patient had a particularly bad experience overnight and he told us staff stayed with him to alleviate his anxieties. He said the nurses cared for him with a real personal warmth and understanding.

Another patient told us staff provided her with a private cubicle, as she was frightened of strangers. She added, as she had no family, the nurses allowed her friends to visit anytime they wanted.

- On Ward 13, a number of patients commented they felt motivated and encouraged to be independent but added that if they needed assistance, staff provided this immediately.
- We observed staff at all levels recognising patients who required emotional support. On two wards, we observed domestic and housekeeping staff take time to spend with patients who appeared upset and distressed.
- On ward 9, we observed birthday celebrations after staff arranged a cake for a patient.
- Staff informed us patients received emotional support from a variety of sources and not always led by clinical staff. Staff told us the chaplaincy service was available at all times for patients and carers.
- Patients informed us staff tried their best to make the hospital environment as normal as possible and we observed a number of patients had personal belongings with them such as photographs.
- There was a quiet room set aside on most wards for patients and relatives to use if they were distressed and needed some privacy away from the main ward area.

## Are medical care services responsive?

Good



We rated responsive as good because:

- The directorate planned and adapted services, in conjunction with stakeholder input, to meet the needs of the local and wider UK population with a number of specialist services being offered.
- Demands had seen a number of patients boarded out to non-medical wards however there was a good tracking system and care remained medical consultant led.
- Ambulatory care services had developed to implement care pathways for specific medical conditions under strict criteria thus avoiding the need for hospitalisation and inpatient treatment.

# Medical care (including older people's care)

- The service provided reasonable adjustments for vulnerable patient groups such as those living with dementia and those who have additional needs due to learning disabilities.
- The service was the biggest contributor to overall complaint numbers. We noted the service used the trust complaint policy and observed information for patients and relatives on the wards.

However

- Bed occupancy rates in the service were high and length of stay for elective and non-elective admissions was particularly higher than national averages in respiratory medicine.
- Due to the services offered at Freeman Hospital, particularly around older person's medicine and those patients on stroke pathway, staff confirmed discharge planning had become more complex due to patients having more needs that are complex and being referred from a wider geography where community referral pathways were not fully known.

## Service planning and delivery to meet the needs of local people

- Management staff attended meetings with local Clinical Commissioning Groups (CCG's) in order to feed into the local health network and identify service improvements to meet the needs of local people.
- Management staff knew of issues regarding delays in the repatriation of patients back to their local authority/hospital. Staff told us managers worked closely with local agencies highlighting concerns to commissioners. The NHS Newcastle/ Gateshead CCG Vanguard were reviewing integrated community home based care services.
- Stroke research nursing staff contributed to clinical assessments and worked on a combined rota making it possible for the trust to offer treatments that were under trial, seven days a week.
- In planning services, there were a number of specialist nurses and clinical educators across the site to support ward provision and to meet the needs of patients requiring specialist care.
- The Institute of Transplantation, one of six retrieval centres in the UK, was developed to ensure 24/7 services were available to patients requiring donors.
- An increased demand for sleep apnoea services saw the trust build new resources to accommodate this service.

## Access and flow

- Medicine (including those wards at National Centre Cancer Care) (NCCC) had approximately 38,500 combined admissions to its service between July 2014 and July 2015. Admissions were broken down into day case (averaging 77.5%) emergency admissions (averaging 11%) and elective care (12%). The majority of admissions to Freeman Hospital were in general medicine, cardiology and rheumatology. Admissions to NCCC were shared across medical oncology, haematology and clinical oncology.
- During the inspection, the service had a number of medical outliers. During December 2015, there was an average of 12 patients every day (range 4 to 21 patients) being cared for on non-medical wards ("Boarders"). Senior staff were aware that this was an issue within the trust and explained that this situation had improved over the past 12-24 months. The service had trialled a 'Perfect Week' (an NHS initiative looking at best practice in patient flow and discharge coordination) and found that this helped to reduce the number of outlying patients. Senior staff told us they had learnt from this with new practices embedded to reduce outlier numbers.
- Nursing staff we spoke with on the wards where patients were out-lying told us that they observed medical staff attending the ward every day to check on patients.
- Senior nurses received a daily e-mail advising of the number of boarders. The e-mail also detailed patient admission date, the date when the boarding occurred, the treating physician and the base ward the service would like the patient returned to. When beds became available, senior staff discussed and arranged the move of the patient accordingly.
- As of September 2015, the trust was performing better than the target of 90% of patients beginning treatment within 18 weeks. The trust met the standard since February 2015 across cardiology, dermatology, general medicine, neurology and rheumatology. Services were able to demonstrate 100% of patients referred within 18 weeks in general medicine, geriatric medicine and gastroenterology.
- The average length of stay for elective admissions in respiratory was twice as high as national average (7.1 days compared to 3.5 days), lower in general medicine and almost the same as national averages in cardiology.

# Medical care (including older people's care)

Non-elective patients stay was higher than national averages in respiratory medicine and significantly higher in general medicine (27.2 days compared to 6.4 days). Cardiology stay was lower than national average.

- Elective and non-elective stays at NCCC were higher in all categories (medical oncology, clinical oncology, clinical haematology and nephrology) than national averages.
- Ward 16 and the endoscopy suite had commenced evening and Saturday lists to address patient demand for their service and were carrying out approximately 12,000 procedures a year.
- Bed occupancy levels had consistently been below the England average during the reporting period for this inspection however in older people's medicine, all wards recorded occupancy around 95%. The services had identified lengthening stays on older person's wards and were planning to work more closely with social services to develop better patient outcomes. The Internal Medicine Activity Dashboard from October 2015 confirmed ward occupancy levels continuing to be in excess of 97% for eight of the medical wards.
- The directorate had partially developed an ambulatory care model which some 500 patients per month were benefitting from, allowing access to streamed care pathways without admission, such as the treatment of anaemia and low risk upper gastrointestinal bleeding. These pathways provided criteria to help staff identify patients who could be safely cared for in ambulatory care without hospitalisation.
- Staff on the emergency assessment suite told us they received new patients from directly from GPs, A&E or known patients from specialisms. The unit took adult patients from urology, medicine and surgery along with adult and children. This allowed a certain cohort of patients to avoid unnecessary referral to the RVI assessment suite.
- In respiratory services, there was a specialist nurse for complex respiratory medicine. The nurse had set up and maintained home IV service allowing patients to administer their own IV medication at home to avoid unnecessary hospitalisation. By empowering and enabling patients to manage their own condition, the service aimed to reduce avoidable exacerbations, deteriorations and maintain patient control in the home environment or in consultation with local care providers.
- Overall, the relative risk of readmission for elective and non-elective patients was slightly higher than the England average for the period between June 2014 and May 2015 (107 and 106 compared to 100 England average). The Northern Cancer Care Centre (NCCC) relative risk of admission rates were higher than national average for elective patients and lower for non-elective patients (123 and 82 compared to 100 England average).
- Between October 2014 and September 2015, the trust reported that 56,107 inpatients were admitted to the Freeman Hospital and 20,086 admitted to NCCC. Of these patients, an average of 85% had not been required to move ward during their admission, 11% on 1 occasion, 3% on two occasions, less than 1% on three occasions and less than 1% on four or more occasions.
- During April – September 2015 there were a number of patients moved wards after 10pm. The total numbers were similar each month and in September totalled 294 across all services. The majority came from medical services with 138 recorded against the emergency assessment suite.
- Staff told us they got many patients who were out of area and they had challenges around discharging these patients due to unfamiliar or a lack of formal discharge pathways. This often led to the need for additional layers and wider geographical involvement in the discharge process.
- We spoke to a medical social worker from older person's medicine who informed us of discharge planning issues. Internally, staff not completing MCA/DoLS documentation or a Continuing Healthcare Checklist (CHC) not being received sometimes-caused delays. Due to referrals coming from other areas, a number of local authorities did not have agreed pathways with the trust. Additionally, where family members sourced continuing care beds outside the trust this often took time.
- The trust provided data, which confirmed 36% of delayed transfers of care were due to the patient waiting for further non-acute NHS care. A further 35% of delayed transfers were due to patient or family choice.
- Day to day discharge problems were referred to the Patient Services Co-Ordinators who liaised with the relevant services to address any stalling, delays or obstructions allowing the patient to be discharged as planned and to free the bed.



# Medical care (including older people's care)

## Meeting people's individual needs

- At the time of our inspection, on average 46% of ward staff had undergone training to help in treating people with learning disabilities (LD). This was against a trust target of 95%.
- The trust used a gold star flag on electronic records to inform staff that an individual may have additional needs because of LD. Staff provided a 'passport' to patients with LD, which was owned by the patient and detailed personal preferences, likes/dislikes, anxiety triggers and interventions. The LD nurse specialist identified when a patient was admitted and attended the ward to liaise with clinical staff, the patient and family to see what reasonable adjustments were required to support the patient whilst in hospital. Staff allowed family members to stay.
- A number of staff commented how the LD team appeared to be a step ahead and knew everything about the patient before they arrived on the ward.
- On ward 38, staff invited patients with LD and their carers, to the unit in advance to help reassure and orientate before admission.
- Staff informed us that where patients attended with visual or auditory deficits they discussed what specific assistance the patient required. We heard how staff had successfully resolved some transient visual and auditory problems with support from specialist colleagues in ophthalmology and ENT.
- We saw a number of information leaflets produced in an 'easy to read' format such as 'have your say' and 'PALS'. The trust offered all patient information in a variety of languages (11 in total), in large print/braille and other formats.
- Staff explained that translation services were available by telephone, which included British Sign Language (BSL) services.
- Staff we spoke with explained that they could easily access bariatric equipment from the moving and handling team when this was required. This included access to special beds, wheelchairs and chairs.
- Staff explained that a variety of measures were in place to help patients with dementia. This included the use of red lids and cups at mealtimes to identify the extra needs these patients may have and 'forget me not' cards. This provided staff with details about patients, such as social history and favourite foods. Staff, the patient and the carers completed this together.
- The Falls and Syncope Service had introduced disposable "patch" ECG monitors for those patients with specific needs (e.g. learning difficulties, dementia) who cannot tolerate standard ECG monitoring equipment.
- We saw that pictorial menus and a pictorial 'basic needs' folder was available to help staff communicate with patients with communication difficulties.
- We observed a number of wards and areas that had been designed as 'dementia friendly' with appropriate signage to aid communication and perception, with triggers for reminiscence such as music, photographs and decorations to encourage positive interactions and to reduce environmental conflict.
- In conjunction with Age Concern, ward 9 and ward, 18 used 'dementia navigators' to help signpost and inform patients and family members about dementia services in their location.
- As part of the cognitive care pathway, staff assessed patients with known or possible dementia, cognitive impairment or delirium. The service monitored compliance with these assessment measures. Step 1 Dementia Awareness Reporting for September 2015 was 92.36%; Step 2 was 90.9% and Step 3 83.3%.
- Staff informed us they had ease of access/referral into psychiatric services for those patients requiring this care, in particular when needing MCA/DoLS guidance.
- Patients who had particular cultural or religious needs could have treatments organised accordingly where appropriate.

## Learning from complaints and concerns

- Medicine generated 36% of the total number of complaints reported by the trust in May 2015.
- The wards we visited displayed leaflets and posters outlining the complaints procedure. We also saw posters displayed on some wards advertising the trust 'helpline' service. This was a telephone number that could be called when the ward manager or matron were unavailable. A nominated senior member of staff would then return the call within one hour.
- We saw that the trust had a complaint policy and staff were aware of it.
- Feedback from complaints and lessons learnt were discussed either on an individual basis with the staff member concerned where applicable or general observations were provided at ward meetings and staff forum.

# Medical care (including older people's care)

## Are medical care services well-led?

Good



We found well-led to be good because:

- The trust and the service had a clear strategy and vision with patients at the heart.
- Governance arrangements enabled the effective identification of risks and the service monitored these against agreed action plans. There was evidence that controls were in place to mitigate such risks.
- Staff informed us of an open-door policy and a culture of openness and honesty. Senior medical staff and nursing staff were visible and accessible. Local ward managers and matrons were approachable and supportive.
- Staff felt part of the service and able to contribute to local initiatives. Evidence of public and staff engagement was apparent across the service.
- Links, partnerships and relationships with academic bodies was very good. Innovations, research and pioneering treatments were evident throughout the service with all grades of staff involved.

### Vision and strategy for this service

- The trust vision, strategic goals and core values highlighted its desire to be a leading healthcare provider where patients were put first in a service, which aimed to focus on safety, quality and pride in what they do.
- The medical directorate 'vision statement' was clear and mirrored the trust agenda. The same was set out in the directorate strategy plan, 'to deliver services which were characterised by excellence in clinical outcomes, which was managed efficiently and effectively and in doing so ensured comprehensive patient satisfaction.'
- In the NCCC and Clinical Haematology service, they aimed to continue to deliver excellent haematology, oncology and bone marrow transplant services across the North of England.
- The service had a clear and planned strategy in place to help it to achieve its vision statement. This included reference to the importance of quality clinical governance, encouraging an open culture, and listening to patients, carers and staff.
- Staff told us they felt proud to work for the organisation.

- In the National Staff Survey 2014, 84% agreed or strongly agreed that care of patients was the trust's top priority, compared to 67% nationally.

### Governance, risk management and quality measurement

- As part of the directorate strategy, the medical management team conducted a SWOT (strength, weakness, opportunity, and threat) analysis to identify risks and opportunities for the service. These were then action planned to identify a directorate lead, a management plan, and to focus resources needed to address the matters. Patient safety themes were apparent in the analysis.
- In conjunction with the directorate strategy, we were provided with sight of a very detailed and comprehensive risk register which recorded concerns, rated according to risk/priority, along with control measures and action plan progress.
- There was a consistency, and alignment in what the directorate was concerned about and what appeared within the register. The senior management were open and honest about this and their plans to address perceived shortfalls in areas of concern.
- The service had governance systems and processes in place ensuring continual monitoring of performance, quality and risk. This included weekly executive activity summaries and internal monthly dashboards about financial, HR and operational performance, and monthly team meetings. The minutes we reviewed showed staff discussed relevant matters, considered risk and quality issues, including the provision of training.
- There was a clear and involved clinical and internal audit programme. This drove the vision, strategy and quality measures.
- The service used quality measurement outcomes from such activity to identify areas for improvements in future initiatives. The service provided numerous examples of how they used this evidence to evolve service provision, for example, addressing falls reduction and reducing the incidence of HCAI's.

### Leadership of service

- The service had a clear management structure defining lines of responsibility and accountability.
- The Clinical Directors had an open-door policy and invited regular contact with their unit heads and directorate consultants meeting monthly.

# Medical care (including older people's care)

- Staff considered their respective managers to be part of the team.
- A number of staff we spoke with told us their leaders were visible and approachable. Ward staff interacted with matrons and managers as peers.
- We saw that the trust had an up to date whistleblowing policy ('Speak up, we're listening') that provided guidance on how to raise concerns. The trust had also appointed a 'Freedom to Speak up Guardian' in line with the recommendations made by Sir Robert Francis in the 'Learning Not Blaming' report. The trust developed an intranet site to house information on this topic.
- There was a 'Speak in Confidence', an anonymous facility to allow staff to raise issues with senior managers in confidence.
- Staff we spoke with were aware of the whistleblowing policy and said that they would feel comfortable in raising concerns about the service to their immediate line manager. In the National Staff Survey 2014, 73% of staff agreed or strongly agreed that their manager would be supportive in such situations, compared to 71% nationally.

## Culture within the service

- Staff at all levels spoke enthusiastically about their work, describing the pride and enjoyment; they felt working for the trust. In Quarter 1 - Staff Family and Friends Test 2015/16, 73% of staff would recommend the trust to friends and family as a place to work.
- All staff we spoke with told us that their immediate line managers were professional, supportive and helpful.
- Newly qualified nursing staff told us they were welcomed and integrated into the ward. They found the senior staff and ward managers to be very knowledgeable and more than willing to share their experiences with them to enable their development. On ward 24, nursing staff at all grades took time to reflect upon practice as a means to support each other.
- Institute of Transplant specialist nurses had difficulty in securing compensatory rest time following on-call duties. After raising this with human resources and senior management, a new process was agreed and implemented.
- Senior medical colleagues and consultants supported junior medical staff.
- Staff worked with supportive and professional colleagues. Staff explained they had strong peer groups

and aimed to support each other wherever possible. The National Staff Survey 2014 mirrors this with 79% agreeing or strongly agreeing colleagues were supportive.

- Senior staff supported colleagues who had been off work for a period. Staff felt they received extra support on their phased return and during reintegration.
- Staff agreed there was a culture of openness and honesty throughout the service.
- Morale was good on the wards we visited with a number of staff commenting on the strength of teams.

## Public and staff engagement

- The medicine service quarterly e-bulletin provided staff with information on senior staff, risks, complaints and staff awards.
- Services such as the inflammatory bowel disease clinic carried out audits of patient experience. Of the 100 patients surveyed, over 70% of patients rated the service as excellent. The audit also took steps to identify areas for improvement, including increasing awareness of how to contact the team and access to MDT support.
- The stroke service sent out questionnaires to patients and carers to seek comments on the stroke service. The service also held a listening event for carers and patients in order to take their comments in person. Comments received during our inspection showed both patients and carers felt engaged and well supported by the service.
- Staff invited former and current patients to assist in the redesign of ward 29.
- The trust published a monthly 'open and honest' care report on its website containing information relevant to the service. This included details such as patient complaints, safety thermometer data, and infection control statistics.
- Staff engagement had brought about service development within the trust. For example, nurses wanted to improve support services for patients and carers leading to the instigation of focus groups to improve the experience of patients living with dementia.
- The trust also had an active Lesbian, Gay, Bisexual and Transgender service, a Black, Asian and Minority Ethnic Staff Network and was a Stonewall Diversity Champion. Patients influenced the moulding of these groups, for example, nurse preceptorship training now incorporated gender identity awareness.



# Medical care (including older people's care)

- The service invited patients to 'Take 2 minutes' to give comments on elements of care during their stay. The trust used this real-time feedback to consider areas for improvement in future service provision.
- The service was involved and worked closely with a number of local and national charities, which engaged public and staff opinion.

## **Innovation, improvement and sustainability**

- The trust aimed to build on care partnerships and research opportunities to develop innovations and pioneering services to improve patient health, care and treatment.
- The medical directorate had long established relationships with Newcastle University Medical School and Northumbria University.
- The respiratory department looked at sleep apnoea in patients with diabetic eye disease and had representation as national lead with BTS for sleep apnoea.
- There was a nationally recognised stroke service as a centre for innovation and excellence. Examples of this included: being part of eight sites in the country that carry out complex hyper-acute stroke research; being one of only two sites in the country to successfully implement a trial in providing stem cell intravenous therapy (PISCES); and receiving a national award from the stroke research network for being the top recruiter in commercial clinical trials.
- In 2015, the fatigue clinic received a first place award from the NHS Innovations North at the Bright Ideas in

Health Awards. The clinic developed in conjunction with Newcastle University and was the first in England to focus on patients who complained of feeling 'tired all the time'.

- The service worked with Newcastle University's Institute of Cellular Medicine on a Knowledge Transfer Partnership (KTP). The aim of the KTP was to deliver a multi-disciplinary 'aero-digestive approach' for lung fibrosis, improving patient care and increasing revenue from patient referrals. The KTP published four academic papers following its work into Interstitial Lung Disease (ILD).
- In cardiology, the service had devised a new and improved pathway for patients requiring urgent pacing. This developed into a 24/7 consultant led service and reduced patients length of stay.
- The service had fully integrated bedside point of care testing of blood glucose and ketone monitoring with electronic insulin prescribing/adjustments. This system empowered patients to self-manage their own insulin requirements and brought about a 50% reduction in insulin prescription errors and dose omission.
- The gastroenterology department identified a gap in training provision for doctors in nutrition and hydration management. Consequently, they developed a 3-day course combining core knowledge and practical sessions to develop trainee knowledge and raise awareness of these issues.
- In haematology, the service carried out novel bone marrow transplants in 2015.
- The International Osteoporosis Foundation (IOF) in the North of England recognised the musculoskeletal service as 'gold' standard for their fracture liaison service.

# Surgery

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

## Information about the service

Services provided at the Freeman Hospital included cardiothoracic, urology, hepatobiliary (HPB), colorectal, gastro-intestinal, vascular, ENT, liver, cardiac, orthopaedic, transplant and general, surgery.

The hospital had 24 theatres. Surgical spells were the highest in England at 76,629 with 59% day cases, 20% elective, 21% emergency. Spells by speciality were 39% other, 13% upper gastrointestinal (GI), 18% plastic surgery and 30% ophthalmology.

During this inspection we visited surgical Ward 2 (urology), Ward 6 (colorectal, HPB, vascular), Ward 8 (vascular), Ward 19 (surgery), Ward 25 (cardiac), Ward 30 (cardiothoracic) and the Day Treatment Unit. We observed care being given and surgical procedures being undertaken in theatres.

We spoke with 42 patients and relatives and 36 members of staff. We observed care and treatment and looked at 19 care records.

## Summary of findings

The overall rating for surgery was outstanding because:

- Performance in surgery showed a very good track record and improvement in safety. When incidents occurred, patients and relatives received a sincere and timely apology. Full investigations were routinely undertaken and both patients and families were told about any actions taken to improve processes to prevent the same happening again.
- Staffing levels and skill mix were planned, implemented and reviewed to keep patients safe. Staff shortages were responded to quickly.
- Risks were assessed, monitored and managed daily. These included signs of deteriorating health, medical emergencies or challenging behaviours.
- We found that surgical outcomes for patients were mostly better than expected when compared with other similar services.
- There was a holistic approach to assessing, planning and delivery of care with safe use of innovative and pioneering approaches encouraged.
- Patients were supported and treated with dignity and respect. Feedback from patients, relatives and stakeholders was consistently positive.
- Services were tailored to meet the needs of individual patients and were delivered in a way to ensure flexibility, choice and continuity of care.

# Surgery

- The complaints process was well embedded, thorough and managed in a way that ensured robust investigations and outcomes were achieved. All complaints were taken seriously and dealt with quickly.
- Leaders had an inspiring shared purpose and strived to deliver and motivate staff to succeed. Comprehensive and successful leadership strategies were in place to ensure delivery and to develop the desired culture. Rigorous and constructive challenge was welcomed and seen as a way of holding services to account.

## Are surgery services safe?

Good



We rated safe as good because:

- Performance in surgery showed a good record of accomplishment and improvements in safety. When incidents occurred, patients and relatives received a sincere and timely apology. Full investigations were routinely undertaken and patients and families were told about any actions taken to improve processes to prevent the same happening again. Openness and transparency about safety was encouraged at all levels and across all disciplines. Lessons were learned and communicated widely to support improvement in all areas.
- There were clearly defined and embedded surgical systems, processes and standard operating procedures that kept patients safe and safeguarded from abuse.
- Staffing levels and skill mix were managed effectively. Staff shortages were responded to quickly and adequately.
- Plans were in place to respond to emergencies and major situations. All relevant parties understood their role and the incident plans were tested and reviewed.

### Incidents

- There were no never events reported within surgery between August 2014 and July 2015.
- During the inspection, we were informed of two serious incidents that had occurred at the Freeman Hospital (FH) in the last twelve months. We saw these had been investigated, root cause analyses undertaken and changes to practice made where appropriate.
- Staff had a good reporting culture and 30 serious incidents were reported in the division between August 2014 and July 2015. Serious incidents related to pressure ulcers (11), falls (nine), unexpected death of inpatients (three), infection control (two), surgical incidents (two) and three others.
- Staff at the hospital understood their responsibilities to raise concerns and report incidents and near misses. Staff were fully supported and attended regular meetings where feedback and learning was encouraged.

# Surgery

- Staff told us how they reported incidents through the electronic system. Learning was shared through meetings, communication books and team briefings.
- Matrons had an overview of every incident, complaint and concern and operated a good system of response and feedback to patients and staff. The trust held monthly mortality and morbidity case review meetings attended by multi-disciplinary teams and lessons learnt were identified and used to inform service development through safety huddles, ward meetings, newsletters and on a one to one basis.
- Duty of Candour requirements were stated within the trust 'Being Open/Duty of Candour Policy', the trust intranet, training and trust incident policies. Matrons and directorate managers received e-mail notification if an incident was graded moderate or above. Serious Incident report templates were revised for falls, pressure ulcers and general incidents to include a section to record that an apology and explanation was given to the patient and/or their relatives.

## Safety thermometer

- All wards participated in the NHS Safety Thermometer to display consistent data to show the ward was improving. This tool was used to measure, monitor and analyse patient 'harm free' care.
- This information was displayed in ward entrances and was easy to understand; staff had knowledge of the displayed information and ward performance.
- Information for the past year was displayed for monthly incidence of hospital acquired pressure ulcers, patient falls, urine infections associated with catheter insertion and the prevention of blood clots in those patients assessed as being at risk.
- There were 86 pressure ulcers, 16 falls and 24 catheterised urinary tract infections (CUTIs) between September 2014 and September 2015 recorded within the trust.
- Investigations were undertaken for each incident, and because of the findings, staff began working with the Falls and Syncope Service (FASS), 'time to turn' and pressure ulcers prevention (PUP) groups to reduce pressure ulcers and falls.
- The National Early Warning System (NEWS) was used to monitor and record patient observations. Observation and escalation processes were in place for all patients and used the Glasgow Coma Scale (GCS).
- All patients, on admission, received an assessment of venous thromboembolism (VTE) and bleeding risk using the clinical risk assessment criteria described in the national tool. We saw patients were re-assessed within 24 hours of admission.
- Patient safety was monitored through the completion of moving and handling assessments; falls risk assessments, completion of 'Braden' scores (for predicting pressure sore risk), NEWS and malnutrition assessments and by following infection, prevention and control measures.

## Cleanliness, infection control and hygiene

- Policies on infection prevention and control (IPC) were available. Monthly reports showed rates of clostridium difficile (C difficile) infection, and Methicillin Resistant Staphylococcus Aureus (MRSA).
- The trust reported 7 incidences of MRSA and 95 cases of c. difficile between August 2014 and September 2015, which met the trust target. The number of cases per 10,000 bed days was consistent over time and similar to the England rate.
- We saw that the standard of environmental cleanliness was good across all wards inspected. Infection control and hand hygiene signage was consistently good and we observed signage for isolation of patients in single rooms.
- Each ward had a daily, 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.
- Incidence of infection and cleaning audits were displayed clearly to visitors at the entrance to all wards and surgical areas. These showed 100% compliance with clean commodes, hand hygiene, cannula and catheter audits.
- The 'infection prevention and control clinical assurance toolkit' (CAT) was used. This showed environmental cleanliness at 99%, assurance measures at 96%, clinical assurance at 99% and staff knowledge at 86.9% against trust targets of 95%.
- We observed staff washing their hands and all patients we spoke with said this was done without exception. Hand gel was available at the point of care and staff used personal protective equipment (PPE).

# Surgery

- Monthly environmental cleanliness audits showed compliance with hand hygiene techniques at 99%, IPC practice 100% and waiting room seating/couch integrity 100%. The overall achievement was 99%.
- We observed clean equipment throughout surgical areas and staff completed cleaning records and domestic cleaning schedules, and used a tape system, which identified clean equipment.
- Wards had appropriately equipped treatment rooms, used solely for aseptic technique and dressing changes. Nurse assessment of aseptic technique competence took place annually.
- A comprehensive screening and management programme (use of disposable instruments and quarantining instruments to prevent potential contamination) in line with NHS/Public Health England guidelines for Management of Patients at Risk of CJD were in use.
- Clinical and domestic waste disposal and signage was good, staff observed disposing of clinical waste appropriately. Linen storage, segregation of soiled linen in sluice rooms and the disposal of sharps followed trust policy.
- Ward managers reported that the domestic team had been outsourced but were accessible and good practice was evident.

## Environment and equipment

- All wards and surgical areas were bright, uncluttered and in a good state of repair. Wards had a spacious design and large floor plan. Additional storeroom capacity was available on all wards. The standard of fixtures and fittings in ward kitchens was of an excellent standard; staff told us this had improved the service to patients.
- We inspected resuscitation trolleys and suction equipment on wards and found all appropriately tested, stocked and checked weekly as determined by policy. All equipment maintenance was up-to-date and safety tested. Staff had attended medical device equipment training.
- Plans to improve dementia environments were in place and included the replacement of white crockery, appropriate analogue clocks, coloured toilet seats, coloured counterpanes for beds, and dementia friendly

signage. The plans included review of day room décor and furnishings, the creation of reminiscence boxes, pictures on walls in day rooms and options for an outdoor space for patients.

- Equipment used for bariatric services was held by the moving and handling team. The team delivered the equipment and trained staff in its proper use.

## Medicines

- In all wards, the day treatment unit and theatres, medicines were stored and locked away in line with policy. Clinical treatment rooms had locked keypads for staff access.
- Medicine prescription records for individual patients were clearly written and medicines were prescribed and administered in line with trust policy and procedures, reducing the risk of errors.
- Pharmacists liaised with the ward team regularly.
- We found allergies clearly documented in the prescribing document. We checked eight records at random and found all 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. difficile.
- Staff attended a mandatory yearly update on storage and recording of controlled drugs. 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 reported errors in an open and honest way.
- The storage of medication in refrigerated units was monitored and daily temperature checks recorded. These were not all within the correct limits and were recorded outside the margins for the safe storage of medicines. No action had been taken to check whether records were accurate or whether there was a fault with equipment.
- Drug cupboards were kept locked, contained no controlled drugs and were checked weekly. Intravenous (IV) fluids were kept in a separate cupboard and expiry dates were checked weekly. Controlled drugs cupboards were checked at the end of each shift and signed.

## Records

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- We looked at 19 sets of medical records, saw they were completed appropriately, legible, and organised consistently.
- Patient medical notes were stored in lockable trolleys and patient care charts were kept at the bedside for ease of access to staff. All documentation checked was signed and dated, clearly stating named nurse and clinician.
- Daily entries of care and treatment plans were clearly documented and care plans and charts reviewed had completed patient assessments, observation charts and evaluations food and fluid balance sheets, consent forms with mental capacity assessments where necessary, diabetes and wound care charts as applicable.
- All records examined included a pain score and allergies documented in the notes. We observed patients wearing red wristbands to raise staff awareness of allergies.
- We reviewed handover sheets used by ward staff and the escalation documentation, which was effective in communication and decision making for those patients at risk of deterioration.
- We saw good examples of complete preoperative checklists and consent documentation in patient's notes.
- Surgical services had an action plan in place to achieve compliance with mandatory training targets by March 2016 and attendance at mandatory training programmes for all staff was monitored locally and also by the education department.
- At the time of inspection, the overall training rate was 82% with an annual trust compliance rate for each training programme of 95%.
- Training audits showed 90% of staff had completed the trust induction, 91% completed equality and diversity training and 88% of staff had completed moving and handling training. 68% of staff had attended adult basic life support, 87% infection, prevention and control training.
- There was an education strategy agreed by the trust Early Warning Score steering group and included the introduction of National Early Warning Score (NEWS) training sessions delivered through online access and classroom sessions.
- Staff told us they accessed mandatory training in a number of ways, such as online modules and eLearning, workbooks and key trainer delivered sessions. Staff said they were supported with professional development through education
- Staff said they had a good induction and preceptorship programme when joining the trust and attended local sessions and those provided at a trust level.
- We spoke with 36 staff and they told us they were up to date with mandatory training, the access to the training system online was good and they felt supported to attend training and mandatory update sessions.
- Clinical educators were in post and supported staff with all training, their continued professional development and professional revalidation.

## Safeguarding

- Staff understood their responsibilities and discussed safeguarding policies and procedures confidently and competently. Staff felt safeguarding processes were embedded throughout the trust. Those who lacked experience were aware of who to contact, where to seek advice and what initial actions to take.
- An information file was available at ward level with guides, advice and details of contact leads to support staff in safeguarding decision making.
- Records showed 90% of staff had completed safeguarding adults' level 1 and 50% safeguarding adults' level two against a trust target of 95%.
- Bulletins informing staff about Female Genital Mutilation (FGM) and sexual exploitation were available throughout surgical services.

## Mandatory training

### Assessing and responding to patient risk

- The trust used the National Early Warning Score (NEWS) risk assessment system. The strategy and processes for recognition and treatment of the deteriorating patient in surgery was embedded. This allowed staff on the ward to record observations, with trigger levels to generate alerts, which identified acutely unwell patients.
- We saw full completion of NEWS risk assessments and sepsis screening tools and staff were aware of escalation procedures.
- Staff knew how to highlight and escalate key risks that could affect patient safety, such as staffing and patient assessment and screening.



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- Patients at risk of falls were identified and assessed on admission and an individualised plan of care was put in place. We saw planned care delivered, for example one to one nurse patient ratio, close observation, safety rails on beds, falls stockings, stickers to identify risk on display boards and nurse call systems in reach.
- The trust Falls and Syncope Service (FASS) was the largest of its kind in Europe and undertook research and treatment for patients presenting with a range of problems such as balance disorders, dizziness, low blood pressure, balance problems or unspecified lack of co-ordination and falls. Surgical wards referred to FASS as necessary.
- Trust data (December 2015) compliance with the World Health Organisation (WHO) safer surgery checklist ('Safe surgery saved lives', 2010), showed note completion at 98%, sign in at 96%, time out at 94%, and sign out at 91%. Audit showed that 98% of the entire team attended surgical briefings.
- The WHO checklist audit showed theatre staff followed the 'Five Steps to Safer Surgery', and completed the World Health Organisation (WHO) checklist appropriately.
- We observed the checklist being used in theatres and saw completed preoperative checklists and consent documentation in patient's notes. We also observed correct surgical site marking on a patient immediately prior to their surgery. We observed the WHO surgical checklist being used for radiological interventions.
- There was 24 hours a day, seven days a week access to interventional radiology and therapeutic endoscopy.
- Critical care for patients was provided within recovery on occasions while waiting for critical care beds to become available. When this was necessary recovery staff were supported by anaesthetic and intensive care medical staff. Trust data showed seven patients had been admitted over a twelve-month period with an average stay of just under five hours.
- Joint working between anaesthetists, pre-op assessment team, senior surgical matrons, pharmacy and diabetes teams used audit data to analyse danger zones in the journey for patients from pre-op to post-operative diabetes management. A structured peri-operative management plan was used during assessments through to discharge.
- The trust had a formal nurse staffing review process in place since October 2012 subject to regular review by the trust board. The surgical division had a funded establishment agreement based upon agreed methodology and professional judgment triangulated through benchmarking, relevant national guidance and acuity information.
- Senior nursing staff had daily responsibility for safe and effective nurse staffing levels. Staffing guidelines with clear escalation procedures were in place. Site cover was provided out of hours 24 hours a day, seven days a week by a team of senior nurses (patient services co-ordinators) with access to an on-call manager.
- Numbers of staff on duty was displayed clearly at ward entrances. On all wards, actual staffing levels were less than planned staffing levels on some shifts but appropriate as surgical activity and patient acuity had been assessed.
- Matrons told us shortfalls in nursing cover were managed daily through regular senior nurse team meetings and cross-site conference calls. Monitoring of actual against planned staffing levels took place on a shift-by-shift basis. There were monthly assessments of patient acuity and dependency for in-patient areas using the Safer Nursing Care Tool, and reported through the trust's Clinical Assurance Toolkit.
- The trust had an established staff 'bank', which provided cover for short notice requests. Trust data (May 2015) showed bank usage at 5.3%, bank staff were trained and managed "in house".
- Trust data (May 2015) showed nurse vacancy rates varied between 25% (band 7) and 0% (bands 8A-8C). Sickness rates varied between 7.7% (bands 2-4) and 0% (bands 8A-8C).

## Surgical staffing

- Medical staffing skill mix across the hospital was similar to the England average at 42% consultant (national average 41%), 4% Middle career (national average 11%), 45% Registrar group (national average 37%) and 9% junior doctors (national average 12%).
- Medical staffing vacancies, sickness and turnover for surgery were consistently below the national average between April 2014 and May 2015.
- Sickness absence rates in this trust were similar to the national average and showed sickness rates for vascular surgery 0%, Hepatobiliary 0%, and ENT speciality 4% (May 2015).

## Nursing staffing

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- Arrangements were in place for the use of locum, bank and agency staff to ensure patient safety. Hospital data (May 2015) showed the use of locums varied between specialities and was 41% within cardiothoracic surgery, 41% within vascular surgery, 5% within cardiac surgery, 3% within hepatobiliary surgery, 1% within thoracic surgery, 1%, colorectal surgery and 1% within ENT surgery.
- Surgical handovers took place twice daily and were primarily consultant led. An electronic handover tool was used.

## Major incident awareness and training

- The trust had major incident and business continuity plans. Major incident plans were reviewed and updated in August 2015. Maintenance of the plan was the responsibility of the Major Incident Steering Committee and was reviewed at least every year.
- The theatre coordination team consisting of a theatre manager or coordinator and an anaesthetic coordinator controlled theatre activity. They received requests from the critical care coordinator, specialist assessment team which included a consultant orthopaedic surgeon, consultant general surgeon, consultant neurosurgeon, burns & plastic surgeon, consultant paediatric surgeon and a consultant general physician.
- Protocols were in place for deferring elective activity to prioritise unscheduled emergency procedures. Non urgent surgery was delayed (if not already underway) on both hospital sites until a review was undertaken to assess nature, size and type of incident and immediate staff available to manage admissions.
- There was a lockdown policy. This policy enabled the lockdown of buildings and sites owned by the trust in response to an anticipated or presenting threat or hazard in order to protect patients, staff and assets. Staff were aware of the procedures to follow.
- Staff ensured potential risks were taken into account when planning services and consideration given at daily safety huddles regarding seasonal fluctuations in demand, the impact of adverse weather, and any disruption to staffing levels. Action plans were discussed and implemented as necessary.

## Are surgery services effective?

Good



We rated effective as good because:

- Surgical outcomes for patients were similar and some were better than the England national average.
- There was a holistic approach to assessing, planning and delivery of care and treatment. Staff were engaged in activities to monitor and improve patient outcomes. There were opportunities to participate in benchmarking, peer review, accreditation and research.
- Staff were encouraged to develop their skills and knowledge to maintain and improve the quality of care.
- There was strong team working. Electronic recording and sharing of information across the surgical services and with external partners was integrated and provided real-time information across teams and services.
- Consent practices and records were regularly monitored and reviewed to improve patient inclusion around decision making about their care and treatment.

## Evidence-based care and treatment

- Patients were treated based on national guidance from the National Institute of Health and Care Excellence (NICE), the Association of Anaesthetics, Great Britain and Ireland and the Royal College of Surgeons.
- Enhanced recovery pathways were used for patients and patients were escorted through the care pathways. Patients received continuing care, including preoperative assessments, perioperative admission and postoperative discharge and follow up.
- Enhanced recovery for major renal surgery using a new anaesthetic technique and a pathway of ward care had decreased post-op admission time for patients having their kidneys removed, especially in the donor nephrectomy group for transplantation.
- Local policies were written in line with national guidelines and updated every two years or if national guidance changed. For example, there were local guidelines for pre-operative assessments and these were in line with best practice.
- Surgery took part in all the national clinical audits that they were eligible. There was a clinical audit programme where national guidance was audited and local priorities for audit were identified.



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- New evidence-based techniques and technologies supported the delivery of high quality care. Staff actively monitored and improved patient outcomes and undertook opportunities to participate in benchmarking, peer review, accreditation and research proactively.
- There were 30 active audits and 10 reviews underway at the time of inspection. The trust participated in the bowel cancer, lung cancer, national emergency laparotomy, and hip fracture audits nationally.
- A weekly-dedicated day case gallbladder surgery list, was introduced with specific listing, assessment and follow-up of patients, which resulted between 53% and 62% of elective gallbladder surgery as day cases.
- The trust had developed an e-record to identify quality indicators for all patients within theatres and identify the performance of all consultant anaesthetists. This provided significant benefits in clinical outcomes, for example, the avoidance of perioperative hypothermia.

## Pain relief

- Patients were regularly asked about their pain levels, and this was recorded on a pain-scoring tool. All patients reported their pain management needs were met.
- There was a pain assessment scale within the NEWS chart used throughout the hospital. These showed 100% of NEWS charts were correctly recorded.
- Each ward had identified a pain link nurse.
- An audit of pain management in the recovery room recommended the provision of more information to patients regarding patient controlled analgesia (PCA) to optimise pain relief. Staff asked patients regularly if they had any pain, so they could administer analgesia promptly or request an anaesthetic review.
- Chronic Post-Surgical Pain (CPSP) was acknowledged as a significant postoperative complication. The trust audited assess to the grade of doctors highlighting pain as a significant risk factor when obtaining consent from patients. Outcomes showed that of the 114 doctors, 49 discussed pain as a complication and 65 did not.
- The trust had a specialist pain management unit who researched the benefits of using Ketamine as an effective way to reduce pain scores and increase physical movement for specific areas of pain.
- A dedicated pain team was accessible to educate on new equipment and medications. The pain team visited

patients with PCAs the day after surgery. The pain team were available Monday to Friday 8am to 5pm. Anaesthetists provided support with pain relief out of hours.

## Nutrition and hydration

- Patients were screened using the Malnutrition Universal Screening Tool (MUST). Where necessary patients at risk of malnutrition were referred to the dietician.
- MUST screening and nutritional care plan completion had increased annually to 99% and 94%. Fluid Balance and food charts both achieved 100% completion rates. 'Assisted fed as required' scored 90%, down from 100% in 2014, which was an improvement on the 2012 score of 45%.
- Staff reported that dieticians were accessible and visited wards daily and there was a dedicated upper GI dietician as part of the enhanced recovery initiative. Dieticians met with bariatric patients before and after procedures and followed them up at home after discharge.
- Dieticians developed feeding plans for patients requiring nasal gastric feeds out of hours, which allowed nurses to commence feeding regimes.
- An audit showed that hand wash was offered to 88% of patients. The lowest scoring areas were for awareness of guidance on adults with cognitive impairment at 56% for clinical management of complex feeding problems and 62% for meeting the nutritional needs.
- Nutritional information and lessons learnt was shared with clinical leaders, clinical managers and nutrition link nurses forums, nutrition steering group, and with catering managers. Mealtime audits to monitor progress took place biannually with monthly self-assessment by ward sisters.
- Records showed patients were advised as to what time they would need to fast from. Fasting times varied depending on whether the surgery was in the morning or afternoon.
- We reviewed 19 records and saw nurses completed food charts for patients who were vulnerable or required nutritional supplements and the dietetic department provided support.
- A trust wide nutrition audit showed an average of 96% of patients had received a nutritional assessment within 24 hours of admission (July and August 2015).

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- Protected patient mealtimes were complied with. Patients reported their meals to be very good, with good choice and it was clear that staff prioritised nutrition for surgical patients offering snacks and individualised choice for patients before and after surgical procedures.

## Patient outcomes

- In the 2014 national bowel cancer audit, the trust performed better than the England average for all indicators.
- The trust performed better than the England average for one out of three indicators in the 2014 lung cancer audit. This showed 98% of 345 patients were discussed at multidisciplinary team meetings in comparison to 96% nationally. Patients receiving a CT scan before bronchoscopy were 86%, which was lower than the national average of 91%.
- Mortality indicators for elective hip and knee patients were in line with the national average. The overall value score was 97.8 over a two-year period, which was as expected. The trust is one of 109 trusts who had an 'as expected' value.
- Standardised relative risk readmission rates for elective surgery showed the Freeman was similar to the England national average for readmissions at a ratio of 108. Urology had a ratio of 109, ENT surgery 123 and hepatobiliary and pancreatic surgery was 101 (100, England average).
- For non-elective surgery, the Freeman hospital performance showed a ratio of 100 for all surgery, the same as the national average. Non-elective urology surgery had a ratio of 89, ENT surgery 118 and vascular surgery was 98 (100, England average).
- Theatre utilisation averaged 94%. The anaesthetic department had introduced the '6-4-2 rule', co-ordinated at a fortnightly meeting attended by all speciality waiting list coordinators, the anaesthetic rota-maker, and anaesthetic secretary.
- The National Hip Fracture Database (2015) showed the trust was better than the national average for perioperative medical assessment (92%, England average 85%), surgery performed on the day or, or the day after surgery (77%, England average 72%), general anaesthetic and nerve block (97%, England average 54%), spinal anaesthetic and nerve block (80%, England average 26%).
- The trust had a mixed performance in the 2014 and 2015 national emergency laparotomy audits (NELA). Actions

plans showed 24 recommendation points of which five had been completed; six were in progress and one recommendation agreed but not yet actioned. Areas of good practice were the collection of NELA data, access to CT scanning, consultant involvement in theatre, and access to critical care post-operatively.

- Patient reported outcome measures (PROMs) from groin hernia surgery, results were slightly below the national average. Varicose vein surgery, and hip and knee replacement outcomes were similar to national results.
- The mean length of orthopaedic acute stay was 11.5 days in comparison to the 16 days England average. The assessments of falls were 100% compared to 96% England averages.

## Competent staff

- Staff appraisals were undertaken annually and there were also informal one to one meetings for staff should they request these.
- Staff told us the appraisal process was helpful and allowed them to discuss developmental objectives. These were agreed between staff and managers. Staff learning needs were identified during appraisal on an individual basis. Generic training needs were addressed through the trust and local induction as well as ongoing mandatory training sessions and updates.
- Junior doctors told us they attended teaching sessions and participated in clinical audits. They told us they had good ward-based teaching and were well supported by the ward team and could approach their seniors if they had concerns.
- Staff were advised of the Nursing and Midwifery Council revalidation process through the trust intranet. New nursing staff underwent an induction programme and completed learning logs with a designated supervisor.
- Nurse practitioners had a designated consultant who provided clinical supervision and guidance.
- Ward managers advised that all appraisals were up to date with some areas achieving 100% completion. During appraisal, line managers discussed achievements, performance, training needs, revalidation, objective and goals for the coming year.
- Staff advised that supervision was undertaken frequently but on an informal basis rather than a formal one to one meeting. All staff said they could approach their line manager at any time, openly about any concerns.

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- Ward managers were clear during discussion that new members of staff were mentored and supported until they gained the necessary skills, knowledge and experience to do their job when they started their employment. Experienced members of staff were gradually encouraged to take on additional role and responsibilities once it was deemed appropriate.
- The Newcastle Surgical Training Centre had been developed at the hospital to provide advanced cadaveric education through the delivery of advanced training courses from regional, national and international surgeons across specialties. This was driving a greater understanding of surgical techniques to deliver improved patient care and pioneering research into new techniques. The centre became the first in England to receive full accreditation from the Royal College of Surgeons.

## Multidisciplinary working

- Daily handovers were carried out with members of the multidisciplinary team and referrals were made to the dietician, diabetes nurse, or speech and language team when needed.
- Therapists worked closely with the nursing teams on the ward where appropriate. Ward staff told us they had good access to physiotherapists and occupational therapists.
- There was pharmacy input on the wards during weekdays and dedicated pharmacy provision.
- The wards worked with local authority services as part of discharge planning and weekend discharges requiring support were identified at pre-assessment so that appropriate equipment and support could be arranged.
- We observed staff, including those in different teams and services, involved in assessing, planning and delivering patient's care and treatment.
- There were established multi-disciplinary team meetings for care pathways and these included nurse specialists, surgeons, anaesthetists, and radiologists.
- Ward staff worked closely with the patient, their family, allied professionals and the local authority when planning discharge of complex patients to ensure the relevant care was in place and that discharge timings were appropriate.
- The urology team produced a large range of patient information leaflets for both operations and pathways

and developed GP education. The team worked with GP's, primary care managers and CCG commissioners to change and develop teaching and education, accessible to GP's and primary care staff with excellent feedback.

## Seven-day services

- The trust provided seven-day services for all emergency attendances and admissions. A comprehensive transfer plan was in place for deteriorating patients to access emergency care seven days a week.
- Seven-day rotas for consultant working had been introduced and were led by the trust's clinical teams to improve care for patients by having clinical decision makers at the start of the patient pathway.
- Consultants were available on-call out of hours and would attend when required to see patients at weekends. Daily ward rounds were arranged for all patients and new patients were seen at weekends when necessary.
- Access to diagnostic services was available seven days a week.

## Access to information

- Risk assessments, care plans and test results were completed at appropriate times during a patient's care and treatment and we saw these were available to staff enabling effective care and treatment.
- We reviewed discharge arrangements and planning started as soon as possible for patients. We saw discharge letters were completed appropriately and shared relevant information with a patient's general practitioner.
- There were appropriate and effective systems in place to ensure patient information was co-ordinated between systems and accessible to staff.
- Appropriate guidelines were available for staff to ensure they were working to best practice.
- All staff had access to policies, procedures and NICE guidelines on the trust intranet site. The staff we spoke to stated they were competent using the intranet to obtain information.
- Drug charts, blood results and x-rays were kept electronically in real-time and were available to both doctors and nurses as required. All wards had portable laptops for the ward rounds.
- Electronic notes went direct to GPs in the Newcastle and Gateshead area following the patients discharge.

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## Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- The trust had policies in place to cover Deprivation of Liberty Safeguards (DoLS) and the Mental Capacity Act (MCA). Information and guidance was provided to staff on terminology, issues surrounding capacity when taking patient consent and identifying trust leads for the escalation of issues.
- Staff we spoke with were confident in identifying issues regarding mental capacity and knew how to escalate concerns in accordance with trust guidance.
- The consultant responsible for the patient's care undertook mental capacity assessments and DoLS were referred to the trust safeguarding team.
- There was access to an independent mental capacity advocate (IMCA) for when best interest decision meetings were required.
- Consent, MCA and DoLS training was delivered as part of staff induction. The development of nurse practitioners had enabled patients to be consented in a timely manner and MCA and DoLS assessments were included in risk assessments.
- We looked at 19 records and all patients had consented in line with the trust policy and Department of Health guidelines. All records we reviewed contained appropriate consent from patients and patients described to us that staff took their consent before providing care.

## Are surgery services caring?

Outstanding



We rated caring as outstanding because:

- Patients were supported, treated with dignity and respect and we observed, without exception, patients being cared for with compassion in all surgical wards. Feedback from patients, relatives and stakeholders was positive about the way staff treated them. Patients felt supported by staff and said they were very caring. Patients were involved and encouraged to be involved in their care planning and decision making, with additional support when required.
- Staff spent time talking to patients and providing information, reassurance and emotional support. Patients were communicated with and received

information in a way they understood. We found that patients were helped to understand their care, treatment and condition by talking with nursing staff and the medical team. Surgical services received consistently positive feedback scores and comments from a comprehensive approach used by the trust to capture the patient experience.

- Staff responded compassionately when patients or relatives needed help and supported them to meet their basic personal needs as and when required. Needs were anticipated and patient privacy and confidentiality was respected at all times.
- Staff helped patients and relatives to cope emotionally with their care and treatment. They were supported to maintain and develop relationships with those close to them. Patients were enabled to manage their own health and care when they could to maintain independence.

## Compassionate care

- The NHS Friends and Family Test (FFT) in July 2015 showed 95% to 100% of patients would recommend surgical wards to friends and family. These results were displayed on all surgical wards and areas during our inspection.
- The trust also used 'How are we doing' and 'take two minutes' surveys to capture patient feedback. These showed between 98% and 100% satisfaction with staff knowledge, communication and caring.
- We observed staff treating patients with kindness and respect. Staff took time to introduce themselves to patients and explain the treatment and care provided.
- Wards visited and the day treatment unit were compliant with single sex accommodation guidelines. Patients reported that curtains were drawn to provide privacy during ward rounds and to provide personal care. Rooms were available to provide additional privacy and confidentiality for patients and relatives.
- We spoke to 42 patients and relatives and they told us that staff were kind and caring, with patients stating that they had been 'treated well' and they received 'excellent care from great staff.' We observed staff being friendly and professional at all times.
- We spoke to 36 staff and it was clear that the demonstration of a caring approach was a high priority. Staff spoke to patients as individuals and demonstrated

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knowledge of their care and treatment. We observed examples in practice of kindness and professionalism in all staff interactions with patients and colleagues, without exception.

- Patients told us staff responded promptly to the call bell system and that they asked about pain control. Pain relief was given as required.
- Staff understood and respected people's personal, cultural, social and religious needs, and considered these when delivering care and planning discharge. We observed staff take time to interact with patients and relatives in a respectful and considerate manner.
- Staff showed empathy and were supportive to people in their care. People's privacy and dignity was respected when assisting with physical or intimate care. We saw staff give emotional support to patients who needed reassurance in a calm, friendly and patient manner. One transgender patient spoke positively of her experience within the hospital, how staff had treated her with dignity and respect and met her care needs.
- Staff promoted independence and encouraged those in bed to take part in personal care, to mobilise within their limits and positively encourage those patients who were having difficulty.

## Understanding and involvement of patients and those close to them

- Patients said staff took time to explain procedures, risks and possible outcomes of surgery and after care.
- Complex information was repeated more than once by different levels of staff so that patients understood their care, treatment and condition. Patients and relatives felt involved in their care, regular ward rounds gave patients the opportunity to ask questions, and have their surgery and treatment explained to them.
- Patients and their families received information in a way they could understand and were knowledgeable about treatment, progress and their discharge plan.
- Senior nursing staff were visible on the day of inspection and staff reported the ward manager and matron were available for patients and their relatives. It was made clear to patients and visitors to the ward who was on duty as this was displayed at the ward entrance.
- Patients told us family and relatives were informed and involved in care planning and spoke of good arrangements for discharge home.

- Staff spoke with patients to ensure they knew 'what, why, how' regarding their procedure and aftercare. Nursing staff felt this enabled patients to ask additional questions and have their fears alleviated.

## Emotional support

- Patients reported that staff spent time with them and staff recognised the importance of time to care and support patients emotional needs. Care plans highlighted the assessment of patients emotional, spiritual and mental health needs.
- We were given information about support groups for patients. These included stoma care support groups, pain management groups and open access to clinical nurse specialist helplines for surgical patients.
- An extensive multi-faith chaplaincy service was available within the hospital. We observed chaplains supporting patients and relatives. Patients and relatives said this was an extremely positive experience.
- The trust had developed plans to appoint Honorary Muslim Chaplains and to develop a Faith Forum to support the work in a more formal way.
- Clinical psychology support services commissioned by the trust supported patients as necessary. For example, support was routinely provided for burns patients, amputees and those requiring stomas.
- Staff were aware of the impact that a person's care, treatment or condition may have on their wellbeing, both emotionally and socially. When they had concerns about a patient's emotional well-being, they referred to the psychology team and patients were offered professional therapy and support.

## Are surgery services responsive?

Outstanding



We rated responsive as outstanding because:

- Services were tailored to meet the needs of individual patients and were delivered in a way to ensure flexibility, choice and continuity of care. Patient's individual needs and preferences were central to the planning and delivery of services.
- The inclusion of patient views and the needs of the local community were integral to how services were planned to ensure that patients' needs were met. There were



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innovative approaches to providing integrated and patient centred pathways of care that involved other service providers, particularly for patients with multiple and complex needs.

- 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.
- The complaint processes were well embedded, thorough and managed in a way that ensured robust investigations and outcomes were achieved. All complaints were taken seriously and dealt with promptly.
- Patients and their relatives were encouraged to feedback to the surgical service following an investigation into their complaint. Staff could learn from the process and make any necessary improvements.

## **Service planning and delivery to meet the needs of local people**

- Commissioners, third party providers and stakeholders were involved in planning services. Consultation was undertaken with commissioners regarding the directorate five year plan.
- Commissioners were involved in annual reviews of the service and discussion had been held with national commissioning groups. The trust actively worked with stakeholders to provide an appropriate level of service, based on demand, complexity and commissioning requirements.
- Surgical teams personalised patient care in line with patient preferences and individual cultural needs when they planned new services. This ensured flexibility, choice and continuity of care. An example was the 'telehealth' initiative, which was supported by patients.
- The trust had developed a network of weekly peripheral clinics for cardiac and thoracic surgery patients to provide care closer to home.
- Outreach clinics have been developed in Carlisle and Middlesbrough to meet the difficult travel needs of severely disabled patients. Telephone clinics for tumour patients were available to save patients lengthy journeys.

## **Access and flow**

- A pre-assessment meeting was held with the patient before the surgery date and any issues concerning discharge planning or other patient needs were discussed at this stage.
- Patients requiring assistance from social services upon discharge were identified at pre-assessment and plans were continuously reviewed during the discharge planning process.
- At the end of November 2015, the trust was meeting (94%) against the NHS operational target of 92% of patients waiting less than 18 weeks for treatment.
- Referral to treatment targets (RTTs) were met within general surgery (96%), urology (97%), ENT (95%), ophthalmology (99%), neurosurgery (92%), plastic surgery (92%), cardiothoracic surgery (92%), cardiology (95%) and oral surgery (98%).
- Trauma and orthopaedics was the only area where this target was not met 87% (November 2015) and 92% of patients were waiting less than 23 weeks.
- The primary reasons for delayed transfer of care at the trust was patients waiting for further NHS non-acute care (36%) and patient or family choice (34%).
- The trust used an enhanced recovery programme to assist in patients recovering from surgery and included a mobilisation of patients on day zero undergoing hip replacement surgery. Staff worked closely with allied health staff to aid recovery and patients were routinely discharged within one to two days.
- A dedicated team contacted patients by telephone following discharge to gather information about any immediate concerns the patient may have and provide advice and guidance. If they identified any concerns during the call, staff invited the patient to return to the hospital for assistance.
- The average lengths of stay (June 2015) for elective patients undergoing urology (2.7 days, England average 2.1 days), trauma and orthopaedic (4.5 days, England average 3.4 days) and ENT surgery (2.3 days, England average 1.5 days), were all above the average lengths of stay within England.
- The average lengths of stay (June 2015) for non-elective patients undergoing urology (4.4 days, England average 3.1 days), ENT (3 days, England average 2.4 days) and vascular surgery (15 days, England average 12 days), were all above the average lengths of stay within England.



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- The hospital had an escalation and surge policy and procedure to deal with busy times. Capacity bed meetings were held to monitor bed availability, review planned discharges and assess bed availability throughout the trust on a daily basis.
- There were 556 cancelled operations over a two-year period out of 153,258 spells (Q2 2013 to Q2 2015/16).
- Seventeen patients were not treated within 28 days (Q2 2013 to Q2 2015/16). There were fewer cancelled operations as a proportion of elective admissions in surgical services, compared to England as a whole.

## Meeting people's individual needs

- The service was responsive to the needs of patients living with dementia and learning disabilities. Link nurses provided advice and support in caring for patients with learning disabilities and dementia.
- We saw suitable information leaflets were available in pictorial and easy read formats and described what to expect when undergoing surgery and postoperative care. These were available in languages other than English on request. Wards had access to interpreters as required, requests for interpreter services were identified at the pre-assessment meeting.
- Information leaflets were available on each ward covering various conditions and surgical procedures to enable patients and family members to find further information. Nursing staff and specialist nurses were available to ask questions about care and treatment at any time.
- A trust learning disability audit (September 2015) confirmed staff working in inpatient areas were aware of the patient record alert system which identified when patients had a learning disability and patients with a learning disability had or had been offered a hospital passport.
- Documented evidence of adherence to the Mental Capacity Act 2005 was not always clear, identifying the need to ensure the formal recording of the assessment of capacity within the patient notes (35.7%). The audit had identified occasions when no application for Deprivation of Liberty were submitted.
- We saw that the care of patients following surgery was particularly effective through the provision of on-going physiotherapy services.
- The Pancreatitis Remote Care service had been developed to assist clinicians in outlying hospitals manage patients locally with advice and avoid

transferring ill patients in to the hospital. This had saved patients from being unnecessarily transferred and ensured those patients who required specialist care were transferred appropriately. Newcastle developed an innovative database that allowed team members and doctors in outlying hospitals to track patients diagnosed with cancer through their "treatment journey"

- An orthoptic led diplopia clinic, supported by a neuro-ophthalmologist, had been developed for patients with a known neurological diagnosis and symptomatic double vision. This had removed more timely assessment and treatment of symptoms.

## Learning from complaints and concerns

- Complaints were handled in line with trust policy that provided guidance on the complaint process, including the nominated investigative lead and timescales for responses.
- The surgical directorate received nine complaints in May 2015, which was 14% of the Trust wide complaints for that month.
- Seventy-one percent of complaints related to clinical issues, 11% staff attitudes and 17% combines of delays, cancellations and communication.
- Patients or relatives making an informal complaint were able to speak to individual members of staff or the ward manager and staff were able to explain this process.
- Staff were able to describe complaint escalation procedures, the role of the Patient Advice and Liaison Service (PALS) and the mechanisms for making a formal complaint.
- If patients or their relatives needed help or assistance with making a complaint, the Independent Complaints Advocacy Services (ICAS) contact details were visible in the ward and throughout the hospital.
- We saw leaflets available throughout the hospital informing patients and relatives about this process. All wards had 'Complaints Procedure' booklets for patients and relatives which provided information and were available in a number of formats to ensure they were accessible to all, including easy-read, large font and the top five foreign languages.
- Complaints and concerns were discussed at monthly staff meetings where training needs and learning was identified as appropriate. Conflict resolution training had been identified as a means to deal with complaints at a local level and was included as part of mandatory training for some staff groups.

# Surgery

- Patients and relatives raised concerns informally through comments on Friends and Family responses, 'Tell us what you think' cards and portals throughout the trust. Concerns raised were passed to departmental management immediately for resolution.

## Are surgery services well-led?

Outstanding



We rated well-led as outstanding because:

- The leadership, governance and culture were used to drive and improve the delivery of high quality person-centred care. The strategy and supporting objectives were stretching, challenging and innovative while remaining achievable. A systematic approach was taken to working with other organisations to improve care outcomes, tackle health inequalities and obtain best value for money.
- Governance and performance management arrangements were reviewed and reflected best practice. Leaders had an inspiring shared purpose and strived to deliver and motivate staff to succeed. Comprehensive and successful leadership strategies were in place to ensure delivery and to develop the desired culture.
- There were high levels of staff satisfaction. Staff were proud of the organisation as a place to work and spoke highly of the culture. There were consistently high levels of constructive engagement with staff, including all equality groups.
- Staff spoken to were clear about the trust vision and understood their role in contributing to achieving the trust wide and directorate goals, giving examples of good practice, improving performance and quality improvement through training, continued professional development and detailed risk assessing.
- Innovative approaches were used to gather feedback from patients and the public.
- The vision and strategy had been communicated throughout the trust and staff at all levels contributed to its development. Staff were able to repeat this vision and discuss its meaning with us during individual interviews.
- The trust vision and strategy was displayed in wards and staff were able to articulate to us the trust's values and objectives across the surgery. Staff demonstrated the values of the trust during the inspection, were clear about the trust vision, and understood their role in contributing to achieving the trust wide and directorate goals.
- The trust had a commitment to a people centred approach delivering high quality care with robust assurance and safeguarding and we saw this in practice during the inspection.
- Senior managers told us the trust Strategic Plan (2014-2019) and published annual plans had taken account of increasing demand for services, the 'Financial Recovery Programme (North Tyneside)' and 'The Better Together strategy'.
- A trust transformation programme was in place to challenge existing processes and improve quality, safety and efficiency. Initial priorities included reviews of admission and discharge, demand and capacity, outpatient services and theatre utilisation.
- The surgical division had developed strategies aimed at no surgical never events, reduce harm associated with post-operative care by 50% by 2018, reduce adverse incidents associated with elective surgery in the diabetic patient by 50% by 2018 and to reduce spinal surgery infection rates to less than 1% by 2018.

## Governance, risk management and quality measurement

- Joint clinical governance and directorate meetings were held each month. We saw agendas and minutes with evidence of audit activity, learning from complaints and clinical risk management issues. The trust held monthly mortality and morbidity case review meetings that were well attended.
- We observed peer review data, and patient and public involvement was evident. A rolling agenda was discussed in these meetings that included infection control, alert notices, examples of good practice, compliance with national service frameworks, and research projects. Evidence of action taken and staff responsibilities was found in minutes.

## Vision and strategy for this service

- We met with senior managers who had a clear vision and strategy and identified actions for addressing issues within surgery.

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- There was a systematic programme of clinical and internal audit, which was used to monitor quality and systems to identify where action should be taken. Monthly audits were undertaken and audit outcomes were published quarterly. Trust committees sanctioned any outcomes requiring change, such as new equipment, innovation or improved pathways. This process also applied to clinical trials.
- The division's risk register was updated following these meetings and when needed. Risks were assigned to specific staff responsible for the monitoring of actions and the revision of the risk assessment as required.
- The risk register included risk ratings, action plans, and information on timescales in which issues were to be resolved. We saw that action plans were monitored and sub groups were tasked with implementing them. The risk register was updated with any progress or new risks.
- Reports identified risks throughout the service, actions taken to address risks and changes in performance. These monitored (amongst other indicators) MRSA and C. Difficile rates, RTTs, pressure ulcer prevalence, complaints, never events, incidents and mortality ratios.
- There was a regular performance meeting with the Deputy Chief Executive and Business and Development Director.

## Leadership of service

- Clinical directors (CDs) and directorate managers (DMs) led surgical services; matrons led, managed and supported the ward managers.
- During interview, senior managers expressed their understanding of the challenges associated with good quality care and identified actions needed.
- Senior staff were motivated, enthusiastic about their role and had clear direction with action plans in relation to improving patient care. Senior managers and clinical leads showed knowledge, capability, skills and experience to lead effectively.
- Staff said service leads and managers were available, visible within the division and approachable; leadership of the service was good, there was good staff morale and they felt supported at ward level. Clinical management meetings were held weekly and involved service leads and speciality managers.
- Monthly speciality meetings were held and discussed financial and clinical performance, patient safety and operational issues.

- Staff spoke positively about the service they provided for patients and emphasised quality and patient experience was a priority and everyone's responsibility.
- Nursing staff stated that they were well supported by their managers. We were told they could access one-to-one meetings, which were mostly informal, as well as more structured meetings and forums.
- Ward managers were clear about zero tolerance of discrimination.
- Medical staff stated that they were supported by consultants and confirmed they received feedback from governance and action planning meetings.
- Staff understood the value of raising concerns and were encouraged to do so. All staff spoken to were confident that action taken was a result of concerns raised.

## Culture within the service

- Staff morale was high on wards and in theatres. Staff were enthusiastic about their work the service they provided and about the organisation, they worked for. Staff explained that during periods of high pressure morale remained high due to leadership support and good team working.
- Staff were motivated and enthusiastic and told us they felt valued, appreciated and listened to by colleagues and senior staff. Staff described the teamwork as one of the best things about working for the trust.
- At ward and theatre levels, we saw staff worked well together and there was respect between specialities and across disciplines. We saw examples of good team working on the wards between staff of different disciplines and grades.
- All staff we spoke with felt that they received appropriate support from management to allow them to complete their jobs effectively. Staff reported an open and transparent culture on their individual wards and felt they were able to raise concerns. All staff explained that they would be happy to approach senior staff to raise concerns and that they would expect issues to be dealt with in a timely manner.
- All junior staff we spoke with spoke positively about their line managers and felt that they provided excellent support and guidance.
- Staff reflected on the strong leadership and visibility of senior members of the trust board. This motivated staff and staff felt that senior leadership reflected the vision and values that they shared with the organisation.

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- Ward managers were given dedicated management time. This allowed them to focus on management and administrative issues. Management staff told us that they had appropriate access to senior staff members, this included being able to access support and leadership courses to help them in leading their services.

## Public engagement

- The trust engaged the public in assessing the hospital environment. This helped the trust to gain an understanding of how patients and service users felt about the care provided. Recent audits (December 2015) showed 100% of patients would recommend the hospital to friends and relatives.
- The Friends and Family test showed a response rate of 35%, the same as the England average. From these responses between 93% and 100% would recommend the hospital.
- People using the service were encouraged to give their opinion on the quality of service they received. Leaflets about the friends and family test, PALS and Two Minutes of Your Time, Tell us what you think questionnaires were available on all ward and reception area. Internet feedback was gathered along with complaint trends and outcomes.
- Ward managers were visible on the ward, which provided patients opportunity to express their views and opinions.

## Staff engagement

- We saw senior managers communicated to staff through the trust e-bulletin, team briefs, the staff magazine and internal campaigns.
- 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.

- Staff told us that leaders listened to their views. They felt supported and able to voice their opinion openly and honestly. They told us that they were confident that they were listened to and that actions would be taken following concerns or ideas to improve an area of practice. Staff felt encouraged to be involved in service improvement.
- Morale was high on each ward and all staffing levels engaged well with each other. Senior managers told us that both medical and nursing staff were always eager to talk with them.
- All staff were welcome to attend an open monthly forum where they were able to voice their opinions, listen to updates and discuss any concerns.

## Innovation, improvement and sustainability

- When considering developments to services or efficiency changes, the trust undertook trials and audits prior to a full roll out of a new system or procedure. The relevant Board committees sanctioned all innovation through review, monitoring and subject to approval.
- There were many examples of innovation to improve the quality of patient care. The hospital had introduced robotic surgery as a means of providing effective procedures with the largest multi-speciality robotic programme in the country within urology, thoracic, gynaecology, ENT, hepatobiliary and colorectal surgery (458 cases in 2015).
- The trust came first in the national clinical Research League Table for the second year running and launched an Innovation Strategy in April 2015.
- The Newcastle Surgical Training Centre was the first centre in England to receive full accreditation from the Royal College of Surgeons.
- A virtual Fracture Clinic provided a streamlined pathway for patients who needed to attend the fracture clinic for a plaster/fixation device, future soft tissue appointment or conservative treatment.

# Critical care

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

## Information about the service

The Newcastle upon Tyne Hospitals NHS Foundation Trust provides critical care services in the Freeman hospital and Royal Victoria Infirmary (RVI) hospital. The Freeman hospital is home to the Cardiothoracic and Transplantation service and is predominantly an elective surgical hospital.

Critical care is a vital hospital service and is the area where the sickest patients in the hospital have care and treatment. Newcastle is home to one of the largest critical care units in the United Kingdom with a total of 89 adult's beds and approximately 7000 admissions a year from across the north of England, United Kingdom and occasionally from other parts of Europe.

Across two sites, there are four critical care units. 46 'intensive care' (ITU) beds, for complex level 3 patients, who require advanced respiratory support or at least support for two organ systems; and 43 'high dependency' (HDU) beds, for level 2 patients who require very close observation, pre-operative optimisation, extended post-operative care or single organ support and care for those 'stepping down' from level 3 care.

The focus of this report is the two designated critical care units and additional services delivered at the Freeman Hospital:

- Ward 37 is located in the institute of transplantation. It is a general adult critical care unit, with 22 beds. It provides intensive and high dependency care for patients with medical problems and after complex surgery. This can include transplantation of the liver,

pancreas, kidneys, and care for patients who need medical treatment for breathing, blood and liver disorders. The team also provides complex care for kidney patients requiring surgery and dialysis.

- Ward 21 is the regional cardiothoracic critical care unit, with 25 beds. It provides intensive and high dependency care for adults following urgent and planned major cardiac and thoracic surgery, including heart and lung transplantation. Patients are admitted from all over the UK and Northern Ireland for complex cardiothoracic care and treatment.
- In addition to the critical care units there are four beds in post anaesthetic care unit (PACU). This is located within the theatre recovery unit and provides high dependency care to post-operative patients.
- There is a nurse-led critical care outreach team providing a 24/7 service at the Freeman General Hospital. The team share their skills and expertise to ensure that acutely ill ward-based patients receive appropriate care.

We inspected all of the critical care services at the Freeman hospital. We spoke with 23 members of staff, including consultants, senior managers, nursing staff, nurse consultant, allied health professionals, and domestic staff. We spoke with two patients and nine relatives. We observed care, reviewed documentation and checked equipment in all units. We observed a nursing handover and consultant led team safety brief in the cardiothoracic unit. We attended and observed the clinical governance

# Critical care

meeting. We were able to review a range of performance data to inform the inspection and the team listened to the experiences of people who use the services of the trust and critical care.

## Summary of findings

We rated critical care as outstanding for safe, effective, caring and well led and good for responsive because:

- During our inspection, patients and staff consistently shared good experiences; it was evident that critical care had a good and safe reputation. The service demonstrated a balance between getting the basics right and innovation. There were excellent examples of sustained innovative practice.
- The teams in critical care services were very well led. The service was consultant-led and we observed good relationships with nurses and the multi-disciplinary team. A genuine culture of listening, learning and improvement was evident amongst all staff. Governance arrangements were clear. Critical care was represented at board and trust level and information was shared across perioperative and cardiothoracic services.
- Standards for infection prevention and control were good and rates of infections were better than national averages. Ward 37 was a large critical care unit with an impressive environment and facilities. Ward 21 was also spacious and modern in design.
- Patients and their families had access to an established range of support services, a bereavement service, annual memorial service, legal and family advice and psychological and spiritual support and a follow up rehabilitation service. It was clear that patients were at the centre of decisions and the positive comments available to the inspection team gave evidence of staff caring and having compassion.
- The critical care unit performed well or above national averages in governance and performance areas.
- Patient outcomes were the same as or better than the national averages. Care and treatment was planned and delivered in line with current evidence based guidance and standards.
- The team were able to identify and mitigate risks, which was communicated to all staff. Pain and nutritional assessments were documented and we observed good practice. There was innovative and on-going progress towards a harm free culture. We



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observed a consistent and thorough approach to consultant led safety briefings in both units. Patient care had been affected positively according to reports and evaluation.

However

- Although nurse staffing was in line with the Core Standards for Intensive Care (2013) Consultant to patient ratios out of hours and pharmacy cover did not meet the standard. Staff we spoke with and documents we reviewed described good systems of support to mitigate risks in these areas. There were plans for staged recruitment solutions.

## Are critical care services safe?

Outstanding



We rated safe as outstanding because:

- The service demonstrated effective systems and a transparent culture to reporting, investigating and learning from incidents. They had a good record of patient safety. There was a good understanding of Duty of Candour with staff informing patients and families of incidents with an honest account and apology. Staff we spoke with had a good understanding of how and why to raise concerns.
- Patient care was safe. We saw a low incidence of patient incidents, avoidable harm and hospital acquired infection. The critical care quality dashboard was produced monthly to share performance, activity and patient safety indicators. Staff understood how to raise concerns and protected the vulnerable adult in critical care by following good practice and safeguarding policy.
- Both units were visibly clean and equipment was maintained. Ward 37 was spacious and contemporary in design that exceeded national standards. Cardiothoracic ward 21 had a well-equipped spacious ITU/HDU main unit and a separate 6-bed HDU area. This had moved (from ward 25a) as part of reconfiguration of critical care beds two weeks prior to the inspection visit. Signage outside the unit had been updated to reflect the ward changes. We noted good provision of isolation rooms in both units.
- Mandatory training was well attended by all groups of staff and we observed a commitment to education, which prepared staff to deliver knowledgeable and safe critical care.
- Staff demonstrated a consistent and organised checklist approach to consultant led daily safety briefings across both units, there was prompt staff introductions, discussion of safety issues, quality and reporting of incidents in critical care. Handovers we observed were detailed and consistent.
- Nurse staffing met the Guidelines for Provision of Intensive Care Services (2015)

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- Compliance across the wards with documenting and calculating the National Early Warning Score (NEWS) was good. The critical care outreach team (CCOR) on both sites supported this. They covered a 24 hour, 7 days a week rota.
- Arrangements for managing medicines were good, and there was evidence of antimicrobial stewardship. Care records were consistently documented, and securely stored.

However

- During the inspection, we found pharmacist-staffing levels did not meet the guidelines for the provision of intensive care services (GPICS). This issue was not identified on the critical care or pharmacy risk register. Despite the shortfall in staff, the pharmacy team delivered a comprehensive service, contributed to all relevant audit and performed the role consistently well in critical care.
- Consultant to patient ratios for care out of hours did not meet the standard in both ward 37 and 21. Staff we spoke with and documents we reviewed described good systems of support to mitigate any nursing and medical staffing risks. There were plans for a staged medical recruitment solution in both units. The issues were included in the risk register.

## Incidents

- There have been no never events or serious incidents reported in critical care at Freeman Hospital in both ward 37 and 21 in 2014/2015.
- Staff reported 219 incidents in June to September 2015. All staff we spoke with knew how to report incidents and how to escalate any concerns. We saw evidence of feedback and learning from incidents in both units. There was a consistently good reporting culture across sites.
- Ward 37 reported 91 incidents and graded no major harm, eight moderate harm, 77 minor harm, and six no harm incidents.
- Ward 21 reported 130 incidents and graded one major harm, three moderate harm, 104 minor harm, and 22 no harm incidents.

- Reporting was good and incidents were appropriately graded with clear descriptions of the incident and actions that had been taken. There was a higher reporting rate each year, which represented an open reporting culture.
- Pressure ulcer reporting was thorough with 48 reports for all levels of patient skin damage. Staff we spoke with told us that the Duty of Candour had been followed for incidents of hospital acquired pressure ulcers. We saw evidence of improvements across all units, which had reduced the number of pressure ulcers by 60% over the past four years.
- Staff we spoke with were aware of the electronic reporting prompt mechanism to senior managers to be open to patients through Duty of Candour for any incident graded as moderate or above.
- Doctors and members of the multidisciplinary team attended monthly mortality and morbidity meetings. Consultant staff we spoke with told us that the Freeman hospital critical care units had higher standardised mortality ratio (SMR) figures than the RVI units in recent figures. We noted that this had prompted thorough investigation and changes to processes, to include a two consultant independent review of all critical care deaths using a structured approach. SMR was not higher than the national average as reported to ICNARC.
- Nursing staff attended a monthly review of incidents. Senior nurses gave feedback in a variety of ways including newsletters, meetings, emails and teaching sessions. Incidents were discussed in the safety brief we observed.
- The critical care monthly quality dashboard allowed the multidisciplinary team to view and monitor trends in performance, activity and patient safety. It included mortality, readmission rates and delayed discharges and rates of pressure ulcers and central venous infections.

## Safety thermometer

- Safety Thermometer data was displayed in ward 21 and 37. There was a variation of 82%-100% compliance total with all aspects of 'harm free' performance for 2014/15. The NHS Safety Thermometer is a national improvement tool for measuring, monitoring and analysing preventable patient harm-free care. It focuses

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on four avoidable harms: pressure ulcers, falls, catheter-associated urinary tract infections (CAUTI), and assessment and treatment for preventing venous thromboembolism (VTE).

- The introduction of the pressure ulcer prevention group, by the critical care nurse consultant, in 2011 had led to significant reduction in pressure ulcers. 161 pressure ulcers were reported in 2010/11 across all critical care units compared to 27 pressure ulcers reported in 2014/2015, which represented an 83% reduction in less than four years.
- There had been one patient fall in ward 37 (with no harm) and no falls in ward 21 since June 2015. The actions taken after the patient fall were documented and measures taken to prevent reoccurrence included 'one to one' care and supervision by a healthcare assistant.
- There had been zero incidence of CAUTI in ward 21 and 37.
- There had been no incidence of VTE in ward 21 or 37 in 2014/2015.
- We spoke with two junior nurses who did not have clear knowledge of VTE risk assessment, although they were aware of the guidance booklets kept at the patient bedside.
- Inconsistent compliance with VTE assessment across critical care had triggered additional audit and monitoring and from September 2015 to the time of inspection, the units had achieved a 95% target for risk assessment. Medical staff carried out audit on Sunday and Tuesday evenings at midnight and we saw evidence of this in the safety brief and minutes of meetings. Of the eight sets of notes, we checked five did not have a complete VTE risk assessment.
- The critical care team had identified VTE and prophylaxis treatment for patients at risk as a priority requiring further action and improvement. VTE audit was discussed in the monthly meetings attended by MDT. During the inspection, we noted VTE was a topic for presentation in audit meetings.
- The incidence of Methicillin-sensitive *Staphylococcus aureus* (MSSA) bacteraemia was recorded, with nil incidences in ward 21 and ward 37 during 2014/2015. In addition, nil cases of *Escherichia coli* (E.coli) were reported in the Freeman critical care units.
- There had been seven unit acquired *Clostridium Difficile* (C. Difficile) in 2014/2015. Staff we spoke with told us that two cases were reviewed by the regional appeals panel as unavoidable and were removed from the data for critical care. We saw root cause analysis and discussion in MDT meetings as part of a structured review process. Ward 37 had reported three incidences with good root cause analysis (RCA).
- We saw good evidence of antimicrobial stewardship and pharmacists were leading audit and daily review of prescriptions for antibiotics in critical care and across the trust. In August 2015, there had been 100% compliance with stop and review dates and 84% compliance with documented indications for antibiotics in ward 37, with a plan for improvement. The MDT discussed any issues as part of the safety brief handovers and staff we spoke with had good understanding.
- Central Venous Catheter (CVC) Blood Stream Infection (BSI) surveillance had seen a substantial decrease in total number of infections and rate of infections for all critical care units over the last 3 years. In 2014/2015 this had been maintained with a CVC Infection rate of 0.72/1000 patient CVC days, well below the published national and international averages of 1.4/1000 catheter days. Cardiothoracic ward 21 had a much higher incidence than ward 37, and RVI ward 38 and 18. For example, in September 2015 ward 37 had rates of 0.26, ward 38 had 0.38, ward 18 had 0.00, however ward 21 had 1.82/1000 patient CVC days. Monthly rates were stable in each unit, but ward 21 incidence was higher.
- Audit and changes in medical and nursing clinical practice to comply with evidence and best practice for care of CVC lines had contributed to the overall reduction in infection.
- We found all areas inspected to be clean to a very high standard in ward 21 and ward 37, and PACU. There was good access to hand washing sinks and hand gel dispensers for staff and visitors and we observed good practice with the use of personal protective equipment

## Cleanliness, infection control and hygiene

- There had been no incidence of Methicillin-resistant *Staphylococcus aureus* (MRSA) bacteraemia for the past 5 years in critical care units. An admission-screening programme was in place.

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(PPE). We noted one incidence of a cardiothoracic consultant surgeon not take opportunity for hand hygiene prior to patient contact and reported this to the senior nurse on duty who challenged this practice

- The matron scorecard consistently reported 100% of staff took opportunities for hand hygiene, and reported a consistent 100% compliance with staff demonstrating the correct hand washing technique. Ward 21 and 37 recorded 100% compliance with infection prevention and control practice in July-September 2015.
- The critical care unit performed a local satisfaction survey, which asked visitors a wide-range of questions about their experience. Within the survey, people were asked about infection control and environment in critical care. The respondent's comments did not identify any issues with the cleanliness of the environment in ward 21 or 37.
- 873 family members were recruited to the Family Reported Experiences Evaluation (FREE) survey in 2014. This was a pilot ICNARC research survey carried out in ward 37 critical care. In over 250 comments there were no concerns expressed about environmental cleanliness, or staff infection control practices
- Availability of single isolation rooms was good in ward 37 and 21. We observed staff working well as a team, caring for patients in isolation. Signage systems were good to identify isolation of patients with infection.
- Daily ward rounds and safety briefings in both units included the consultant microbiologist. This was particularly important as ward 37 admitted neutropenic haematology cancer patients who were more vulnerable to infection.
- We spoke with domestic staff in ward 37 who reported that they had enjoyed working in the unit over the past three years. We were told that the environment was practical to perform the job well, this included arrangements for deep cleaning when needed. Trust staff provided this service.
- We saw cleaning procedures and standards that were up to date and had document control and review dates. There was good account for all cleaning duties including, curtain changes, deep cleans and daily water flushing. The domestics had good understanding of infection prevention and control.

- Staff attended training for infection control as part of mandatory training. Ward 21 nursing staff achieved 87% against the 95% compliance and ward 37 had 95% at the time of inspection with an action plan to achieve the target before April 2016.

## Environment and equipment

- Ward 21 and 37 critical care units were modern and spacious in design.
- Ward 21 and 37 environmental audit scored 96 -100% from July 2015 to the time of inspection. This information was recorded in the matron's scorecard and shared with staff and visitors in newsletters, meetings and displays.
- There were good facilities for patients and visitors, including quiet rooms that could be utilised for privacy and breaking bad news. Charitable donations were used for refurbishment of visitors and overnight stay areas.
- Ward 37 had exceptional facilities, with spacious design and acoustics that assisted noise reduction for patients. It was located within the Institute of Transplantation, which is a modern building. Good privacy systems using 'blink glass' technology between bed areas was observed. Ward 37 and 21 had a good natural light. Ward 37 had the facility to move equipment and beds to enable patients to see window light as part of their recovery. Staff we spoke with told us how patients enjoyed this experience after long periods restricted to one position and view of the unit.
- The location and signage for ward 21 HDU was not clear to relatives we spoke with and we noted a member of staff had reported another informal complaint from a relative. Maps at the entrance of the hospital and online information on the trust website had not been updated.
- The six bed HDU in cardiothoracic ward 21 had a spacious and clean environment but was not to the same standard as ward 21 ITU or ward 37. Nursing staff we spoke with in HDU told us that they had moved into the facility from ward 25a, two weeks prior to the inspection visit. It had been recently refurbished, had good facilities and space for additional bed capacity in the future. HDU was connected to the ITU area but was self-contained. Patients could be admitted to HDU from ITU or directly from theatre or wards by different entrances. There was one single isolation room in ward 21 HDU.
- Staff we spoke with told us that the private garden visible from ward 37, was used to support patients'

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recovery and rehabilitation. There was good lift access to the garden from wards 37. A patient had been able to have a large family visit in the garden and arrangements made for their pet dog to visit. It was possible to take ventilated patients into the garden.

- Staff we spoke with told us that the new monitoring equipment in ward 21 had been unreliable. Five incidents of failing alarms had been reported and staff had been asked to document any issues through incident reporting. Senior managers were in negotiations with the company to prevent further incidents and find solutions.
- We checked 18 items of equipment in ward 37 and 21. We found all equipment to be well maintained.
- We noted that staff checked resuscitation equipment and trolleys and they were stocked as per policy. We observed the standardised airway rescue carts, which were well stocked and checked. We checked emergency 'chest opening' thoracotomy equipment in cardiothoracic, which were correct.
- We checked two emergency transfer bags stored at the entrance to ward 37. The team had positioned them for ease of 'pick up and run' for emergency calls.
- Blood gas monitoring equipment in both units was checked and staff we spoke with were aware of the maintenance programme responsibilities for this equipment. Perfusionist staff were responsible for quality assurance of blood gas machines and equipment in cardiothoracic critical care.
- Storage in both units was excellent. Staff had additional office and teaching space.

## Medicines

- Pharmacists provided medicines management support to all critical care areas, with daily review of prescribing.
- Four critical care pharmacists (one with a part time role) provided medicines management support and rotated to cover all four units. The team provided daily review of prescribing Monday to Friday and an on-call system at weekends. Pharmacists accompanied the consultant-led ward round and worked 08.00-17.00hrs.
- We spoke with pharmacists who reported a shortfall in dedicated staffing with little mitigation or support for limited cover. The guidelines for the provision of intensive care services (GPICS) state that there should

be at least 0.1 WTE 8a specialist clinical pharmacists for each single Level 3 bed and for every two Level 2 beds. This issue was not identified on the unit or pharmacy risk register.

- In respect of the size of critical care (87 beds) across both hospital sites, the pharmacy provision was not adequate against guidelines for either the cover available, seniority or characteristics of the team. A senior critical care pharmacist was not available for each unit and technician support was only available for top up of stock in the units.
- The pharmacists we spoke with and observed were highly skilled in critical care pharmacy and available 5 days a week with a general on call service out of hours.
- Pharmacists performed medicines reconciliation for all patients in critical care within 24 hours of admission. The patient's regular medications were suspended until their condition improved. This ensured that usual medicines were not forgotten during recovery and they could be unsuspended as the patient's condition improved.
- Medicines were prescribed using the trust wide e-Record system, which also incorporated laboratory, microbiology and radiology results.
- The pharmacy team produced a quarterly comprehensive 'critical care drug review' which informed staff of costs, supply issues, updated guidelines and The Medicines and Healthcare Products Regulatory Agency (MHRA) safety alert updates and gave highlights of where cost savings could be made. An annual 'drug safety review' was also produced in detail for the peri-operative and critical care units. An annual 'drug safety review' was also produced in detail for the perioperative and critical care units.
- There was clear display of patient allergies in care records and on identification bracelets.
- Pharmacists completed monthly audits. The results were shared with the team across both units. Audit results showed good compliance with trust policies around the use of;
  - antibiotics, an important factor in reducing incidence of C.Difficile and MRSA,
  - storage and security,
  - controlled drug management and,
  - fridge temperatures



# Critical care

- We observed six paper and electronic medicine prescription charts in ward 37 and 21 and no errors were noted.
- 114 drug incidents were reported and followed up across critical care units in 2014/15. Ward 37 reported 28 incidents, with eight of those being a prescribing error, and 14 administration errors. Two controlled drug errors were documented in ward 37. Ward 21 reported 20 errors with similar trends in prescribing, administration and two controlled drugs errors. We observed that measures were in place to improve medication safety and reduce incidents.

## Records

- Ward 37 and 21 had a paper system for recording and documenting healthcare practice and treatment. Ward 21 ITU had an electronic observation charting system. Staff in the unit were familiar with the system. Critical care staff we spoke with were aware that the development of an electronic care record was a trust priority and a pilot was about to commence outside of critical care.
- We observed 12 care records, including bed space critical care charts and six prescription charts. Most entries were clear and appropriately complete with the exception of variable legibility of written entries by nurses and medical staff and, not all VTE risk assessments were complete.
- We observed one set of patient records in ward 21 HDU. They were found to be well organised, signed and dated clearly by staff.
- Consultants, junior doctors and nursing staff completed bedside notes as part of their critical care daily review and assessment. The plan for care and treatment was clear in the notes we observed.
- Physiotherapists had separate notes and a documented daily entry in the health care record. Staff we spoke with said they could easily access and locate the patient information and treatment plans they needed. This was observed in practice.
- Information governance training was provided as part of the mandatory programme. Ward 37 had achieved 85% against the 95% compliance target for attendance; ward 21 had 88% attendance by nursing staff with a plan to achieve 95% by March 2016.

## Safeguarding

- The trust safeguarding policy was available to staff. Safeguarding awareness information was observed in critical care offices and on display. Staff we spoke with were aware of how to contact the trust safeguarding lead.
- Staff told us that they had attended safeguarding training as part of induction and mandatory training. They understood the processes in place to escalate any concerns for vulnerable adults and children.
- We spoke with nursing staff who told us of an example involving a patient's relative whereby it was necessary to follow the safeguarding policy and appropriate processes had been followed. The procedures had been clear and the nurse felt supported by the safeguarding team and had completed their training.
- At the time of inspection, 87% of all staff in ward 37 had attended level 1 safeguarding for adults and 68% at level 2 against the 95% compliance target for safeguarding adults. 87% of all staff in ward 37 had attended level 1 safeguarding for children and 76% at level 2 against a 95% compliance target.
- At the time of inspection, 90% of all staff in ward 21 had attended level 1 safeguarding for adults and 51% at level 2 against the compliance target of 95%. 90% of staff in ward 21 had attended level 1 safeguarding for children and 41% at level 2 against the 95% compliance target.
- We saw evidence of action plans to achieve targets in both ward 18 and 37, staff could access an e-learning module for training.

## Mandatory training

- The trust had a mandatory training policy and compliance targets of 95% for many of its courses. At the time of inspection, it was part year into the training plan and staff had been booked to attend forthcoming sessions. This advance planning would suggest that staff would meet the target for 2015/2016.
- Ward 37 had achieved the 95% compliance target in 7 out of 19 modules for nursing staff. The 12 modules that were under target included adult basic life support, safeguarding adults, mental capacity act, learning disabilities and anti-bribery and corruption training. An action plan was in place to achieve the 95% target before April 2016. Targets for administrative and support staff had been achieved.



# Critical care

- Ward 21 had achieved the 95% compliance target in 6 out of 19 modules for nursing staff. The 13 modules that were under target included safeguarding adults, mental capacity act, learning disabilities, anti-bribery, corruption training, moving, and handling. An action plan was in place to achieve the target before April 2016. Targets for administrative and support staff had been achieved.
- Staff we spoke with across critical care were positive about the training they received, and told us it was easily accessed via the intranet.
- In addition to mandatory training, the critical care units had dedicated educational staff to support new and junior nurses with structured programmes of education essential to competence in critical care.

## Assessing and responding to patient risk

- Patients had a range of risk assessments completed on admission to critical care. We observed good compliance with completion for nutritional assessment, moving and handling, tissue viability, VTE and falls risk. If a patient was identified as having an elevated risk, the action required to reduce it was evident in the care plan and practice.
- Consultant led safety briefings; doctors and the multidisciplinary team attended on each shift. Clinical risks were discussed for all patient admissions.
- There was established 24/7 critical care outreach team available on both hospital sites. The trust used a recognised national early warning score (NEWS) which was calculated by ward staff as part of daily observations. The NEWS can indicate when a patient's condition may be deteriorating and 'trigger' that they may require a higher level of care.
- Critical care outreach nurses taught and managed "the patient at risk of deteriorating" course. This was well attended (over 4000 frontline staff to date) and all new doctors at Foundation Year 1 attend.
- Trust-wide audit of NEWS was bi-monthly to ensure compliance and accuracy of recording observations in wards. Audit results were fair with a stable average compliance of 85% since March 2015, of ward staff recording NEWS correctly according to the patient's condition.
- The purpose of the NEWS system, supports staff in early recognition and treatment of the deteriorating or acutely unwell patient, and helps to avoid late or

inappropriate admissions to critical care. The audit performed by the trust supported that patients who had needed escalation of their care were found to have an appropriate recording of NEWS.

- Evidence supported that patients identified as needing intensive care were admitted within 4 hours of the decision to admit by medical staff in ward 21. Audit for ward 37 was partially complete for 2015 at the time of inspection. Consultant staff we spoke with did not have any concerns about meeting 100% target.
- Patients were risk assessed with cardiopulmonary exercise testing as part of pre-assessment for some elective surgery. This identifies low risk patients who are able to recover postoperatively in PACU or the ward, who otherwise would have been admitted to a critical care bed.

## Nursing staffing

- The nursing establishment in critical care at the Freeman hospital corresponded to Royal College of Nursing (RCN) and British Association of Critical Care Nurses (BACCN) national guidance and could provide 1:1 care for level 3 patients and 1:2 care for level 2 patients across ward 21 and 37.
- Nurse staffing in ward 21 and 37 was good at the time of inspection. A number of nursing staff we spoke with told us that critical care had a good reputation and was an attractive place to work. A newly qualified nurse on ward 37 told us that they had chosen to travel for a post as they had been supported during a management placement as student nurse.
- Staff in both units told us nursing vacancies had been a problem in 2015 but recruitment had been positive and posts were quickly filled. Ward 37 had over established to cover staff maternity leave and cardiothoracic critical care had appointed nine new nursing staff in October 2015. The critical care educational team had planned an induction and training programme for the group as a whole. We spoke with two nurses who had been part of the group. They gave positive feedback about the experience and level of professional support.
- Nurse leaders proactively recruited monthly, worked hard to attract nursing staff, and newly qualified nurses from across the region. Senior nurses we spoke with told us that a strategy of over recruitment to cover maternity leave in nursing establishments had transformed the staffing position and had improved actual staffing levels.

# Critical care

- During inspection, we spoke with the senior matron in ward 21. It was her last day on duty prior to her retirement and she told us how arrangements for succession planning had been good. Recruitment had already taken place and the successful candidate was in post to avoid any gap in unit leadership.
- On the day of our inspection, actual levels of staff were good against planned levels and ward 21 and 37 followed staffing guidelines for the provision of intensive care services (2015). We noted that ward 37 had been flexible with their skill mix and patient acuity planning for staff. They had increased critical care support workers to support numbers of level 2 patients in the unit, which enabled reduction in the registered nurse staffing levels for that day.
- Nurses we spoke with reported that safety and critical care nurse/patient ratios were a priority. Staff rotas observed in both units had consistent staffing levels recorded. We spoke with a band 6 nurse in the cardiothoracic ward 21 HDU area and were assured that staffing was organised across the unit.
- Ward 37 had used nil agency staff and minimal bank staff to cover short notice sickness and staff shortage. Any escalated demands for staff due to an increase in patient acuity or close observation needs were well managed. Ward 21 had used nil agency and 0-7% bank staff in 2014/15. Unit matrons collected monthly data.
- Sickness and absence rates across the critical care unit were 4.3% against a trust average of 4.3%. Ward 37 had a consistent 3.5% rate and ward 21 had 4.8% sickness absence. This had been stable since 2013.
- We observed a good approach to bedside nursing handovers, patient transfers and the safety briefs with all staff. We listened to a detailed senior nurse handover in ward 21. It was well-organised and included relevant information about individual needs of patients and risk assessments. The family circumstances of each patient were discussed.
- There were designated lead nurses to oversee operational management and strategic direction of the units, with good provision of management time at unit level for nursing staff.
- We spoke with a nursing assistant training to be a critical care assistant who had been recruited from overseas. She worked closely with a mentor and was able to extend the role to care for level 2 patients. Experiences were reported as very positive.

- Advanced Critical Care Practitioners (ACCP) were held in high regard by their nursing and consultant colleagues. The training programme had been long established to support two tier rotas and 14 ACCP's were in post. Staff we spoke with in ward 21 told us of the benefits of the role. We observed the ACCP's contribution to the consultant led ward round in ward 21. ACCP's rotated across all 4 units to ensure professional development in each specialist area.

## Medical staffing

- Ward 37 and 21 at the Freeman hospital met most of the requirements of the Core Standards for Intensive Care (2013) for medical staffing, with the exception of standard 1.1.3, for ratio of consultants to patients out of hours.
- The guidelines for the provision of intensive care services (GPICS) states that 'in general, the consultant/patient ratio must not exceed a range between 1:8 to 1:15 and the ICU resident/patient ratio should not exceed 1:8.
- The current consultant establishment achieved weekday daytime consultant to patient ratios of 1:10-12 in ward 37. In ward 21 daytime consultants to patient ratio was 2:16 level 3 and 2:9 level 2. Two Consultants were available to cover 25 patients in the cardiothoracic critical care unit. The cover arrangements for the six bed HDU area was not clear at the time of inspection; however, the availability of consultant staff met standards.
- Out of hours consultant to patient ratio cover for both units was 1:22 or 1:25.
- The consultant responsible out of hours for ward 37 had no other duties. There was two resident anaesthetic trainees who had support from a second on call senior anaesthetic trainee, who had dual responsibility for theatre and critical care.
- The consultant responsible for cardiothoracic out of hours covered anaesthetics and critical care 6pm-8am. At weekends, cover was provided 8am – 2pm with additional consultant on call for dual 8am-8am 24 hour cover.
- There was good resident cover in ward 21, including specialist trainees in anaesthetics or critical care medicine plus 2 ACCP's. Two tier systems were working well for critical care cover in and out of hours. In order to

# Critical care

provide continuity of care for patients, consultants who cover Friday daytime are also on call Saturday.

Consultants who are on call on Friday cover on call on Sunday.

- There was an established hospital at night and critical care outreach team at the Freeman hospital, which gave good support out of hours.
- Critical care had a long term, trust-wide approach to medical staffing. The executive team had a detailed plan of optimal consultant levels of staffing across all units. The plan included recruitment and increase in consultant staff over the next 5 years, with annual targets to provide 7-day week cover 08.00-20.00hrs.
- Cardiothoracic ward 21 was recruiting for anaesthetic and critical care consultant cover. Staff reported that there was significantly reduced cover at weekends and out of hours in cardiothoracic critical care. It was reported that the current dual responsibility for theatres and ITU as part of the on-call rota was dismissed as an option due to it not meeting NHS Commissioning standard D16 (Adult Critical Care Service Specification). There were currently 11 consultants covering ward 21 with the aspiration for an additional 2 consultants to support 7 day working and out of hours cover.
- Ward 37 had the same cover arrangements as critical care at the RVI site. Two consultants were available during the day, one covering level 3 and one covering level 2. 'Orange' or out of unit cover was covered by consultants and junior doctors with support of senior colleagues. This level of cover was closely monitored and featured in the risk register for ward 21 and 37.
- The consultant team ensured trainees did not compromise their training and were sufficiently supported in times of high demand. There was evidence of this in unit meeting minutes and there had been no associated patient safety incidents. The critical care units had good mitigating actions in place to provide safe medical staffing in both units at the Freeman hospital.
- Nursing staff we spoke with in cardiothoracic ward 21 HDU area explained the medical cover appeared more variable than in ward 21 ITU and ward 37 and units at RVI. We were told that not all consultants provided a routine daily ward round for their patients. We were told that there was immediate cover for emergency care and review by anaesthetic staff covering cardiothoracic ITU. At the time of inspection, we were not clear how the

lines of accountability between cardiothoracic surgeons and anaesthetic consultants worked for the HDU patients and who the nurses should contact for routine medical duties.

- There was minimal use of locum or agency critical care medical staff or anaesthetists at the Freeman site in 2014/2015. Cardiothoracic anaesthetic locum use was more variable month to month from 0.3% to 13.4%. Ward 37 had an average of 5% locum use across 2014/15.
- Handovers were consultant led and safety briefs were collaborative with good attendance and communication by the multidisciplinary team. We saw good evidence of teamwork and effective communication across the disciplines and roles in critical care.
- Consultants we spoke with told us that teamwork was excellent and that critical care in Newcastle was a very positive place to work.

## Major incident awareness and training

- The trust took part in a major test of the hospitals major incident policy. The Emergo Train System (ETS) took place in March 2015 and a Public Health England report was produced as part of the feedback.
- The critical care team achieved 35 out of a 36 possible points in the performance indicators, with excellent feedback around leadership, teamwork and communication. The team had proven to be "well organised, proactive and very efficient in managing critical care capacity for the incident."
- The critical care team had major involvement in the 2015 response to Ebola virus outbreak. Preparedness was planned in 2014/15 and doctors and nursing staff undertook intensive training in delivery of specialist PPE. The RVI site is prepared for the role of second receiving UK hospital. We saw information displayed in staff areas in ward 21 and 37 about emergency preparedness.

## Are critical care services effective?

Outstanding



We rated effective as outstanding because:

# Critical care

- Patient care was planned and delivered by staff who were knowledgeable and aware of implementing current evidence based guidance and standards.
- Patient outcomes were comparable or better than the national average. An extensive programme of clinical audit was influencing and improving patient care and treatment. Critical care was actively involved in local, national and international audit and research, with staff from all disciplines leading in a number of areas of clinical practice and patient care.
- Mortality was consistently 7-9% across all units during the past 5 years. Unit mortality was reported as a percentage of all discharges, deaths and transfers out of the unit. Ward 37 had a 9.2% (138 deaths) and ward 21 had 9.2 % (96 deaths). We were told that ward 21 and 37 had a higher than predicted standardised mortality ratio (SMR) than that of the RVI units and this had prompted a detailed review of cases. However, national comparison data from the Intensive Care National Audit and Research Centre reported that mortality was comparable with other units.
- The commitment to education and training was excellent across the multidisciplinary team, with dedicated staff in educational posts across critical care and supernumerary trainee nurses. We saw all staff working well together to deliver person centred care and treatment. We saw examples of multidisciplinary approaches to learning and education.
- Staff we spoke with understood the consent process in critical care, the Mental Capacity Act and Deprivation of Liberty Safeguards. Consultant staff had taken a professional lead to develop this area further for the critical care patient through liaison with the Law Commission.

## Evidence-based care and treatment

- The unit used a combination of national guidelines and policy to determine the treatment they provided. These included guidance from National Institute for Health and Care Excellence (NICE), Intensive Care Society and the Faculty of Intensive Care Medicine and the North of England Critical Care Network. There was access to guidelines and policy on the trust intranet system.
- Adherence to NICE CG50 for care of acutely ill patients in hospital was good at the Freeman hospital. Work included, bi-monthly and annual audit, , neurological and spinal charts, and a clear NEWS policy. We saw critical care discharge letters in practice in ward 37 and training across the trust, including the 'patient at risk course' delivered by the critical care outreach team.
- The senior physiotherapist had led an audit in 2015 to investigate compliance with The Commissioning for Quality and Innovation (CQUIN) indicators related to NICE CG83, Rehabilitation after Critical Illness. The aim of the project was to deliver the target within the current resources or analyse the deficit to provide solutions to rehabilitation for patients in critical care. The current arrangements could meet assessment and treatment for patients Monday to Friday but not at weekends. This deficit was included in the critical care risk register.
- A tracheostomy care pathway informed by the National Confidential Enquiry into Patient Outcome and Death (NCEPOD) guidelines for managing patients with a tracheostomy was in use and all patients with a tracheostomy were discharged to designated wards in the hospital and followed up by the critical care outreach team. The critical care team provided a structured training course to all staff caring for patients with tracheostomy and laryngectomy.
- The department had implemented cardio-pulmonary exercise testing pre assessment and information giving clinics. There were clinics held each week, led by consultants across each site and met national guidance from The Association of Anaesthetists of Great Britain and Ireland, 2010.
- The Department of Health required that patients recovering from cardiac surgery have access to a programme of cardiac rehabilitation. Patients admitted to ward 21 HDU or ITU had planned rehabilitation during admission and after discharge home. It included comprehensive risk assessment, structured exercise and psychological and social support.
- Consultant led follow up clinics had been in place for some time for critical care patients who had experienced a stay in critical care of longer than 4 days in ward 37. This gave the patient opportunity to gain further explanation of events, access screening for critical care complications, including psychological or pharmacological support. Patients were supported to revisit the unit, which helped make sense of confusing memories.

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- Patients at risk of VTE were risk assessed and prescribed prophylaxis in accordance with NICE QS3 Statement 5. Audit and monitoring were in place to ensure compliance targets were maintained.
- A medical and MDT clinical audit programme was embedded and in 2015 had included audit activity for antimicrobial stewardship, cuff pressure audit, post cardiac arrest care, blood culture technique, and VTE risk assessment. An annual report detailed the main findings and changes in practice or improvements for patients in over 40 audits in 2013-15.

## Pain relief

- We reviewed seven care records and charts in ward 37 and five in cardiothoracic ward 21 and noted recording of pain assessments.
- A validated tool for pain assessment in intubated patients, the critical care pain observation tool (CPOT) had been recently introduced on ward 37 and required evaluation. Staff we spoke with were aware of the tool and reported that it was simple to use. We saw laminated advice sheets for staff in files at the bed space.
- We observed a doctor discussing and assessing the need for analgesia with a patient in ward 37. Changes in analgesia were being explained and patient preferences were taken into account. It was explained that the analgesia plan would support the patient's physiotherapy and rehabilitation.
- Nursing staff we spoke with told us that the pain team was easy to access and performed daily wards rounds in critical care.
- We spoke with patients and their relatives who told us that staff managed their pain well and asked them if they were comfortable.

## Nutrition and hydration

- Patients admitted to critical care had a malnutrition universal screening tool (MUST) assessment. Patients who are malnourished, at risk of malnutrition or obese were identified using this tool. In 12 notes, we checked 100% of patients had MUST assessment.
- A dietician was dedicated to ward 21 and 37 and had expertise in critical care in order to support patients effectively. Patients were commenced on feeding

regimes as soon as possible. We observed patients receiving total parenteral nutrition (TPN) and Nasogastric (NG) feeding and we observed dietary supplements for patients at the bedside.

- We saw excellent fluid management and hourly documentation of fluid balance in ward 21 and 37 in 100% of the charts we observed.
- Patient information to help patients and relatives understand nutrition in critical care had been developed by the team was available. They included advice around nasogastric and intravenous feeding and helpful contact details.

## Patient outcomes

- Each unit could demonstrate continuous patient data contributions to the Intensive Care National Audit and Research Centre (ICNARC). Dedicated staff were in post to support ICNARC data collection and submission.
- ICNARC supports critically ill patients by providing information and feedback data on specific quality indicators as part of its case mix programme (CMP). Critical care units can benchmark their practice and services against 90% of other units. This was in line with the recommendations of the Faculty of Intensive Care Medicine Core Standards (FICM). We also saw benchmarking activity within the North of England Critical Care Network (NoECCN) for the period 1st April 2014 to the 31st March 2015.
- Mortality was consistently 7-9% across all units during the past 5 years. Unit mortality was reported as a percentage of all discharges, deaths and transfers out of the unit. Ward 37 had a 9.2% (138 deaths) and ward 21 had 9.2 % (96 deaths). National comparison data in ICNARC CMP reported that mortality was comparable with other units.
- However, consultant staff we spoke with told us that Ward 37 and 21 had higher standardised mortality ratio (SMR) figures, compared with the RVI units in 2014/15. Ward 37 had a SMP of 111% and ward 21 had 118%. SMP is recorded as a percentage with figures greater than 100% indicating excess mortality and figures less than 100% indicating greater than expected survivors. We noted that this had prompted thorough investigation and changes to processes, to include a two consultant independent review of all critical care deaths using a structured approach and review of clinical coding.
- Staff used a 'ward-watcher' system to collect patient data, consultants were responsible for clinical coding



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the reason for patient admission and nurses captured physiology data. The ward watcher system generated immediate predicted mortality figures. The consultant team used the information to review 'outliers' as part of the monthly mortality and morbidity meetings. Outliers can be patients with a high predicted risk of death who survive or those with low predicted risk of death who died in critical care.

- Discharges out of hours, between 22.00hrs and 07.00hrs have been proven to have a negative effect on patient outcome and recovery. Trust critical care discharges out of hours were 2.6%, which was consistently lower than the national average of 8.4% for 2014/15. Cardiothoracic ward 21 had 0.4% incidence significantly less than ward 37 (1.9%), 38 (4.4%) and 18 (4.4%).
- We noted that early readmission to critical care after discharge (within 48 hours) had improved overall in 2014/15 across both hospital sites. The national average was 1% and ward 37 reported 2.3% and ward 21 reported 2.4%, which was higher than the RVI site in 2014/15. Early readmissions were discussed in MDT meetings.
- Overall readmission to critical care after discharge was 7.8%, which exceeded the national average of 4.2%. Ward 37 had 9% and ward 21 reported 10% readmission rates, slightly higher than the RVI units although performance was comparable with the network average for 2014/15.
- There was no evidence to suggest that ward 21 and 37 discharged the patient early or for non-clinical need and out of hours, discharges were low in number. We also noted that against regional units the 'post unit in hospital survivorship' was better than the NoECCN average.
- There had been a significant decrease in total number of central venous catheter (CVC) associated infections over the past 3 years. For example in 2014/15 an infection rate of 0.7/1000 patient CVC days was well below the published national and international averages of 1.4/1000 CVC days. Ward 21 had the highest prevalence at 1.5/1000 patient CVC days and targeted improvement work had been introduced.
- Patients identified as needing critical care were admitted within 4 hours of the decision to admit by medical staff.
- Staff we spoke with told us that they received trust induction and we noted that 100% had attended. Appraisals had been carried out for 95-100% of staff at the time of inspection, including consultant staff.
- Critical care had developed a local induction programme that was attended by all new starters. A specific induction programme had been developed for staff from overseas.
- Experts working in the department from every discipline delivered local induction sessions in a variety of ways. The commitment from the critical care team for education and professional development of staff was excellent.
- A critical care nurse consultant post had been established in 2001. The post holder had led and been involved in a range of improvements for the benefit of patients and staff in critical care, for example;
  - A focus on quality in key areas of patient care, with particular reference to pressure ulcers and moisture lesions in critical care, developing a critical care specific 8-point assessment tool (CALCULATE).
  - An evaluation study of central venous catheter dressings had a positive reduction in infection rates.
- Critical care had an excellent preceptorship programme for newly qualified staff nurses. Staff received 10-12 weeks supernumerary whilst they achieved critical care competencies essential for safe practice. The nurse educators facilitated this across each site, and delivered a variety of educational programmes.
- Critical care nurse educators were supernumerary as recommended in GPICS 2013 and nursing staff we spoke with told us that they felt supported in achieving the NoECCN National Competency Framework for Registered Nurses in Adult Critical Care – Step 1- 3 training programme which can lead to a professional module accredited by Northumbria University.
- According to Guidelines for the Provision of Intensive Care Services (GPICS) 50% of staff should hold a post registration award in critical care nursing. At the time of reporting 64% of nursing staff on ward 37 (70 of 110 staff) and 48% (57 of 120 staff) on ward 21 had achieved this target. The cross-site unit total was 55% at the time of inspection.
- Nursing staff were able to rotate across any of the four critical care units as part of their professional development.

## Competent staff



# Critical care

- Nurses we spoke with told us clinical supervision was available and the trust had a supportive strategy in place for revalidation. We saw a programme developed by the critical care educational staff.
- Clinical research was well established. A dedicated multidisciplinary team worked across all sites and recruited successfully to high quality National Institute for Health Research (NIHR) portfolio studies, compared to other trusts and research networks and contributing to development of clinical trials at Newcastle upon Tyne Hospitals NHS Foundation Trust.
- We saw positive evaluations from the teaching sessions provided by unit staff.

## Multidisciplinary working

- We observed the multidisciplinary team working and communicating well with each other during the inspection of ward 21 and 37. This included physiotherapist, dietetics, speech and language, occupational therapists and pharmacy staff.
- A weekly multidisciplinary meeting took place in ward 37 and 21 to discuss and plan in detail the rehabilitation needs of long stay patients in the critical care unit.
- Physiotherapy staff reported good compliance with core standards for intensive care units for Monday to Friday services. Patients had rehabilitation assessments completed but we observed significantly less compliance at weekends. Minimum rehabilitation standards of 45-minute sessions were also achieved during weekdays but not at weekends when staffing operated an on-call system. These issues were documented on the unit risk register and a proposal to recruit had been developed and submitted through the executive team.
- We spoke with the senior lead physiotherapist in ward 37 who told us that there was investment in a band 4 assistant practitioner physiotherapy role to support the rehabilitation of patients.
- The physiotherapy team had good opportunity to work with ventilated patients who required weaning and rehabilitation over a long-term admission and after discharge. Ventilators on wheelbases enabled ventilated patients to be mobilised. We spoke with staff who told us patients could access the garden area in ward 37. There was also opportunity for patients to use the hydrotherapy pool for rehabilitation.

- Liaison with the North of England Critical Care Network gave opportunity to share good practice across the MDT in the region. Regular meetings and online forums through social media offered staff access to professional support and critical care expertise.
- The lead physiotherapist told us of their involvement in the consultant led follow-up clinics for critical care patients after discharge.

## Seven-day services

- The Freeman hospital was the tertiary centre for major and complex elective surgery. The emergency or 'hot' site was the RVI, with a large accident and emergency department. Admission to critical care was planned as far as possible; however, responses to admit emergency and unplanned patients could be at any time of day or night.
- There was a commitment from staff to achieve the seven-day service strategy at the trust.
- Consultant Intensivists were available 24/7 on site through an on call system to support the junior team when required. There was a robust and supportive system in place. The cardiothoracic team had a 24/7 on-call response system in place for any surgical emergencies.
- An embedded process of minimum daily consultant patient ward rounds and review was clear in wards 21 and 37.
- There was access to diagnostic services 24/7 at the Freeman hospital site.
- Critical Care Outreach achieved considerable activity across 24/7 provision. In 2014/15, they had 10,607 contact visits with patients across wards and took 1,900 emergency and direct referrals.

## Access to information

- Staff had excellent handover process in critical care. They were observed to communicate in a number of ways that supported the sharing of patient information, delivery of effective care and reduction of risk.
- Information was easy to access in care plans, risk assessment, care charting, case notes and test results were clear in records we checked.
- Staff developed good relationships with patients and their relatives to support assessment and gathering of information to inform care and treatment.
- There was evidence of electronic systems for pharmacy however, most information was documented in a paper

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system. The trust had a plan to roll out a pilot for an electronic patient record across wards initially and staff reported that this would be a positive step. Ward 21 had introduced electronic charting and this was seen to be working well.

- There was the capability to produce detailed discharge letters for complex critical care patients using the electronic system.
- Collaborative work with the NoECCN was on going to improve information given to GP's about patients critical care interventions and problems.
- The 'Newsletter' that the units produced was informative and the design was simple and colourful. A consistent approach to sharing key messages appeared to be working well.

## Consent , Mental Capacity Act and Deprivation of Liberty Safeguards

- Critical care was taking a proactive approach to the management of patient's assessment of capacity and Deprivation of Liberty Safeguards (DoLS). They had developed local guidelines with the lead for the trust and safeguarding team and in consultation with the Intensive Care Society, the trusts appointed solicitor and the Law Commission.
- The critical care guideline supported staff and gave scenarios of what action to take if patients did have capacity at admission and more detail around decision making for patients who lacked capacity in context to critical care admissions.
- Strict adherence to legislation meant that critically ill patients who lack capacity to consent to treatment, either due to the effects of sedative medicines or because of brain pathology, should have an application for DoLS. The new guideline advised an assessment of patient capacity to make decisions about receiving critical care at day 4 into admission, which determined if capacity was likely to be regained by day 7. If it was assessed as unlikely that a patient would regain capacity a DoLS application was made to the local safeguarding team.
- There was good engagement with the trust DoLS lead and daily documentation of assessment was required in critical care. It was clear that the critical care unit had a sound approach to the best interest decisions for the

patient and subsequent care and actions. MCA and DoLS had been incorporated into the critical care team safety-briefing checklist for discussion daily at each shift.

- The protocol form for review of patients was completed daily; it encouraged a 2-consultant approach and involvement of family or friends and in their absence an Independent Mental Capacity Advocate (IMCA).
- Consultation from the Law Commission to progress with the guidelines and flowchart that had been developed would assist in critical care management of DoLS.
- We viewed five care records to review consent processes in ward 21 and appropriate consent had been documented and obtained in all notes.
- We noted that the care charts at the patient bedside had a daily prompt and nursing sign off for MCA and DoLS assessment.
- During the inspection, we looked at the resources available for staff to support acute assessment of communication needs in patients with learning disability. Staff were taught to involve family and carers and consider the Mental Capacity Act and possible Deprivation of Liberty applications.
- Compliance with MCA training was 79% of nurses in ward 37, and 69% in ward 21. The senior staff we spoke with had planned to achieve the 95% target for staff by April 2016.

## Are critical care services caring?

Outstanding



We rated caring as outstanding because:

- From the data we reviewed, our observations and the conversations we had with patients, their families and staff we judged the critical care unit at Freeman hospital as having a strong, visible person centred culture. Staff were highly motivated and delivered care that was kind and promoted peoples dignity.
- We observed examples of relationships with patients and their visitors that prompted positive responses in patients and their families.
- There was evidence that patients and their relatives were involved in planning care and making decisions, during difficult and emotional times. This was anticipated and supported by the critical care team.

# Critical care

- The team had implemented ICNARC national Family Reported Experiences Evaluation (FREE) study to capture the experiences of patient's families. 873 family members of 475 patients in ward 37 were surveyed in 2014 and highlighted awareness of family feedback across all units. The survey detailed predominantly positive responses with suggestions for improvement, which had been shared with staff across all units.
- People's spiritual needs and the drive to improve a good quality of life were embedded into practice.

## Compassionate care

- Without exception our team observed staff being caring and compassionate with patients and relatives during the inspection. We observed that patients were treated with dignity and respect.
- There was no Family and Friends Test data in critical care therefore; feedback was collected in a variety of other ways. We observed letters and cards of thanks in both units. In 2015, critical care carried out a visitor satisfaction audit with 28 responses at the Freeman hospital and a 35% response rate from the 40 surveys distributed in both units. One patient commented, "The nurses were thorough, very caring and extremely professional – they were wonderful".
- Families and patients who took part in the patient satisfaction survey in 2015 had experience in any of the four critical care units for 3 days or longer. Those families that were bereaved were sent an invitation to the annual memorial service and a questionnaire. The results were more detailed and relevant to the critical care patient and environment.
- We spoke with relatives of patients who were experiencing long stays in critical care of over 8 weeks, and they told us the "staff and doctors were fantastic". They had been given full explanations and updates. Relatives told us that the use of tablet computer technology was supporting communication and encouraging independence. We were told, "They are all doing a fantastic job". We later spoke with a consultant who described this trial of using technology systems for patients with tracheostomy, who are unable to talk, to support their communication needs.
- The 'FREE' study or Family Reported Experiences Evaluation (2014) had captured the experiences of 873 family members of 475 patients in ward 37 ICU/HDU at the Freeman hospital. This was a National ICNARC study

investigating family experiences in a detailed approach. It has highlighted awareness of family feedback across all units and plans to roll out were in place. Staff had implemented a change in visiting hours for relatives who work shifts as an early response to results and further work was planned.

- We had opportunity to see data results from the FREE survey and reviewed in excess of 250 comments made by families around satisfaction with care, symptom control, communication and consideration of family members, environment and decision making. The survey detailed predominantly positive and less negative responses with suggestions for improvement, which had been shared with staff across all units.
- We observed a nurse providing mouth care to a patient who was nil by mouth. The nurse explained the reasons for this to the patient in a kind and patient manner, touching his hand whilst explaining his need for speech and language assessment prior to being able to eat and drink.
- We spoke with staff who told us patients could access the garden area in ward 37. There were good examples of families being able to spend time in the gardens with loved ones who had experienced long admissions in critical care, and we were told of a patient who was able to spend time with his pet dog.
- We spoke with physiotherapists who told us they had good opportunity and continuity to work with ventilated patients who required weaning and rehabilitation over a long-term admission and after discharge. Ventilators on wheelbases enabled ventilated patients to be mobilised. There was also opportunity for patients to use the hydrotherapy pool for rehabilitation.

## Understanding and involvement of patients and those close to them

- Critical care patients were able to use a diary process and staff we spoke with told us that this could be helpful as part of recovery and memory of critical care after discharge. We noted that the patient diary systems were used in different scenarios to support patients.
- We noted information in ward 21 and 37 to promote understanding of patients admitted with dementia. Work around 'Dementia friends', had involved identifying a key trainer, a relatives course, dementia clocks and forget me not cards for patients in ward 37.

# Critical care

- Staff we spoke with on ward 18 explained how patients with specific needs would be assessed and if possible given a single cubicle with open visiting for any family or carers. We were told that additional staff from the nurse bank had been requested to support patients.
- During observation of handovers and safety briefs we listened to staff discuss individual needs of patients. This included good examples of assessment of capacity and dementia, discussion with family around support and overnight stays where appropriate. We noted comments in the patient survey that supported this approach; relatives stated that they had “been able to sit with the patient most of the time even outside of visiting hours when appropriate”.
- Specialist Nurses-Organ Donation or SN-OD’s were closely involved with the critical care team in order to achieve best practice in introducing organ donation into an end of life discussion. These were sensitive and key skills delivered by knowledgeable and experienced staff.
- We observed the care of a critically ill patient in ward 21. The needs of the family were accounted for as part of the plan for the patient’s rehabilitation and visiting had been arranged to meet their individual needs.
- As a response to suggestions from people that ward 21 could, be a noisy place, all units had introduced patient eye masks and earplugs to promote sleep by reducing noise and distraction for the patient. The team had shared this good practice in a professional journal publication.
- Nursing staff in ward 37 had received a trust ‘personal touch award’ from a patient nomination process. This award recognised individuals in the unit who the patient had felt were caring, attentive and responsive to their individual needs.
- A patient we spoke with, who was a retired nurse told us that she was able to use the phone at the bedside to ‘speak to loved ones’ and that this was ‘a big comfort to her’. The patient ‘couldn’t praise the staff enough’.
- We saw good facilities for relatives visiting those close to them in ward 37 and 21. Staff worked hard to find accommodation for relatives in the hospital residence or close to the hospital if the visitor’s rooms were in use.

## Emotional support

- The spiritual needs of patients were a high priority in critical care and the trust had good provision of spiritual, religious and pastoral support. As part of daily assessment of patients, we noted that individual

patient’s needs were recorded. One relative told us “everyone had been lovely without exception and it had made a huge difference at a very difficult time for their family”.

- The trust ‘care after death’ policy gave excellent advice to staff and those we spoke with were aware of how to seek advice in the unit and across the trust.
- Memorial services in critical care are arranged annually. Over 400 relatives of patients who had died within the critical care units attended the service in November 2015.
- The Schwartz Round programme gave opportunity for all staff to attend once a month to discuss and reflect on the emotional and social challenges associated with working in healthcare and critical care. These rounds provide a confidential space for staff to share experiences.
- Nursing staff in ward 37 told us that patients could be referred to the psychology service for support when they are assessed as experiencing “feeling down” in low mood or depression during or after critical care admission. These issues were discussed in the weekly MDT meeting.

## Are critical care services responsive?

Good



We rated responsive as good because:

- The team worked hard to ensure it met needs of local people and considered their opinions when trying to make improvements or develop services. It was clear that the opinion of patients and relatives was valued.
- There was a low level of complaints and when people did complain action was taken to make improvements. The policy and processes for managing complaints was good and understood by all staff. Lessons were shared with staff at all levels.
- Patients received timely access to critical care treatment, with a low number of cancellations of critical care elective admissions. Ward 21 had the highest cancellation rate of 5%, however this was better than national average of 9%. Patients were not transferred out of the unit for the wrong reasons and out of hours, discharges were kept to a minimum across both units.

# Critical care

- The post anaesthetic care unit (PACU), in theatre recovery had been operational for 10 years and offered four beds for overnight recovery of higher risk patients. The area was well staffed by the recovery team and anaesthetic staff from theatre. This system was used flexibly to meet capacity demands in critical care. PACU nurses we spoke with were enthusiastic about the role and told us patient support and safety was good.
- Critical care follow up clinics and rehabilitation after critical illness was a priority development for patients. Follow up processes and clinics were well established. The physiotherapy team were establishing early rehabilitation models for critical care patients.

However

- Discharges should not occur in excess of 4 hours of the decision made by a consultant. This was frequently not achieved due to bed pressures at the Freeman site. Ward 37, at 68.5% and ward 21 at 27.4%. Across all units, approximately 3000 of all the 6400 unit discharges were delayed more than 4 hours from decision to discharge in 2014 to 2015.
- Bed occupancy in critical care was 85% overall and had steadily increased over the past 5 years. The team was planning future services and took into account the current lack of capacity. Aspirations for expansion of critical care services at the Freeman hospital were evident in unit business proposals and the risk register.

## Service planning and delivery to meet the needs of local people

- Critical care leads worked across the trust to plan service delivery. There was evidence of consistent and joint working during our inspection and when we reviewed minutes of meetings.
- There was active involvement in the NoECCN and good practice and learning was shared across the region.
- Rehabilitation after critical illness was a priority development for patients. Ward 37 physiotherapy team were exploring achievement of CQUIN targets and NICE guidance CG83 for early rehabilitation with support of the consultant team.
- We saw evidence of critical care follow up clinics that had been well established. Those patients with a stay of 4 days or more were considered for follow up and then assessed for its benefits. Arrangements were established for follow up care of patients discharged from the cardiothoracic ward 21.

- Visitor's areas were good at the hospital and in critical care. Both units had dedicated quiet rooms and visitors rooms. Facilities were good with overnight stay for patient's families from across the UK.

## Meeting people's individual needs

- The trust had interpreter services and an awareness of their local population in order to address their needs as patients and visitors to the hospital. Services also included British Sign Language.
- The critical care team were skilled in managing patients with complex needs and we saw evidence of individual care planning.
- The learning disability liaison service team were well known to staff. There was good access to resources and education to support patients with specific needs. A 'core principles' learning disability care pathway was available to staff and a specific critical care pathway. Staff were encouraged to use the patient passport system
- A range of specific information guides to support patients and relatives was available, and information files for visitors to both units.
- An external legal advice service had been introduced as a pilot project for 12-18 months to support patients and their families regarding financial and family issues in critical care. Uptake had been from around 1-2 family appointments a week.
- A national ICNARC study 'Family Related Experiences Evaluation' (FREE) was led by the nurse consultant in critical care to investigate family related experiences and satisfaction of critical care. The results led to adoption of more flexible and open visiting times and a higher awareness of the value of family feedback in critical care environments.

## Access and flow

- The overall number of admissions in critical care ward 37 had steadily increased from 1181 in 2010/11 to 1621 in 2014/15. Cardiothoracic critical care admission numbers had been stable during the same timescale for level 3 and level 2 admissions, in total 2199. Cardiothoracic ward 21 admitted 31% of critical care patients.
- Ward 37 had 22 beds (ten level 3 and twelve level 2) and had a case-mix of 45% elective surgery and 55% complex medical cases.



# Critical care

- Ward 21 had 25 beds (sixteen level 3 and 9 level 2 beds). Access to level 2 and 3 care was planned flexibly within existing bed capacity to meet demands on service.
- The post anaesthetic care unit (PACU), in theatre recovery had been operational for 10 years and offered four beds for overnight recovery of higher risk patients. The area was well staffed by the recovery team and anaesthetic staff from theatre. This system was used flexibly to meet capacity demands in critical care. PACU nurses we spoke with were enthusiastic about the role and told us patient support and safety was good. Level 3 ventilated patients were not cared for in the PACU.
- Consultants were responsible for coordinating admissions with theatre teams based on critical care capacity. They used a computer system to determine unit acuity and capacity. When there was insufficient capacity for the booked elective or urgent cases, there was an agreed priority of cancellations based on clinical need.
- A critical care consultant reviewed 100% admissions to the unit within 12 hours of admission in both units as per GPICS standards through the system of twice-daily ward rounds.
- The Intensive Care Society identified 80% as an average occupancy for critical care to accommodate the frequently changing needs of emergency and elective services. The Freeman hospital average occupancy was high at a minimum of 85% at midnight recording. The Royal College of Anaesthetics recommends that bed occupancy should be below 70%.
- Bed occupancy at midnight overall was 85%. Ward 37 had 83% in 2014/15 and cardiothoracic ward 21 had lower occupancy than all other units at 79%.
- Discharges should not occur in excess of 4 hours of the decision made by a consultant. This was frequently not achieved due to bed pressures at the Freeman site. Ward 37, at 68.5% and ward 21 at 27.4%. Approximately 3000 of all the 6400 unit discharges were delayed more than 4 hours from decision to discharge in 2014 to 2015.
- Cancellations for cardiothoracic ward 21 remained higher than that in ward 18, 37 and 38, at 115 in 2014/15. This represented a 5.6% against national average of 9%. There had been 12 cancellations due to lack of critical care bed availability on ward 37 in the same period, 1% against the 9% national average. The issues associated with frequent cancellations were identified in the critical care risk register.
- CCREST (a computer based intranet site) had been established in 2014 for all critical care units to record bed occupancy at level 2 and 3 and numbers of nursing staff on duty. This was updated four times a day to ensure an accurate picture of critical care capacity across the trust.
- It was reported that there were no single-sex breaches across the units and staff we spoke with told us that they managed delayed discharges well with single room accommodation.
- According to ICNARC data, patients were not transferred out of the unit for non-clinical reasons.

## Learning from complaints and concerns

- Staff followed complaints policy and process and we did not see any exceptions to this during the inspection of critical care. The governance arrangements for complaints at the trust were robust. We saw Patient Advice and Liaison Service (PALS) leaflets in waiting areas and the trust 'raising concerns' information poster was displayed.
- Six formal complaints were investigated in 2014/15 and shared across all critical care units. Two reported in ward 21 and one in ward 37. Key concerns were identified and included communication issues, staff attitudes, and patient harm.
- We saw action plans and the minutes of all meetings had set agenda items to share learning and improvement from incidents, concerns and complaints. The six formal complaints had been complex and in all instances had involved other departments.
- We noted improvements as a response to informal feedback, such as open visiting hours and measures to reduce noise in the critical care units.

## Are critical care services well-led?

Outstanding



We rated well-led as outstanding because:

- An expert and motivated team managed the governance framework in critical care at the Freeman hospital. Staff understood and provided solutions for the challenges of providing high quality care in a very busy large tertiary critical care centre.
- Improvement was achieved by involving the multidisciplinary team and by working closely together.



# Critical care

Staff felt valued and it was evident from conversations with staff that patient centred, quality care was the priority. Staff across the team were passionate about their roles and contribution.

- We found a positive, open culture with confident, knowledgeable staff at all levels. The team communicated very well with one another and consultant led safety briefs were embedded in practice. We observed a good degree of cross-site working and consistency in leadership and practice.
- It was evident that the strategy was centred on delivering a responsive service to the needs of people in the area and the range of innovation and healthcare improvement demonstrated by all levels of the team was excellent. The investment in education and training for staff had supported the development of the service and in many cases the team had led the way regionally and nationally.

## Vision and strategy for this service

- The critical care senior leads had a clear vision and strategy for the units at Freeman hospital and Royal Victoria Infirmary. There was a vision and plans for expansion of services at the Freeman site to meet the needs of future developments and provision of complex surgery across the region and UK. This strategy was clearly documented in minutes of meetings at all levels and staff we spoke with were aware of strategic plans.
- We noted a clear reporting structure and attendance by key staff in several assurance groups that feed up to the executive and board. We were able to check minutes of the team meetings at unit level and the critical care steering group, anaesthetic and perioperative steering group, and critical care executive meetings.
- There was a plan in development for an electronic healthcare record and charting system across all units. Ward 21 had this in place at the time of inspection and it was working well.
- The critical care steering group and anaesthetic executive group had representatives from all specialities. The team had a clear focus on ICNARC data and used this, GPICS and evidence based practice to drive improvement.
- Consultant staffing review was in progress, included training posts for junior doctors, and increased cover at weekends.
- Nurse leaders proactively recruited monthly, worked hard to attract nursing staff, and newly qualified nurses

from across the region. Senior nurses we spoke with told us that a strategy of over recruitment to cover maternity leave in nursing establishments had transformed the staffing position and had improved actual staffing levels.

## Governance, risk management and quality measurement

- Governance arrangements were clear. Critical care was represented at board and trust level and information was shared across the service. Ward 21 was part of the cardiothoracic division arrangements for governance in addition to the peri-operative division. We noted consistent contribution and attendance from all units.
- Guidelines and policy were consistently applied across both sites and all critical care units. Documentation was standardised where relevant.
- Critical care had submitted data to ICNARC since 2007. Dedicated data managers had been recruited and produced the critical care dashboard; this was a feature of clinical governance monthly meetings.
- Safety briefs and handovers in critical care were observed to be an excellent example of effective communication and managing patient risk in practice.
- The cardiothoracic division had weekly discussion of mortality and morbidity to review any readmissions or patients admitted for renal supports. It had been recognised that the unit had a slightly higher incidence of cerebral vascular accident (CVA) post operatively than national data. A thorough review of all cases took place. We noted that incidents and complaints were discussed and messages shared by minutes and team briefings.
- The risk register for critical care detailed 11 risks. We saw good mitigation of risk, timely review and action plans associated to the risk register. However, the inadequate pharmacy cover across all units was not included in the risk register.

## Leadership of service

- We found evidence of strong leadership in this service at junior and senior levels and across staff groups. The consultant team in particular were approachable and visible. Nursing leaders were supportive.
- Teamwork and morale appeared very positive. Staff had confidence in the leadership team at all levels.
- There was excellent representation in governance and team meetings from all staff. A caring and supportive team was observed across both units during our inspection and at every level.

# Critical care

- Senior staff had attended leadership training and managed all aspects of the unit, to include team meetings, appraisal revalidation and training and overall supervision.
- Experts working in critical care at Freeman hospital represented services at national level. The nurse consultant, home ventilation team, organ donation service, ACCP's and critical care outreach had excellent reputations and involvement in sharing best practice across the UK.

## Culture within the service

- Morale was high amongst all 23 staff we spoke with.
- There was an open and transparent culture. Staff were encouraged to share any concerns or comments they had about patient care, colleagues or the service overall. We did not hear of any complaints between staff.
- Joint working in the trust was excellent and this was evident in the critical care network across the region (NoECCN).
- Staff we spoke with without exception told us that they were proud to work in critical care and for the trust; they used positive statements when talking about colleagues at all levels.

## Public engagement

- User groups and charities were engaged to influence patient care and services for example, the organ donation committee and the transplant association.
- Critical care involved patients, their families and the public when developing services or seeking feedback about current provision.
- Visitor satisfaction audit led to improvements in facilities for visitors and overnight stay.
- Public engagement had been arranged with local people for development of a face transplantation service. 100 people attended the public meetings and responses were being used to inform service development.
- The 'ICU steps' UK support group was available locally for relatives to network with others who have been affected by critical illness. It helped many former patients and their relatives.
- Critical care staff supported community fund raising events and we saw evidence of this in the newsletters.

- There was a well-established annual memorial service in critical care. Over 400 people had attended in November 2015.
- Lay members of the public had been appointed to committees.
- Patients had been involved in sharing their experiences at nursing conference events for critical care. Staff we spoke with told us the patient experience was a priority and highly valued.

## Staff engagement

- Apart from the sharing of information from minutes of meetings, the units had developed a newsletter that was a successful way of sharing key messages and engaging with staff.
- 23 members of staff we spoke with were proud of working in critical care services across both sites. Freeman hospital critical care staff were very positive about their roles and had chosen to work in the unit over other regional units. We were told that the unit had a good national reputation and staff 'were proud to be part of the team'.
- Nursing staff in ward 21 were supported to attend training through 'LEAPS', a system developed by the clinical nurse educators similar to a loyalty card, where staff could accumulate hours when they had attended training in their own time and time off in lieu was arranged to encourage attendance at the wide range of opportunities available to critical care staff.
- Staff satisfaction surveys were carried out by the trust. They included elements of the NHS constitution around staff empowerment, satisfaction, equality and diversity and delivering better and safer services. Results for 2015 were only partially available at the time of inspection. 2014 reports were available on the intranet and in meetings, there were no main themes for development and responses were generally positive for critical care. The trust also published an open and honest care report and detailed annual review including all aspects of performance and patients care.
- The employee Partnership Forum was the primary forum through which the trust engaged with its staff. The staff satisfaction survey score was calculated as being in the top 20% of acute trusts.

## Innovation, improvement and sustainability

- Innovation award for sleep optimisation was achieved by ward 37. This was a study over 4 weeks to measure

# Critical care







environmental factors, noise, and temperature, light in patient areas along with a patient sleep survey, which led to the development of a sleep checklist. The North of England Critical Care Network (NoECCN) awarded the team for the study.

- Pressure ulcer surveillance and prevention using a new assessment tool, purchase of new mattress systems and stricter patient turning regimes had an impact on major reduction in pressure injuries. The numbers of incidents had dropped by 67% over 3 years. This was shared at regional level and a peer review journal was published.
- Newcastle critical care was one of the first large trusts in the UK to set up and successfully run an Advanced Critical Care Practitioner (ACCP) programme and introduce these new roles into the junior medical tiers. Since 2009, 14 posts across the four critical care units were successfully recruited, trained and were now

working within the four adult units. Many centres around the UK had visited Newcastle to learn about the programme and how to implement this within their critical care units.

- The critical care outreach team provided a 24/7 service. The commitment to improving NEWS chart compliance through training and audit was consistent, and the establishment of the trust wide patient at risk group and NEWS champions at ward level supported by outreach was excellent.
- Hydrotherapy rehabilitation after critical illness had been developed for patients who were ventilated. Patients, with support from the rehabilitation team, were able to swim in the hydrotherapy pool at the Freeman hospital. This enabled them to move their own limbs supported by the water when they were often too weak to move them freely against gravity. Staff we spoke with told us that this also gave psychological support to patients and helped them engage with their rehabilitation programme.

# Services for children and young people

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

## Information about the service

Services for children and young people at the Freeman Hospital include the Children's Heart Unit, a cardiology outpatient clinic and ENT. The Children's Heart Unit provides care for children up to 18 years old who need medical or surgical help for conditions involving the heart, lung and airways and accepts referrals from across the UK and Ireland. The unit is one of two in the UK to carry out heart and lung transplants, using the Berlin heart to support patients and ECMO (extra corporeal membrane oxygenation) life support. The unit is the only accredited training centre for Berlin heart in the world and has the largest programme outside the Berlin unit. The unit also provides paediatric cardiac surgery and accepts patients outside of the local region, with complex needs. Ward 23 provides inpatient and day-case care and is a 12-bedded ward, with six high dependency beds. There is also a paediatric intensive care unit (PICU) with 12 beds. The ENT unit has 20 beds and provides short-stay inpatient and day-case care.

During our inspection, we spoke with six medical staff, 10 nursing and allied healthcare professionals, and five non-clinical personnel. We also spoke with seven families and reviewed eight sets of healthcare records.

## Summary of findings

Overall, we rated services for children, young people and families at the Freeman Hospital as outstanding because:

- Managers and staff created a strong, visible, person-centred culture and were highly motivated and inspired to offer the best possible care to children and young people, including meeting their emotional needs. Staff were very passionate about their role and, in some cases, went beyond the call of duty to provide care and support to families. There was respect for the different personal, cultural, social and religious needs of the children and young people they cared for, and care and treatment was focussed on the individual person rather than the condition or service.
- Families were very positive about the service they received. They described staff as being very caring, compassionate, understanding and supportive. Children and young people were able to see a healthcare professional when they needed to and received the right care at the right time. Services were flexible, provided choice and ensured continuity of care.
- The care and treatment of children and young people achieved good outcomes and promoted a good quality of life. Staff proactively collected and monitored this data and used the information to improve the care they delivered.

# Services for children and young people

- The culture was open and transparent with a clear focus on putting children and young people at the centre of their care. Services had good strategies and plans, each with service-specific objectives and goals to meet the needs of children and young people and deliver a high quality service. These plans directly linked with the overarching trust vision and goals.
- Staff protected children and young people from avoidable harm and abuse. Managers and staff discussed incidents daily, and at monthly meetings, and took appropriate action to prevent them from happening again. Staff took a proactive approach to safeguarding and focused on early identification.
- The wards, clinics and departments we visited were clean and staff followed national guidance in relation to hand hygiene and infection prevention and control. Staff managed medicines safely and the quality of healthcare records was good.
- On a day-to-day basis, staff assessed, monitored and managed risks to children and young people and this included risks to children who had complex or long-term health needs.
- Staff were very positive about working for the trust and we saw some excellent examples of leadership. There was a clear management structure and managers were visible and involved in the day-to-day running of services. Staff could contact them whenever they needed to and received supervision from line managers and clinical leads. The trust provided opportunities for training and development and staff were well trained and highly motivated to offer the best possible care to children and young people.

## Are services for children and young people safe?

Good



We rated safe as good because:

- Staff protected children and young people from avoidable harm and abuse.
- Managers and staff discussed incidents regularly at daily patient safety briefings and took appropriate action to prevent them from happening again. When something went wrong children, young people and families received a sincere apology. Learning was based on a thorough analysis and investigation and managers encouraged all staff to participate in this learning to improve safety.
- The ward areas and general environment was very clean and child-friendly. Hand hygiene audit results were consistently high and families we spoke with reported positive feedback.
- Managers planned, implemented and reviewed staffing levels and skill mix to keep children and young people safe. Managers responded to staff shortages quickly and adequately however; managers acknowledged the national shortage of junior medical staff was a potential risk to services.
- On a day-to-day basis, staff assessed, monitored and managed risks to children and young people and this included risks to children who had complex health needs, or who were receiving end of life care.
- There were systems, processes and standard operating procedures to safeguard children and young people. Staff took a proactive approach to safeguarding and focused on early identification.

However:

- Although the majority of staff had received safeguarding children level one training, the percentage of nursing and medical staff trained to level three was low.

### Incidents

- The trust had an incident reporting policy and staff reported incidents of harm or risk of harm using a risk

# Services for children and young people

management reporting system. Medical and nursing staff told us they felt very confident reporting incidents and near misses. There was an open, 'no blame' culture and staff felt safe to raise an alert about any errors.

- There were 92 incidents reported between June 2015 and November 2015. Of these, 77 related to cardiothoracic services and 15 to ENT. The majority of incidents were categorised as insignificant or minor and we saw staff had taken action where appropriate. For example, when a patient suddenly experienced bradycardia (slow heart rate) the staff member notified the on-call consultant and activated ECPR (extra-corporeal cardiopulmonary resuscitation). Another example related to medication – the member of staff noticed the incorrect patient name was on the medication label and subsequently checked all other patient information to confirm the drug and dosage data was correct before attaching a new label. We also saw documented evidence of root cause analysis and actions plans.
- The organisation's 'Being Open' policy complied with the Duty of Candour requirements. Medical and nursing staff knew the principles and we observed this in practice. For example, a senior consultant spoke with a senior nurse about a member of staff who had mistakenly told a family to take their child to A&E. The senior nurse investigated the issue immediately and apologised to the parents for the error.
- We saw evidence that staff discussed incidents at monthly clinical governance meetings attended by medical and nursing staff plus senior managers from the service. Staff we spoke with told us they talked about current incidents, any actions, learning from previous incidents or changes to practice at daily handover briefings and team meetings. One clinician recalled a change to practice from several years ago following an incident (categorised as a never event) regarding an intravenous potassium overdose. We heard further examples from senior nurses who explained the trust also encouraged staff to report incidents by displaying promotional material such as posters in staff areas.
- Medical and nursing staff from the Children's Heart Unit discussed mortality and morbidity at monthly clinical governance meetings. Clinicians discussed recent cases, outcomes and actions, and the information was shared across the staff groups.
- We reviewed data from the Clinical Assessment Toolkit (CAT), a tool used to collect data in relation to the safety

thermometer. Between October and December 2015, ENT ward 11 had achieved 100% in all areas. Nursing staff did regular checks on all patients and we reviewed supporting documentation. For example, a young child with a small pressure ulcer on his back was checked frequently, with parental involvement.

- There were no never events recorded between August 2014 and July 2015 and no serious incidents reported relating to children's services at the Freeman. Never events are incidents determined by the Department of Health as serious, wholly preventable patient safety incidents that should not occur if the available preventative measures have been implemented correctly.

## Cleanliness, infection control and hygiene

- All areas we visited were visibly clean. There were handwashing facilities at the entrance of each clinical area and we observed staff and visitors using them appropriately upon entering and leaving the ward. Antibacterial hand gel dispensers were also available at various locations within each ward or unit and staff carried personal hand gels, attached to their uniform.
- Hand hygiene results, collated from data recorded in the Clinical Assessment Toolkit (CAT), showed children's services achieved 99% compliance for hand hygiene opportunity and technique.
- Results from the CQC Children and Young People's Inpatient and Day Case Surgery Survey 2014 showed the trust performed better than other trusts when parents and carers were asked about the cleanliness of the hospital room or ward their child was in.
- The trust waste management officer carried out waste management audits to ensure ward staff were managing the processes safely and effectively. We reviewed several reports and concluded staff were aware of their responsibilities and adhered to the trust's waste management guidance. We also observed this in practice when we visited the wards.
- There were systems in place to prevent healthcare associated infections (HCAIs) and to improve practice. A recent report on sternal surgical site infections in paediatric cardiothoracic surgery highlighted six patients who required post-operative antimicrobial therapy and/or further surgery for sternal surgical site



# Services for children and young people

infections. Root cause analysis suggested, overall, there was no single cause and suggestions for improvement included promoting good hand hygiene and monitoring the level of intra-operative door opening during surgery.

- Matrons also completed monthly checks to monitor cleanliness. This included patient bed space, treatment rooms, the dress and appearance of staff, toilets and clinical waste disposal. We reviewed evidence that showed all wards and units achieved 100% in every category.
- We saw 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.

## Environment and equipment

- The Children's Heart Unit had a warm, family-friendly atmosphere despite its clinical setting. There were separate areas for parents and families, play areas (indoor and outdoor) for children and there were plans for teenage patients to help design an area dedicated to adolescents.
- There were notice boards on the wards, visible to patients and families. They included information about staff teams, such as play specialists and clown doctors, 'thank you' cards, safety thermometer data, presented in an easy to understand format, and staffing levels (planned and actual).
- Results from the CQC Children and Young People's Inpatient and Day Case Surgery Survey 2014 showed the trust performed about the same as other trusts when parents and carers responded the question that asked if the ward where their child stayed had appropriate equipment and adaptations for them.
- We saw evidence of processes to ensure that equipment was safe and we saw documentation for checking and cleaning equipment, including moving and handling risk assessments.
- The trust's medical devices team were responsible for the maintenance of all devices and equipment, using a live database to log and monitor each item. Equipment we checked had been safety tested. 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.

## Medicines

- Medicines were securely stored and handled safely. Storage cupboards and fridges were tidy and locked. Nursing staff recorded and monitored the minimum and maximum fridge temperature appropriately and there was dedicated pharmacy support.
- Staff were aware of the trust protocols for handling medicines to ensure the risks to patients were minimised. Nursing staff explained two people check medication labels and patient wristbands before administering any drugs. Staff completed medicines management training online and managers reviewed competencies to ensure staff were certified to administer medicines safely.
- Staff were encouraged to report incidents about medication errors and we saw documented evidence to support this. There was an escalation policy and staff were aware of what to do should a situation arise.

## Records

- Medical and nursing staff managed and stored records safely. We did not see any unattended notes during our inspection.
- We reviewed eight sets of care records. Overall, we saw staff completed them accurately and included appropriate information, including risk assessments and nutritional status. However, nursing, medical and other allied health professional notes, such as physiotherapy, were not integrated which meant they were not all together in one file.
- We saw evidence that records and paediatric early warning scores (PEWS) charts were peer reviewed twice a year and the results shared across the team. We did not see any evidence of changes or improvements made as a result.

## Safeguarding

- The trust had a safeguarding children policy and a dedicated training page on the trust intranet. Staff we spoke with 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 the necessary statutory staff in post, including the named nurse and named doctor. The director of nursing was the nominated executive lead for safeguarding and attended Local Safeguarding Children Board meetings.

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- Staff we spoke with told us they had completed the mandatory safeguarding children training and to the appropriate level. However, data provided to us by the trust showed this varied across service and staff groups. For example, evidence showed 97% of nursing staff from ward 23 had completed level one safeguarding children training however only 29% had completed level three. The data was similar for nursing staff on ward 11. Compliance for level one was 90% and only 20% for level three. Paediatric intensivists from the paediatric intensive care unit had achieved 100% compliance in level one however; they were the only medical team to achieve the 95% target.
- Staff told us they could complete 'cause for concern' forms if they had any worries about a child or any members of the child's family. According to the 2014/15 Safeguarding Annual Report, the total number of cause for concern forms was 2727, an overall increase in reporting by 13% compared to the previous year. The named nurse for child protection reviewed these on a quarterly basis and outcomes were presented to the trust safeguarding committee.
- Access to wards and departments was restricted. Staff checked and challenged people entering the ward area. We spoke with nursing and administrative staff who told us they received regular updates from local authorities with information about family members not permitted on a particular ward.

## Mandatory training

- The target for mandatory training compliance was 95%. Modules included fire safety, infection prevention and control, moving and handling, safeguarding, equality and diversity and resuscitation.
- Medical and nursing staff told us they were up to date and given sufficient opportunity to complete their training. When we reviewed the data provided to us by the trust, the compliance levels were below the required target in some modules, however, the actual number of staff who had not completed the training was low. Managers explained this was, in part, due to maternity leave and sickness absence.

## Assessing and responding to patient risk

- Daily handovers took place and included discussions about patient safety as well as detailed information sharing about patients. We spoke to nurses from the Children's Heart Unit who explained the meetings were

based on the SBAR principle (situation; background; assessment and recommendation). Medical and nursing staff discussed any incidents relating to a patient and any potential risks.

- Children's services at the Freeman 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 the pain score tools with an assessment table to assist clinical staff in determining what action nursing and medical staff should take for an ill child. We spoke with nurses who demonstrated a clear awareness of how to assess patient risk and what action they would take in response. Doctors from the Children's Heart Unit recognised PEWS was not sensitive enough for heart patients therefore staff tailored charts for each patient, which they reviewed periodically during the day and night. Medical and nursing staff also recorded family concerns and we saw evidence of individualised assessments.
- Senior nurses told us they had recently introduced 'safety huddles' on the wards to increase awareness of deteriorating children. This included medical and nursing staff and focused on assessing and responding to individual patient risk.
- The paediatric risk register identified the paediatric cardiothoracic anaesthesia department was no longer able to support emergency paediatric ENT surgical cases on the Freeman due to lack of staff. There were plans to relocate the paediatric ENT provision to the Great North Children's Hospital. This meant, with the exception of the Children's Heart Unit and cardiothoracic services, all children's services would be located within the one hospital. A new pathway to safely manage patients was in use to mitigate the risk and the Chief Executive informed us the relocation was imminent.

## Nurse staffing

- Children's services took into account guidance from the Royal College of Nursing and the Royal College of Paediatrics and Child Health in relation to paediatric nurse staffing levels. Ward sisters monitored and reviewed the actual, against planned, staffing levels every day on their wards, on a shift-by-shift basis.
- Data published by the trust in January 2016 showed the total monthly actual staff hours were less than total monthly planned staff hours. For example, the average

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fill rate in the paediatric intensive care unit (PICU) was 90.0% during the day and 90.5% at night. On ward 23, the average fill rate was higher, at 98.6% and 91.9% respectively while ENT ward 11 was 74% during the day and 101.6% at night.

- There were enough nurses on ward 23 to ensure patients were safe. There were no recruitment issues and the matron had developed a waiting list system due to the number of nurses who had expressed an interest to work on the unit. We reviewed the rota and spoke with staff. A sister was on duty every shift and patients requiring high dependency care were nursed 2:1 (two nurses to each patient).
- Ward staff displayed Safer Staffing levels on notice boards on ward 23 and ward 11. We saw the planned number of staff versus the actual number of staff was the same. Although the board did not display the seniority of the nursing staff, we could clearly see the number of registered nurses on early and day shifts (seven per shift) and how many were on late shift (six). A senior nurse told us the safety of their patients was paramount. To ensure staffing levels remained safe, they 'closed' beds if they did not have the required number of nurses as recommended by the Royal College of Nursing. To mitigate the continued closure of beds, senior managers had agreed to recruit more nurses and a new cohort was due to join the unit.
- Although both ward 23 and PICU utilised bank staff, the average usage was lower than the trust average. Staff explained the service they provided was too specialist and specific knowledge and experience was required therefore this minimised the opportunity to utilise bank nurses.
- The monthly sickness rate average for children's services at the Freeman was below the trust-wide average in the last financial year. This applied to both medical and nursing staff.

## Medical staffing

- According to the Health and Social Care Information Centre, the skill mix was in line with 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. This applied to all children's services provided by the trust and not just those based at the Freeman.
- Junior medical staffing was a risk on the paediatric risk register in relation to the paediatric intensive care unit

(PICU). One doctor we spoke with told us they had just worked seven nights in a row. Recruitment for middle grade doctors was ongoing and three nurses were in the final year of the Nurse Practitioner postgraduate course. Once qualified, they would provide additional cover and support to the junior doctor rota. Consultants were currently covering shifts when there was a shortfall in junior doctor cover to ensure medical staffing levels remained safe. A junior doctor told us there were also two locum doctors supporting the rotational cover. The directorate had submitted a business case, which included an expansion of junior staff in paediatrics with the aim of encouraging more doctors to apply.

- We spoke with senior clinicians who told us there were six consultant intensivists for PICU, three cardiac surgeons, five paediatric cardiologists plus one locum and four paediatric cardiac anaesthetists. Middle-grade general paediatricians rotating through cardiology provided some of the medical cover on ward 23. Patients on the HDU received medical support from cardiologists and intensivists from PICU, who reviewed children every day.
- Between April 2014 and March 2015, locum usage was slightly above the trust average for cardio paediatric intensivists and anaesthetists, at 8.9%.
- We spoke with senior clinicians from ENT who told us there were no problems with medical staffing. Three GP trainee doctors worked alongside the Senior House Officer and four consultants specialised in paediatric airways. There was also good junior doctor cover.

## Major incident awareness and training

- The trust had an appropriate policy in relation to business continuity and major incident planning. The policy identified key people within the relevant service, the nature of the actions to be taken and key contact information to assist staff when dealing with a major incident.
- Staff we spoke with knew how to access the Business Continuity Management Policy for guidance on the trust intranet.

# Services for children and young people

## Are services for children and young people effective?

Outstanding



We rated effective as outstanding because:

- Policies and guidelines were all evidence based and we saw excellent examples of multidisciplinary working and collaboration. There was a holistic approach to assessing, planning and delivering care to children, young people and families. Staff consistently sought new evidence based techniques and demonstrated their commitment to work in partnership with others to support the delivery of high quality care.
- The care and treatment of children and young people achieved excellent outcomes and promoted a good quality of life. Staff routinely collected and monitored the data to maintain the high standard and engaged in activities to improve outcomes where appropriate. Staff proactively pursued opportunities to participate in benchmarking, accreditation and research.
- There were effective arrangements for young people transitioning to adult services or between services. Needs were assessed early, with the involvement of all necessary staff, teams and services and staff applied Gillick guidelines appropriately in relation to obtaining consent. Arrangements reflected individual circumstances and preferences.
- Children and young people had access to effective pain relief and staff used evidence-based pain-scoring and assessment tools to assess the impact of pain. Non-pharmacological methods were also utilised including 3D televisions and sensory rooms 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. Managers encouraged staff to develop, both personally and professionally, and staff took ownership of their own performance. Managers also proactively supported and encouraged medical and nursing staff to acquire new skills and share best practice. Staff had received an annual appraisal and there were excellent nurse preceptorship programmes.

### Evidence-based care and treatment

- Services for children and young people at the Freeman hospital adhered to guidelines from the Royal College of Nursing, the National Institute for Health and Care Excellence (NICE) and other evidenced-based best practice guidance, such as the International Society for Heart and Lung Transplant (ISHLT) guidelines, Paediatric Intensive Care Society and Mechanical Circulatory Support.
- Managers and clinicians reviewed and approved new policies and guidance at monthly clinical governance and quality meetings. We spoke with staff who told us managers and clinical leads encouraged them to stimulate discussions about new guidance and share their research with the wider team.
- Services participated in a range of national clinical and local audits which was well organised, such as national congenital heart disease audit (NCHDA). Clinicians monitored and discussed the outcomes from audit activity at monthly clinical governance meetings.

### Pain relief

- Children and young people had access to a range of pain relief if needed, including oral analgesia and patient-controlled analgesics. We saw evidence of a pain scoring system and completed pain assessments in the care records we reviewed, for example, FLACC (face; legs; action; cry and console) charts.
- Other non-pharmacological methods were also utilised by staff across the service. Nursery nurses and play specialists told us they used age appropriate play and activities as a means of helping to prepare children for procedures. We also saw sensory rooms and a 3D television on the Children's Heart Unit. Staff told us these were invaluable tools in calming and distracting children and young people.
- Clinicians used oral sucrose analgesia, administered pre-procedure, for newborn infants undergoing painful procedures. The use of sucrose as an analgesia is common practice across the UK and the rest of the world. Nurses 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. The unit also used the Comfort scale, a behaviour scale to assess post-operative pain in babies.
- Results from the CQC Children and Young People's Inpatient and Day Case Surgery Survey 2014 showed the

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trust performed the same as other trusts in relation to a question about pain management. Parents and carers of babies and children aged up to 15 said staff did everything they could to ease their child's pain.

## Nutrition and hydration

- The trust had a nutrition policy and ward food hygiene policy. The nutrition policy stated staff must screen all children for malnutrition within 24 hours of admission and weekly thereafter. We reviewed evidence from the trust-wide food and drink gap analysis, which demonstrated all areas of the trust, including services for children, were compliant in this action.
- Ward 23 used the STAMP (Screening Tool for the Assessment of Malnutrition in Paediatrics) nutritional tool to assess and monitor children. It is a simple five-step tool to identify if a child's condition has any nutritional implications, what the child's nutritional intake is plus their weight and height. Based on the results from the first three steps, the overall risk of malnutrition is calculated and a care plan developed as appropriate. We saw evidence that showed nursing staff used the tool routinely.
- Results from the CQC Children and Young People's Inpatient and Day Case Surgery Survey 2014 showed the trust scored worse than other trusts on the question about hospital food, according to children aged between 8 and 15 years. Results from parents and carers of babies and children aged up to seven years showed the trust scored about the same as other trusts.
- Staff we spoke with were aware of the challenges to provide food that not only met each patient's nutritional need but what they also enjoyed to eat. A child's condition and treatment also affected their enjoyment of food. Dieticians worked with other staff, children and families and reported positive working relationships with the trust-wide catering team.
- To meet the needs of children with complex needs, managers had recently appointed a Well Child post to prioritise cardiac nutrition in children. This was an innovative role designed to address and improve patient outcomes based on the most up-to-date research.
- One of the risks identified on the paediatric risk register highlighted the milk kitchen on ward 23 did not comply with national standards. This meant there was a risk to children who were on prescribed feeds. The matron, dieticians, infection control, children's services and the

trust estates team met regularly to ensure standards were adhered to and the kitchen was due to have a refit with appropriate storage space. There were also plans to provide training to healthcare assistants and housekeepers to adopt the same practice as applied by the Great North Children's Hospital.

## Patient outcomes

- Medical and nursing staff undertook local audits, for example, the senior trust fellow working in the paediatric intensive care unit (PICU) was currently auditing the infection risk for ECMO (extra corporeal membrane oxygenation) patients.
- In October 2015, the unplanned readmission rate to PICU within 48 hours of discharge was 1.5%. This was better than the national average and there were no unplanned readmissions in the previous month.
- Senior clinicians told us a third of all tonsillectomies were day cases. An audit had identified a higher than expected re-admission rate, related to secondary bleeding around the 10th post-operative day. Changes to practice were put in place, including steroids at the time of surgery for all patients and a lower setting on the diathermy machine in theatre. The team were currently re-auditing their outcomes.
- For example, the trust participated in the. Overall, the audit identified NCHDA data was accurate, well-documented, good quality and recorded appropriately in logbooks. Recommendations, such as data managers visiting another congenital centre on an annual basis, had been actioned or were in the process of being delivered.
- Children's services participated in national audits to monitor and improve patient outcomes. The most recent national congenital heart disease audit (NCHDA) report (2011-2014) showed the service performed above the 90% acceptable threshold for data quality in case notes. The overall data quality indicator for surgery and catheter was 97%, which was about the same as the average score for paediatric units across the UK and Ireland. The audit deemed scores above 95% as excellent.
- The NCHDA audit also reported 30-day survival rates for paediatric cardiac surgical or interventional procedures. Between 2011 and 2014, there were 678 surgical



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episodes. The actual survival rate was 98%, about the same as the unit's predicted rate of 97%. Only two out of 14 units in the UK and Ireland achieved a better than predicted outcome.

- The NHS Blood and Transplant Annual Report (September 2015) reported outcomes from paediatric cardiothoracic transplantation. Between April 2014 and March 2015, 37 paediatric heart transplants were performed in the UK. Of these, 33 were categorised as urgent. The Children's Heart Unit performed 56% of all transplants compared to 43% performed by Great Ormond Street in London.
- The 30-day survival rate for paediatric heart transplants, performed between April 2010 and March 2014, was 97%. There were 61 transplants in total and two deaths. Statistically, there was no significant difference between the Children's Heart Unit and Great Ormond Street Hospital in London. The 1-year patient survival rate was 90% and there were four additional deaths within post-transplant period. Again, there was no significant difference between the two centres in Newcastle and London.
- 90-day and 1-year survival rates for paediatric lung transplants, performed between April 2010 and March 2014, were 100%. This result was comparable to statistics from Great Ormond Street Hospital.
- Results from the CQC Children and Young People's Inpatient and Day Case Surgery Survey 2014 showed the trust performed the same as other trusts to 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.

## Competent staff

- All clinical and non-clinical staff attended the trust induction programme upon joining the organisation. Staff spoke positively about the training they received and evidence provided to us by the trust showed the 95% target had been achieved.
- All nurses caring for children and young people on ENT ward 11 had received relevant paediatric training. Adults were also cared for on this ward, however only trained paediatric staff cared for children.
- We found medical and nursing staff were competent to carry out their roles. Staff told us they received appropriate professional development and supervision,

and had received an appraisal. Information provided to us by the trust showed 87% of consultants and 72% of nurses from the Children's Heart Unit had received an appraisal between April 2015 and October 2015. The percentage of nursing staff from paediatric ENT was 93%. Managers told us all staff, with the exception of those on maternity leave or long-term sickness absence, would receive an appraisal by the end of March 2016.

- Minutes from the ENT Board of Management meeting noted some junior doctors did not appear to have much paediatric experience and, as such, tended to prioritise adult patients above children and young people. Following a discussion, members of the committee suggested junior doctors should link in with the training given to junior doctors at the Great North Children's Hospital.
- We spoke with the lead cardiac surgeon who explained there were usually two consultants in theatre for major operations. This ensured continuity of learning.
- Staff told us managers encouraged them to continue their professional development. Nurses and junior doctors told us study leave was available to support them whilst undertaking their studies. Clinical educators were attached to every ward and unit. Part of their role included co-ordinating mandatory training and the revalidation process. Nurse preceptorship was also embedded within the trust. We spoke with a nurse who described her six-month induction as 'excellent'.
- Junior doctors we spoke with were positive about the regular training and support they received to develop their clinical and educational knowledge and skills. Doctors felt well supported by senior medical staff and each doctor had an educational supervisor. There was a regular teaching slot every week and one junior doctor told us they had recommended the trust to a friend because of the ongoing training and development opportunities.
- Clinical supervision across the medical team appeared to be robust and we received many positive comments from staff. Nurses told us they received bi-monthly clinical supervision and added informal supervision and discussions were a regular occurrence. One nurse, who had been in post for less than one year, told us she felt 'lucky to work here' and felt well supported by senior colleagues and peers.

## Multidisciplinary working



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- A multidisciplinary team (MDT), which included physiotherapists, nurses, surgeons, occupational therapists, psychologists, play therapists and teachers ran the Children's Heart Unit. We spoke with a physiotherapist who explained her daily role involved working alongside clinicians, providing respiratory and rehabilitation care for children.
- Medical and nursing staff, and allied health professionals, gave positive examples of MDT working. We observed two physiotherapists and a nursery nurse working alongside clinical staff caring for a young patient on the Children's Heart Unit. They told us they felt part of the wider team who worked collaboratively to ensure they met the needs of children and young people.
- Medical staff from the paediatric intensive care unit also worked closely with colleagues caring for children who required high dependency care and contributed to the overall care and treatment of those patients. Many patients had complex needs that required specialist care. Clinicians told us they were able to manage the intensity of this work due to the supportive atmosphere created by 'dedicated and supportive' colleagues.
- Good MDT working was essential and inherent across services for children and young people. We heard examples where staff had saved children's lives as a result. For example, in the previous six weeks, there had been three cardiac arrests. The MDT team, which included surgeons, the crash team and theatre scrub nurses applied the ECPR (extracorporeal cardiopulmonary resuscitation) protocol and the patient received ECMO (extra corporeal membrane oxygenation) life support within 30 minutes.
- We heard examples of co-ordinated planning and delivery of care, and communication between teams was excellent, focusing around the needs of the child and their family. For example, when the MDT made the decision, in collaboration with the family, to withdraw care from a very poorly child, the team supported the family through the process and explained the stages for palliative care. One of the outcomes included the donation of the child's kidneys to help other sick children.

## Seven-day services

- The Children's Heart Unit operated seven days a week, 365 days of the year. One young patient, at his own

request, underwent a lung transplant on Christmas Day. Due to the unpredictability of organs becoming available, the team assembled to meet the needs of the patient. This could be day or night.

- Consultants were available out of hours and supported the junior doctor rota in the paediatric intensive care unit, covering night shift when necessary.
- Children's services accessed diagnostic services such as the x-ray department, pharmacy and laboratory during the weekend. Staff did not raise significant concerns over accessing these services.

## Access to information

- Staff we spoke with told us 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 we spoke with understood the Gillick guidelines and gave examples of how they had applied it in practice. Staff explained that the consent process actively encouraged young people to be involved in decisions about their care.
- Staff we spoke with understood mental capacity as it related to young people and consent to treatment. If they needed further advice, they told us they would contact the safeguarding team.

## Are services for children and young people caring?

Outstanding



We rated caring as outstanding because:

- Managers and staff created a strong, visible, person-centred culture and were highly motivated and inspired to offer the best possible care to children, young people and families, including meeting their emotional needs. Every member of staff contributed to the overall care and well-being of children and families, from domestic staff through to clinical leads.

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- Senior managers and clinical leads recognised and valued the contribution from every member of staff. Everyone we spoke with, across every service, was warm, compassionate and friendly, and very passionate about his or her role. We heard many examples where staff had gone beyond the call of duty to provide care and support to families. Strong teamwork was prevalent across all areas.
- Staff respected the different personal, cultural, social and religious needs of the children and young people they cared for, and care and treatment was focussed on the individual person rather than the condition or service.
- Feedback from families we spoke with was unanimously positive about all aspects of the care they and their children received. They described staff as being very caring, compassionate, understanding and supportive. Staff worked in partnership with children and young people and promoted empowerment, enabling them to have a voice and realise their own potential.
- Managers and staff valued the emotional and social needs to children and young people and this was reflected in their care and treatment.

## Compassionate care

- There was a deep ethos amongst the medical and nursing team about 'going the extra mile' to meet the needs of children, young people and families. Feedback from parents was unanimously positive. When describing the care their child had received from staff, one family commented, 'I cannot fault them, everything is wonderful and we are really looked after by everyone'. We also observed physical demonstrations of affection between staff and families. For example, one father had not seen the consultant since his child's operation 12 months ago and we saw them embrace and chat to each other like old friends.
- The family of a young boy admitted at short notice for a transplant told us care had been 'world class'. During a previous admission, staff had engaged with the family about end of life care and appropriate plans agreed. The parents told us they had been involved in every aspect of their child's care and all staff, from the domestic team through to the senior clinical leads had been 'amazing'.
- Responses from the Friends and Family Test collated in December 2015 showed 85% of respondents would recommend children's services. This data also included services based at the Great North Children's Hospital.

Staff acknowledged the response rate was low, at 9%, and utilised other methods of collecting feedback about the services they provided. This included surveys and the 'take two minutes, tell us what you think' initiative, which captured patient feedback in the form of comment cards that were widely available on the wards.

- Results from the CQC Children and Young People's Inpatient and Day Case Surgery Survey 2014 showed the trust scored better than other trusts when parents were asked if their child was given enough privacy when receiving care and treatment. Parents, children and young people thought staff were friendly, listened to them 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, when a baby returned to Children's Heart Unit following surgery, he was continually crying and we observed nursing staff reassuring his anxious and distressed parents, discussing pain relief and other options for his care.

## Understanding and involvement of patients and those close to them

- Medical and nursing staff demonstrated their knowledge and understanding of the children and families on the ward. When a nurse spoke with us about a recent death of a child, she lowered her voice and used appropriate body language, displaying empathy and sensitivity. She also asked permission from a mother if she could talk about the care and treatment of her child with us. Siblings of patients receiving long-term care attended the staff nursery and one family, who had relocated from another area of the country, received support from staff to enrol their child in a local school. Families also received support for respite care from the Rainbow Trust.
- The ENT and cardiology wards both displayed 'How are we doing' boards and used them as a communication tool to share information with children and families. For example, a poster explaining the different staff uniforms so families could distinguish between a staff nurse and a healthcare assistant. The boards also included information about the Patient Advice and Liaison Service (PALS) and the ratio of nurses to patients.
- Families on the Children's Heart Unit told us they had a named consultant who they saw regularly. They felt comfortable and confident asking questions of both

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them and other doctors undertaking the ward round. They did not feel there were any barriers between themselves and medical or nursing staff. Parents were very informed of their child's care and treatment, and rapport between patients, families and clinical staff was warm, open, friendly and caring.

- We spoke with the family of a young child who had spent eight months in the Children's Heart Unit (CHU). Before transferring to the unit, he had undergone a heart transplant and eight subsequent operations at another hospital without success. The family was informed no further treatment was available and were left with no further options until their local hospital suggested the CHU 'might' be able to do something'. The consultant from the CHU was very open and honest about the treatment options and potential outcome, ensuring the family could make an informed decision. The parents told us the consultant and his team 'were willing to try and try again' to achieve a successful outcome which they did and the family was in the process of preparing to take the child home. ENT and renal services provided additional multi-disciplinary support, alongside the dietician, who worked with the family to serve different arrangements of food to meet his nutritional needs; the healthcare assistant who made smiley faces with his vegetables and the domestic who always made the young patient smile.
- Staff went beyond the call of duty to care for and support their patients. For example, when one patient made a special request and asked to have his lung transplant operation on Christmas Day, the whole team responded and accommodated his wish. On another occasion, when doctors gave permission for one young patient to have his first fizzy drink in eight months, following his transplant, the sister turned it into a special occasion by arranging a social gathering to celebrate.
- Results from the CQC Children and Young People's Inpatient and Day Case Surgery Survey 2014 showed the trust scored better than other trusts when parents were asked if a member of staff explained what would be done during the operation or procedure.
- Parents we spoke with felt well informed about their child's condition and treatment. They knew all of the details and could explain what was happening and

when. Staff also ensured families were active participants in their child's care. For example, some parents in the Children's Heart Unit had received nasogastric-feeding training from staff.

- 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. For example, a physiotherapist showed a parent how to use the equipment to support her child. Although the equipment looked intimidating and the parent was anxious, the physiotherapist patiently explained the process and ensured they were clear about each step before moving on. At the end of the discussion, the parent told us she felt confident to use it and felt encouraged by the support she had received.
- Clown doctors visited two days a week, providing music and drama therapy, and were universally enjoyed by children, parents and staff. We observed medical and nursing staff work in partnership with the clown doctors and saw the joy they brought to children and families. Clown doctors used distraction techniques to care for children undergoing treatment. For example, they successfully distracted a child with autism, who was distressed about having blood taken, by playing the ukulele and blowing bubbles. They settled the child and relieved the anxieties of his parents.

## Emotional support

- Parents told us staff understood the impact the condition and treatment had on their children and provided emotional support. One parent told us staff constantly offered reassurances and support throughout the treatment process. They kept families informed at every stage. Parents felt empowered to ask questions and were very confident their children were receiving the best care possible. In recognition of the emotional toll a child's illness has on parents, staff had also recently arranged an evening offering holistic therapy treatments, including massage and aromatherapy.
- Children, young people and families could access support from psychologists at clinics and on the ward. Nursery nurses and play specialists also provided emotional support and the trust provided the 'Make Me Sparkle' service, a weekly beautician service for families, encouraging parents to enjoy some relaxing activity for

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themselves. A senior nurse told they were also hoping to introduce pet therapy on the ward, recognising the benefits of such a service in meeting the emotional needs of children and families.

## Are services for children and young people responsive?

Outstanding



We rated responsive as outstanding because:

- Staff actively promoted involvement from children, young people and families, and their individual needs and preferences were central to the planning and delivery of services.
- The involvement of other local, national and international organisations, charities and the local community was integral to how managers planned services to ensure they met the needs of patients and their families.
- There were innovative approaches to providing care integrated person-centred pathways that involved other service providers, and services were flexible, provided choice and ensured continuity of care. Families had access to the right care at the right time, taking into account children and young people with urgent or complex needs.
- There was a proactive approach to understanding the needs of different groups of children and staff delivered care in a way that promoted equality. This included children and young people who were in vulnerable circumstances and those who had complex needs.
- There was an open and transparent approach to handling complaints. Information about how to make a formal complaint was widely available however; families tended to contact the service directly when they had a concern.

### Service planning and delivery to meet the needs of local people

- Managers and clinicians from cardiothoracic services had good links with national commissioners who had agreed extra funding for cardiac care in Newcastle. There were plans to relocate the Children's Heart Unit to

a new building, located on the Freeman site. The new unit would include a new paediatric intensive care unit, increasing the number of beds from 12 to 18, a day-case unit and cath labs.

- One of the senior nurses also explained the purpose of a service improvement project, 'Solving a Ward Capacity Issue', which included allocating a cardiology bed in Scott House, the family accommodation unit, the night prior to the planned operation.
- As the Children's Heart Unit was one of only two specialist centres in the UK offering cardiac and lung transplants, the unit cared for children with complex needs from all areas of the country. We heard many examples of how the trust was willing to accept children who were deemed 'high risk'. One parent told us their child would have died without the care and treatment from staff on the unit. The lead surgeon told us the unit had recently experienced an unprecedented rise in demand and had successfully completed eight transplants within a four-week period. Consequently, this meant making the decision to send less complex patients to other the hospitals across the country to meet the needs of those children and their families.

### Meeting people's individual needs

- Managers and staff planned services to meet the needs of children, young people and families and put the patient at the very centre of their care.
- The Children's Heart Unit met the needs of children with the most complex abnormalities such as hypoplastic left heart syndrome. Children and young people who required urgent care received immediate treatment. For example, a child collapsed and required full cardio-pulmonary resuscitation. Staff inserted a cannula and started ECMO (extracorporeal membrane oxygenation) on the ward as part of his resuscitation. The child went on to make a good recovery. To collect the equipment and team on the ward to complete this in 30 minutes is outstanding practice.
- The Children's Heart Unit also ran a home INR (International Normalized Ratio) monitoring programme. Information provided to us by the trust explained the unit was the first one in the world to establish such a service. Specialist children's cardiac nurses ran the programme and managed results and changes of Warfarin doses as parents phoned in with INR results. Nurses also provided training for parents, who developed a much better understanding of

# Services for children and young people

anti-coagulation and saved families having to make regular visits to hospital. The success of the programme resulted in other children's heart units setting up similar programmes.

- The Children's Heart Unit treated children from all over the country and not just the local region. Recognising the disruption this caused to family life, the trust, in conjunction with the Child Heart Unit Fund charity (CHUF), provided accommodation for parents and siblings so they could remain in close proximity to their child. We visited Scott House, located at the rear of the main hospital site, and spoke with the manager. The unit comprised of 18 ensuite rooms, plus a one-bedroomed flat, with communal areas, including a kitchen, playroom and quiet area. Children who were improving and nearing discharge were able to stay with their family in the flat to support their transition after their long hospital stay.
- New pathways were developed and implemented where appropriate to ensure staff met the needs of the patient. For example, one of the risks on the directorate risk register related to a shortfall in paediatric ENT emergency anaesthetic support. The ENT surgical pathway for acutely ill children included a request from the anaesthetist team to flag potential patients who needed to use this pathway. This would ensure the team could provide adequate cover so children could undergo surgery and inpatient care at the Freeman rather than transfer to the Great North Children's Hospital at the RVI. There were also plans to audit each occurrence to support future planning.
- If an unborn baby was known to have a heart problem, arrangements were made, in conjunction with maternity services, for the baby to be delivered in the Children's Heart Unit (CHU) so appropriate care and treatment could be provided immediately. We met a young child who had been born in the CHU and spent eight months on the ward. He was attending an outpatient appointment and the family had popped in to say 'hello' to the staff. His mum commented, 'this hospital is brilliant. I cannot say how grateful I am. He is alive because of them'.
- There were excellent facilities available for children and young people, encouraging them to play and relax. A nursery nurse explained the facilities in the Children's Heart Unit had expanded to exceed its original size by a significant margin. We saw an open-plan, indoor area that led to a large, garden-style, outdoor play area. The

design and décor met the needs of children of all ages. Multi-disciplinary teams utilised the environment to plan their work together and provide therapy at the same time, where appropriate.

- Play specialists were available seven days a week. Families we spoke with described them as 'excellent'. There were also two nursery nurses on shift per day in the Children's Heart Unit and clown doctors visited twice a week. We observed the clown doctors interacting with children and families and witnessed the joy and laughter they created on the unit, with involvement from staff.
- Some children in the Children's Heart Unit were resident in the unit for a prolonged period. To meet the educational needs of every patient, the trust provided a dedicated teacher from the Newcastle Bridges School, a specialist provider of community teaching. We spoke with parents who told us they valued the service and felt it ensured a sense of normality to their child's life.
- Children from all over the country visited the Freeman for treatment and staff we spoke with told us there were no problems accessing interpreting services.

## Access and flow

- There was a bed management and escalation policy, which provided clear guidance by utilising criteria within the North East Escalation Plan (NEEP). Managers and senior nurses had a clear picture of where the demands and spare beds were in the hospital at any given time. The patient services co-ordinator held responsibility for bed management during the day while the night nurse practitioner assumed responsibility out of hours, during the night. Staff we spoke with did not report any problems.
- There was a Single Point of Access pathway. The Children's Emergency Assessment Unit at the GNCH received all GP referrals. Following assessment, clinicians would discharge the patient, transfer them to long or short stay in the unit or transfer them directly to a base ward. Staff only admitted young people up to the age of 16 years to an adult ward upon request or if their clinical condition dictated the need to do so.
- Access and flow within the Children's Heart Unit and the length of stay varied. Factors such as the child's medical condition or if they required a transplant and were on the waiting list meant the pathway was unpredictable.



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Staff explained it was difficult to know how long children might have to wait for a suitable donor and told us there was an increasing number of children on the waiting list for heart transplantation.

- Staff explained most children were usually receiving care on the unit prior to an organ becoming available and the donor transplant co-ordinator kept families informed about the transplant process. In line with guidelines from the British Transplant Society, the transplant co-ordinator worked closely with clinicians and colleagues across the country to monitor organ donation and retrieval.
- The ENT team consistently met the 18-week referral to treatment target. We spoke with staff from the unit who told us the waiting times were normally around 11 weeks.
- There were arrangements for young people to transition to adult services. We reviewed the trust's comprehensive Transitional Care from Paediatric to Adult services Guidelines, developed in line with national guidance, which clearly set out each stage in the process. Young people with congenital heart problems could transition smoothly to adult services, which were located within the same unit.
- ENT ward 11 was a 20-bedded unit however the occupancy rates depended upon the theatre lists. For example, during our visit, patients occupied three beds, as there was no planned surgery on that day. The following day, there were three planned theatre lists, which meant more patients would populate the ward.
- Nurses on ward 23 in the Children's Heart Unit followed the escalation policy if the number of patients exceeded the number of beds. For example, staff transferred patients with less complex needs to ENT ward 11 however any procedures or treatment were administered by nurses from the referring ward. The senior nurse explained they could also convert the nursery unit to provide space for additional beds.
- Children with complex needs could see many different members of staff. To mitigate any additional stress on families, nursing staff made every effort to co-ordinate appointments to limit the number of visits families made to hospital. For example, one child attended different clinics in cardiology, gastro and ENT and her parents told us this worked well and they had been 'well looked after'.

## Learning from complaints and concerns

- Between October 2014 and September 2015, there were two formal complaints made about cardiothoracic services and three in relation to ENT. There were no discernible themes or trends.
- 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. In most cases, however, parents spoke to the staff on the ward or unit as they had developed strong, positive relationships and knew they would receive an appropriate response.
- Staff told us there had been lessons learned from concerns and complaints. For example, a child with an airway problem was transferred to the cardiology ward for the weekend and the parents complained about the perceived lack of airways skills amongst the clinical staff. The subsequent investigation of the complaint revealed the mother had not received an explanation or any reassurance from staff that the cardiology ward cared for many children with tracheostomies and airway problems. The complaint therefore stemmed from lack of communication rather than clinical skills and the learning was shared with staff.

## Are services for children and young people well-led?

Outstanding



We rated well led as outstanding because:

- Managers and leaders created a culture of openness and transparency with a clear focus on putting children and young people at the centre of their care. Services had good strategies and plans, each with service-specific objectives and goals, to meet the needs of children and young people and deliver a high quality service. Objectives were stretching, challenging and innovative while remaining achievable. They directly linked with the overarching trust vision and goals and most staff knew what these were.
- Staff were very positive about working for the trust and, overall, leadership was good across the different services. Leaders had an inspired shared purpose; they strived to deliver and motivated their staff to succeed. There was a clear management structure and managers were visible and involved in the day-to-day running of services. Staff could contact them whenever they



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needed to and received supervision from line managers and clinical leads. There was strong collaboration and a culture of collective responsibility between teams and services with a common focus on improving quality of care and the patient experience.

- Managers and staff used innovative approaches to gather feedback from children, young people and families. They listened to suggestions and made changes as a result. Managers from every service drove continuous improvement and empowered staff to raise concerns and offer innovative suggestions to improve service delivery, quality and care.
- There was an effective and comprehensive system to identify, monitor and address current and future risks. Managers had embedded clinical and internal audit processes within services and this had a positive impact in relation to quality governance, with clearly defined outcomes and actions.

## Vision and strategy for this service

- There was a strategy for ENT and paediatrics was included within this. It identified areas of concern and actions for improvement. For example, plans to strengthen links with paediatric cardiothoracic and respiratory services to improve ENT support for young children with an established tracheostomy. This included the development of a nurse specialist role. Another area of concern was staffing levels on ward 11. Both of these issues were included in the overarching paediatric risk register.
- Cardiothoracic services for children and young people were included in the overarching directorate strategy. There was a clear vision statement and staff we spoke with demonstrated they understood and applied the concept within their daily practice. The strategy for paediatrics was growth and we saw the plans to develop the service to meet the increasing patient demand.
- Managers reviewed the progress of the business plan at regular directorate and unit level governance meetings, involving and include all medical and nursing staff groups.

## Governance, risk management and quality measurement

- There were good working relationships with other trusts across the UK and worldwide. For example, clinicians had weekly meetings with NHS England, Great Ormond Street and Birmingham Children's Hospital to discuss

the number of required heart failure beds and what appropriate action to take. The Children's Heart Unit also benchmarked its quality and risk management with services outside of the UK such those in North America and Canada where there was the most comparable data. We heard examples of sharing good practice via cross-site visits including morbidity and mortality. Managers and clinical leads also spoke positively about relationships with local clinical commissioning groups and the local authority.

- Governance meetings took place every week and the minutes shared with staff. Medical and nursing staff discussed performance and considered appropriate action to improve outcomes. For example, minutes from a paediatric intensive care unit clinical governance meeting reported one patient had experienced three cardiac arrests. The ensuing discussion included agreement to offer parents the opportunity to be present during the resuscitation process, albeit with the support from a senior nurse or doctor. The team also planned to introduce a Paediatric Cardiac Arrest Record to replace the National Cardiac Arrest Audit sheet, tailored for adults rather than children.
- There was a comprehensive risk register, which staff regularly reviewed at governance meetings. Everyone we spoke with was aware of what the risks were and what action managers were taking to manage and address them. For example, in 2015, there was a significant lack of organs available for transplant. Very poorly children were cared for using the Berlin Heart Ventricular Assist Device (VAD). As one of only two centres in the UK performing both heart and lung transplants, clinical leads and managers were involved in daily phone calls with NHS England and Great Ormond Street to maintain communication and discuss issues to mitigate and manage the continued risk to patients.
- Staff told us they felt they were encouraged to report incidents and near misses, concerns from patients and identified risks to the organisation. Staff were confident that if concerns were raised in relation to patient safety, action would be taken.
- We saw evidence of internal quality audits undertaken routinely across children's service to ensure safe and effective care.

## Leadership of service

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- Medical and nursing staff told us the leaders of children's services at Freeman were supportive and highly visible. When we spoke with senior nurses, they were clear about their responsibilities toward their staff. They spoke about the importance of being visible and providing support, the impact caring for very sick children and those looking after them and maintaining a positive attitude.
- Staff told us leadership was 'all over', not just from the top. One senior nurse commented, 'it crosses all roles and everyone is valued. There is no hierarchy'. The lead consultant from the Children's Heart Unit explained how the contribution from every member of staff counted and was integral to the overall successful running of the unit, from domestic staff to surgeons. We observed the positive relationship the matron had with every member of her team, all of the children and their families. Every interaction was relaxed and demonstrated excellent knowledge and insight of every person.
- There were clear lines of management and accountability and the leadership was organised on a shift-by-shift basis. For example, nurses working on the night shift had responsibility for the pre-allocation of patients to ensure consistency of practice.
- Leaders and managers were responsive to the needs and challenges of the service. For example, NHS England had recently granted approval to recruit additional band 5 nurses in the Children's Heart Unit. To ensure staffing levels remained safe, the sister wanted to ensure she recruited the new cohort of nurse during the current financial quarter. As the matron was on annual leave, the sister emailed the director of nursing who responded immediately and a recruitment plan was in place within one week of receiving the approval.
- We found the culture was very positive, open and transparent. Staff we spoke with told us 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, administrative and domestic staff, 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 and we heard about and saw good examples of collaborative working. One nurse told us about the support she received returning to work following a period of sickness absence. Another nurse had worked for the trust for 14 years and had returned as a bank nurse. She told us she felt part of the team and 'loved' working on the ward.
- We spoke with staff who explained the emotional work pressures they had experienced the previous year due to the high volume of very sick children requiring transplant. Managers enlisted the support of the trust's clinical psychology team and implemented TESS (Team Emotional Support System) sessions to support staff. TESS is a system of support, welfare and emotional care for all staff that aims to prevent or reduce stress related illness following emotionally charged incidents including bereavement.

## Public engagement

### Culture within the service

- Medical and nursing staff were positive and enthusiastic about working for the trust. Some of the comments we heard included 'I love coming to work every day', and staff highly recommended the trust as a place to work. Medical and nursing staff reported no bullying, intimidation or harassment behaviour from managers or colleagues. We learned the Children's Heart Unit was such a popular unit in which to work, the matron operated a waiting list for other nursing staff who had expressed an interest to join the team. The team on the ward described themselves as the 'Ward 23 Family'.
- Medical and nursing staff engaged daily with the children and young people in their care and ensured parents were included. We saw evidence of strong relationships between doctors and nurses with patients and their families.
- We saw and heard many positive examples of engagement with children, young people and their families. Comment cards were widely available and feedback displayed on public notice boards on the wards. The design was very child-friendly, with smiley faces to help children select the appropriate response.
- Rooms specially designated for parents also included 'You Said, We Did' boards where staff displayed the

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results of feedback received from families. Children and families were also engaged with through feedback from the NHS Friends and Family Test and complaints and concerns raised from PALS.

- Families who stayed in Scott House ran their own monthly parents meetings and managed their own Facebook group. One of the senior nurses explained this was a useful way to engage with parents collectively, for example, as part of the safe and sustainable review of children's congenital cardiac services in England.
- The cardiac outpatients department encouraged children and young people to tell staff what they thought about the clinics and waiting areas via 'You Said, We Did' boards. Comments included requests for an Xbox 360, which staff responded to by advising there was already one available in the unit.
- In 2015, Newcastle and Gateshead hosted the British Transplant Games. Children and young people from the Children's Heart Unit had taken part and one young patient won an award for Best Newly Transplanted Athlete.

## Staff engagement






- Staff had taken part in the national NHS staff survey in 2014. The Children's Services directorate had the largest proportion of staff participate in the survey compared to the other clinical directorates. 44% of staff overall agreed that communication between senior staff and staff was effective which was better than the national average (35%).
- Staff from all disciplines told us they felt very involved and encouraged to participate and contribute to new developments in the service.
- The trust had established staff networks to help develop a work environment in which staff felt supported and valued. The networks also provided a forum for

discussion and debate and acted as a driving force to promote continuous practice improvement. Staff told us there were three Network groups: Black, Asian and Minority Ethnic, Lesbian, Gay, Bisexual and Transgender and Disability.

## Innovation, improvement and sustainability

- There was a culture of continuous learning, improvement and innovation across children's services. Staff told us their managers actively encouraged them to look at different ways to improve their service and they had access to the trust's 'Innovations Portal'. The portal allowed any member of staff to log their innovative idea for assessment and consideration by a wide range of professionals.
- Staff from the Children's Heart Unit described the unit as 'first class' and told us innovation was embedded within the service. The trust performed the first infant transplant in 1987 (one of only 100 transplant patients worldwide to survive over 25 years) and the first HLA (genes) mismatched transplant in the UK.
- The Children's Heart Unit was one of the largest mechanical circulatory support centres in the world and Europe. The paediatric Berlin Heart Ventricular Assist Device (VAD) supported children who were waiting for a donor heart and could sustain them for many months. Information provided by the trust showed doctors had implanted the smallest child in the world with the Heartware left ventricular assist device (13.5 kg). He was also the first child in the world to recover and have a device decommissioned. The unit was the only centre in the UK (and one of only three worldwide) with Berlin Heart Training Centre accreditation and were working with the other units in North America to share experience and learning.

# End of life care

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

## Information about the service

The Freeman Hospital is part of the Newcastle upon Tyne Hospitals NHS Foundation Trust. It is one of two hospital sites, where the trust provides end of life care. End of life care encompasses all care given to patients who are approaching the end of their life and following death. It may be given on any ward or within any service in a trust. It includes aspects of essential nursing care, specialist palliative care, and bereavement support and mortuary services. Nursing and medical staff throughout the Freeman Hospital delivered end of life care. Patients requiring end of life care were identified and cared for in the ward areas throughout the hospital, this was with support from the Specialist Palliative Care Team (SPCT).

The service was split into four teams on four sites, the Freeman Hospital, the Royal Victoria Infirmary (RVI), the Northern Centre for Cancer Care and in the community. The team was interdisciplinary and included consultants in palliative medicine, nurse specialists and administrators. There was a lead consultant in palliative medicine and a lead nurse for end of life care. In addition, there was a Macmillan specialist occupational therapist and physiotherapist on a four year MacMillan funded project based at the Freeman hospital. There was also support from the specialist psychology service.

The trust had developed its organisational structure using the international and national definitions of palliative and end of life care. As these definitions were different, the service was divided into the SPCT and the end of life team. The 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-5pm service, with an out of hour's advice line, the community SPCT were also available and could visit the hospital at the weekend if required. The end of life team was created to meet the needs of all patients and families who did not have specialist palliative care needs but who were reaching the end of their lives. The team consisted of a lead nurse and clinician and a recently appointed band 6 nurse.

There was a chaplaincy service providing multi-faith rooms, a mortuary and viewing area and a bereavement service.

As part of our inspection, we observed end of life care and treatment on wards and other clinical areas. We visited critical care, high dependency unit, medicine and respiratory wards and the Northern Centre for Cancer Care. We also visited the chapel, the hospital mortuary, viewing room, and bereavement office. We spoke with four patients and families. We spoke with 19 staff including members of the SPCT, senior staff, ward nurses, ward doctors, healthcare assistants, allied health professionals and bereavement office staff. We looked at the records of four patients receiving end of life care and nine DNACPR (do not attempt cardiopulmonary resuscitation) forms.

Before our inspection, we reviewed performance information, audits, surveys, and reviewed feedback reports specific to end of life care.

# End of life care

## Summary of findings

Overall we rated end of life care as good with well-led as requiring improvement because:

- The Specialist Palliative Care Team and End of Life Care Team were highly visible and accessible and ward staff had a clear referral process in place for patients.
- There were adult safeguarding procedures, supported by mandatory training. Staff knew how to report and escalate concerns regarding patients who were at risk of neglect and abuse.
- Patients received compassionate care and their privacy and dignity was respected. The chaplaincy and mortuary staff demonstrated examples of outstanding care provided to patients and their families.
- Nursing staff told us that they had sufficient staff to prioritise good quality end of life care when needed and that they had the processes in place to escalate staffing concerns should they arise.
- There were systems in the mortuary to ensure good hygiene practices and the prevention of the spread of infection.
- The results of the End of Life Care Dying in Hospitals Audit 2016 showed that the trust met all clinical audit indicators and seven of the eight organisational indicators.

However

- The Caring for the Dying Patient document to replace the Liverpool Care pathway, although fully embedded in the community had only been piloted on a small number of wards in the acute hospitals with ward-based training being prioritised according to the number of patients at the end of life. Interim guidance was available for ward staff, which outlined initial and subsequent assessments, regular documentation of care delivered, interventions and care after death. Plans were in place to roll out training for the new documentation across all wards but there were no formal timescales to specify this at the time of inspection.

- Although risks were identified in the End of Life and Palliative Care update reports to the Board, there was no end of life care risk register used to identify and monitor risks.
- Whilst ward staff were engaged in the provision of end of life care there appeared to be a lack of understanding of the strategies and priorities for end of life care by ward staff. The trust had taken steps to engage with staff to increase awareness of the strategy.
- Although there was some audit for monitoring if, patients achieved their wish for their preferred place of death this was limited and was not routinely identified. The trust acknowledged that future audits would include this.

# End of life care

## Are end of life care services safe?

Good



We rated safe as good because:

- There were systems for reporting actual and near miss incidents across the hospital. We saw lessons learnt following incidents, which were recorded in an incident log and safety briefings provided to ward staff.
- There were systems in place in the mortuary to ensure good hygiene practices and the prevention of the spread of infection.
- There were adult safeguarding procedures in place supported by mandatory staff training. Staff knew how to report and escalate concerns regarding patients who were at risk of neglect and abuse.
- Medications were stored correctly and we saw staff competencies provided by the trust during our inspection in relation to syringe driver use.

However

- Although staff training figures were above the internal target of 95%, the chaplaincy was below target in several areas but plans were in place for this group of staff to receive training by the end of the financial year.

### Incidents

- Staff delivering end of life care and specialist palliative care understood their responsibilities with regard to reporting incidents and they knew how to report them. We saw good evidence of incident sharing between ward staff and end of life teams and lessons learnt because of this.
- We saw 14 incidents recorded on the end of life trust wide incident log between 1 October 2014 and 30 September 2015. All were rated as minor except one, which was moderate. The moderate incident related to aggressive behaviour by a family.
- Members of the SPCT told us that incidents were discussed twice a year during integrated meetings with community teams and we saw evidence of this in meeting minutes.
- The SPCT told us that serious incidents were investigated with the involvement of relevant staff. We saw discussion of serious incidents within the minutes of end of life care governance meetings.

- Staff we spoke with showed some understanding about the duty of candour regulations, they understood their responsibility to be open and transparent. They gave us verbal examples of when they had used duty of candour. We saw duty of candour was included in the incident reporting policy.

### Cleanliness, infection control and hygiene

- The trust had a policy for the prevention and control of infection and hand hygiene. This was available for staff.
- We visited the mortuary at the Freeman hospital, and saw that it was clean and well maintained and that hand-washing facilities were available. Cleaning records were up to date.
- We saw 100% in the handwashing compliance audits within the mortuary. This was consistent over the last three months.
- We saw staff had access to personal protective equipment (PPE), such as gloves and aprons and were seen to be using the equipment
- Mortuary protocols were reviewed and we saw that relevant infection control risks were managed with clear reporting procedures in place.
- Staff were confident in their role for infection control and the reporting protocols in place. Mortuary staff were aware of the cleaning schedules and duties, for example processes were in place for cleaning of concealment trolleys.
- We saw that 100% of staff within the mortuary had completed infection control training. This was against an internal target of 95%.
- The trust ensured that the health and safety of those attending to the deceased were protected and infection control processes were outlined in the trust's 'Care after Death' policy.

### Environment and equipment

- Staff we spoke with said they had no problems accessing equipment for patients at the end of life in the hospital.
- Syringe drivers were available and obtained from a trust wide equipment library. Staff told us they were available out of hours, with a system in place for community colleagues to access them.



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- The trust followed the guidelines within the NPSA Rapid Response Report; Safer Ambulatory Syringe Drivers (NPSA/2010/RRR019) published in December 2010, which advised that ambulatory syringe drivers should change over to devices with specific safety features.
- At the time of inspection there was no formal written syringe driver policy however, the trust subsequently provided us with a syringe driver policy. This was developed on the 28 January 2016.
- The trust provided us with data to show that 1,437 qualified nurses had received training in syringe devices.
- Within the mortuary, there was a separate waiting area for visitors wishing to view the deceased and the environment was calm, peaceful and well organised.
- We saw the mortuary was well equipped and that the capacity was adequate. There was a 95-unit body store. We saw specialist equipment that included bariatric trolleys and five specific body stores. 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.
- The mortuary staff told us that they had not experienced any difficulties involving capacity but they could access the mortuary at the RVI if they experienced problems.

## Medicines

- Patients, who were identified as requiring end of life care, were prescribed anticipatory medicines. Anticipatory medicines are 'as required' medicines that are prescribed in advance to ensure prompt management of pain and other symptoms.
- The trust had produced guidelines for medical staff to follow when prescribing anticipatory medicines. These were available on the trust intranet. Prescribing guidance was also available within the document "Guidance for patients who are ill enough to die" developed by the Northern England Strategic Clinical Networks
- Controlled drugs (medicines controlled under the Misuse of Drugs Legislation and subsequent amendments) were stored securely with appropriate records kept.

- We saw that the SPCT nurses 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 protocol was easy to follow and felt that it worked well.
- We looked at three patients' Medication Administration Records (MAR) and we saw they were completed clearly; including administration of medicines prescribed 'as required'.
- The SPCT nurses were advanced practitioners, which enabled them to prescribe medication for patients, which provided timely administration.

## Records

- There was an alert within the electronic patient recording system when anticipatory medications were prescribed. This ensured the specialist palliative and end of life team, were aware of patients on the acute wards.
- We looked at four patient records. We saw clear documentation within the patients nursing records of SPCT involvement. Outcomes and actions taken were clear and appropriate. We saw patient's daily notes by nursing, medical and therapy staff with updates of any changes in patient symptoms.
- The trust database showed that 100% of palliative care/end of life staff and 86% of the chaplaincy team had completed information governance training.

## Safeguarding

- We spoke with staff around safeguarding. Staff were knowledgeable about the trusts safeguarding policies and their role and responsibilities. Staff could give examples of what constituted a safeguarding concern and how they could raise an alert.
- The trust database showed 100% Palliative Care / End of Life team had completed safeguarding adult's level 3 training. Records showed that 86% of the chaplaincy team had completed safeguarding adult's level 1 training.

## Mandatory training

- All staff providing end of life care and specialist palliative care had completed mandatory training. Data for mandatory training showed 100%.

# End of life care

- End of life care was part of the trust's induction training programme. We spoke with the SPCT nurse who told us there was an expectation of staff to ensure they attended training.
- The end of life lead provided education on new documentation 'Caring for the Dying Patient Document'. Training was to be rolled out across the trust with pilot wards receiving the first sessions. A nurse on ward 13 told us she had received the training and was using the new paperwork. All care of older persons' wards at the Freeman Hospital, had undergone training between September and December 2015, and formally began using the document by the end of December 2015. Specialist Palliative Care Leads told us that there was not a final date agreed as to when all training for the document in the trust would be complete.
- An on-line training package had been created for all clinical staff. This was an electronic learning portal and ensured staff were up to date with the latest policies, procedures and practice.
- Specialist palliative care was provided from 8am to 5pm five days a week. Community SPCT provided on-call cover until 5pm at the weekends. After 5pm, advice was offered through a 'hospice advice line'. This service was available to all staff and patients should they need it.
- There were 21.73 WTE clinical nurse specialists.
- The end of life team consisted of a lead clinician and lead nurse. A band 6 nurse had recently been appointed and would be commencing soon.
- A nurse specialist was starting in March 2016, for three days a week at the Northern Cancer Care Centre. This was for six months initially. The aim of which was to support staff with the roll out of the new Caring for the Dying patient documentation.
- We spoke with the lead nurse in both services who told us there were ongoing plans within the end of life team to review the staffing structure within the service. Additionally there were discussions to deliver a seven-day service within the acute team.
- Within the end of life team, agreement had been reached to fund two band 2 staff to assist patients on the wards. This assistance would provide individualised care to patients, which would support current nursing staff.
- The SPCT also employed two funded Allied Professionals (AHP) staff that provided therapies to patients on the wards such as massage and cognitive behavioural therapy.

## Assessing and responding to patient risk

- Ward staff referred patients to the SPCT who experienced complex symptoms or additional support was required to meet patient needs. Risk assessment tools were in place covering nutrition and hydration, falls and pressure care.
- Ward staff told us the SPCT and end of life team had a visible presence on the wards. Any changes to a patient's condition prompted a visit by the SPCT.
- The SPCT team held a daily team meeting in the morning to discuss ongoing patient care.
- The trust had in place the Northern England Strategic Clinical Network guidance on caring for the dying patient. The guidance included the requirement for the senior clinician in charge of the patient's care to review the patient and to make a plan for symptom management and included daily medical assessment and two hourly nursing assessments.

## Nurse Staffing

- We found staffing levels were sufficient to ensure that patients received safe care and treatment. Nursing staff on the ward told us they felt they had sufficient staffing to prioritise good quality end of life care when needed and that they had a process in place to escalate staffing concerns should they arise.

## Medical Staffing

- The SPCT comprised of 4.15 whole time equivalent (WTE) consultants.
- Medical staff told us that the SPCT were available for specialist advice as needed.
- The consultants within the SPCT did not provide full on-call cover. Ward staff told us they would contact the usual on-call consultant if required.

## Major incident awareness and training

- Major incident and winter management plans were in place on the wards. Senior staff had access to action plans and we saw that these included managers working clinically as appropriate, staff covering from different areas.
- The mortuary manager was fully involved with Newcastle Council in business development planning.

# End of life care

## Are end of life care services effective?

Good



We rated effective as good because:

- The service participated in relevant local and national audits, including clinical audits. Accurate and up-to-date information about effectiveness was shared internally and externally and was understood by end of life care staff. It was used to improve care and treatment and patient outcomes.
- We saw the use of nursing assessment tools within patient documentation, which included the assessment of pain, nutrition, and hydration.
- The trust achieved all of the clinical key performance indicators (KPI's) within the national End of Life Care - Dying in Hospitals Audit 2016 and seven of the eight organisational KPIs. The KPI, which was not achieved, was in relation to face-to-face services by the SPCT at the weekend.
- There was joint working assessment, planning and delivery of patient care and treatment. Ward staff worked together with the specialist palliative and end of life teams to understand and meet the range and complexity of patient's needs.
- When patients were due to move between services or be discharged from hospital their needs were assessed early, with the involvement of all necessary staff, teams and services.
- Staff providing end of life care were qualified and had the skills to carry out their roles effectively and in line with best practice.

However

- The trust did not currently offer a full seven-day palliative care service across acute areas. We saw minutes of governance meetings, which outlined the proposals for improved service provision. The trust had identified April 2018 for full implementation.
- The SPCT advised that for patients who were transferred from hospital to the community, the syringe driver was disconnected at the time of discharge, and reconnected once the patient arrived at home. This posed a risk of

breakthrough pain being encountered. However, all patients we spoke with told us their pain was well managed and that staff were quick to respond to requests for additional medicines when pain occurred.

## Evidence-based care and treatment

- The trust participated in the development and roll out of the new document Caring for the Dying Patient, which replaced the Liverpool Care Pathway. The document included national guidance from sources such as the Leadership Alliance for the Care of Dying People, the Department of Health End Of Life Care Strategy and the National Institute of Health and Care Excellence (NICE).
- Although the Caring for the Dying Patient documentation had only been piloted on a small number of wards, interim guidance 'Care of Patients, who are Ill Enough to Die' was available for staff in their management of end of life processes. To further support and accelerate the rollout and implementation across multiple areas, the trust had reconfigured resources and established a full time band 6-nurse post to focus specifically on the rollout of the Caring for the Dying Patient documentation.
- The service carried out a number of audits to monitor the quality of care and make improvements, for example, an audit of opioids in palliative care in accordance with NICE guideline 140. This was due to be repeated in November 2017. The results found that from a pilot of 20 patients across three wards medication use was appropriate and safe.
- Since July 2014, the trust's guidance on the management of end of life care was based on the priorities outlined in the document One Chance to get it Right. This approach to end of life care was developed by the Leadership Alliance for the Care of the Dying Patient (LACDP 2014) and focused on the needs and wishes of the dying person and those closest to them, in both the planning and delivery of care.

## Pain Relief

- We saw pain assessment tools in place, which were reviewed regularly.
- The SPCT advised that patients who were transferred from hospital to the community the syringe driver was disconnected at the time of discharge, and reconnected once the patient arrived at home. This posed a risk of breakthrough pain being encountered

# End of life care

- Appropriate medication was available in the ward areas, and we saw examples that anticipatory prescribing was being effectively managed.
- When anticipatory medications were prescribed, this activated an electronic alert to the SPCT, end of life and chaplain. This worked as an aid to those teams to advise that there were patients whom may require their services.

## Nutrition and hydration

- The trust used a Malnutrition Universal Screening Tool (MUST), which identified nutritional risks. Records showed that staff followed MUST scoring for nutrition and hydration appropriately.
- Nutrition and hydration needs at the end of life were identified as part of the 'Caring for the Dying Patient' documentation. Prompts were in place to ensure patient choice and comfort was based on an individual's ability to tolerate food and drink.
- We saw accurately completed fluid balance charts; however, they did not show a daily fluid goal.
- Staff told us that snacks were available for patients throughout the day and night. Patients said their nutrition and hydration needs had been met.

## Patient outcomes

- The trust participated in the national End of Life Care - Dying in Hospitals Audit 2016. The results were shown by the use of Key Performance Indicators (KPIs). These were a way to measure how effectively a hospital achieves key objectives or targets. Both organisational and clinical KPIs were measured. The trust achieved all of the five clinical KPI's. These included documented evidence that discussion had occurred with a nominated individual in the last hours or days of life, holistic care planning was in place during the last 24 hours of life and opportunities for the patient to discuss concerns in the final hours of life. For organisational KPI's, the hospital achieved all but one of the indicators. This was in relation to the availability of face-to-face SPCT contact at the weekend.
- The trust collated data using the PaCA (Palliative Care Assessment) outcomes. PaCA is a symptom-scoring tool, which provides numerical data to help quantify the success of palliative care interventions. The PaCA

outcome data for 2014 confirmed the significant impact the specialist palliative care teams made on patients problems (both physical and non-physical) and the trust continued to collect this data for the next financial year.

## Competent staff

- Staff told us they had received an annual appraisal. Trust data showed, 58% of staff had received an appraisal in the palliative care team. The chaplaincy team at the Freeman showed a 67% rate against a trust target of 95% and staff told us that there were plans in place to improve this.
- Allied health professionals (AHPs) and mortuary staff showed 100% appraisal rate.
- SPCT staff told us they welcomed opportunities for colleagues to shadow the team. We saw examples of this such as trainee paramedics working with the SPCT.
- We saw that the porters had the right skills and experience when dealing with end of life or deceased patients. We met two mortuary staff at the hospital. They were experienced in supporting bereaved families.
- A SPCT nurse told us that SPCT staff required specific qualifications in a relevant field of end of life care, to work within the team and this was part of the recruitment process.
- The SPCT AHP staff were trained in many specialist areas, such as acupuncture, anxiety management, cognitive behavioural therapy and rehabilitation.
- Qualified nurses were encouraged to spend time shadowing the SPCT (usually within their third year post qualifying).
- The specialist palliative care team of nurses and doctors were skilled and knowledgeable. They were experienced in providing support and training to other staff. For example, symptom control, opioid prescribing, DNACPR, palliative care emergencies and legal and ethical training.

## Multidisciplinary working

- We saw positive examples of multidisciplinary team (MDT) working between the ward nurses and the SPCT.
- The SPCT participated in MDT meeting's every week. We observed an MDT in process, which was comprehensive and discussed patient treatment outcomes, disease progression and liaison with a variety of disciplines such as medicine, physiotherapy and occupational services.

# End of life care

- The SPCT worked in a collaborative and multidisciplinary manner. The service included spiritual support from the chaplaincy team and bereavement support from the bereavement centre.
- Twice a year the acute end of life and SPCT met with the community teams to discuss key issues.
- Staff on the wards told us they saw members of the SPCT and end of life team regularly to deliver training or provide staff with support.

## Seven-day services

- Although seven-day services were not in place, there were plans to provide a seven-day service with an integrated service trust wide by April 2018. Community SPCT provided weekend support 9am -5pm.
- The mortuary was able to release bodies 24 hours a day, seven days a week.

## Access to information

- An interim guidance sheet 'Guidance for care of patients who are ill enough to die' was provided as laminated sheet on all wards. This ensured staff were consistent in their management of end of life processes in the absence of the full Care of the Dying documentation.
- Information regarding fast track discharge and referral process to the SPCT was available on the intranet.

## Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- The trust had a policy in place regarding consent, which was in line with Department of Health guidelines, the use of advanced decisions, advocates and mental capacity guidance.
- Staff we spoke with all had confidence of their understanding of the Mental Capacity Act and Deprivation of Liberty Safeguards.
- We saw nursing staff seek consent from patients prior to assisting with personal care.
- We viewed nine DNACPR forms when visiting the wards and found these were completed correctly.
- DNACPR forms were kept in the front of patient notes for ease of access to staff. The trust completed DNACPR audits. A re-audit of DNACPR in June 2015, showed that there were 1,344 in-patients at the time of the audit and 108 (8%) had a DNACPR in place. 57% were written on the old version of DNACPR, 41% showed that the patient

had been involved in the discussion and all except one was within the required review date. Recommendations were shown following the audit, with time specific actions in place.

## Are end of life care services caring?

Good



We rated caring as good because:

- All feedback we received from patients regarding their end of life care was positive.
- Patients were involved in their care and we observed care that was attentive and sensitive to the needs of patients. Staff treated patients with dignity and respect.
- We saw examples of care provided where staff had gone the extra mile to ensure patients personal, cultural, social and religious needs were taken into account.
- Patients felt involved in their care and patient's social needs were understood.
- Patients' feedback or views on their experiences were regularly collated through the patient and carer satisfaction surveys. In addition, bereavement services carried out customer care audits.
- Patients and their relatives had good emotional support from the bereavement office and ward staff.

## Compassionate care

- We observed staff interacting with patients on the wards with compassion.
- Although the trust did not record friends and family data specifically for end of life care, we saw for example that within cancer services at the Freeman hospital the SPCT carried out a satisfaction survey between August and October 2015. The survey showed the majority of patients felt highly supported, involved in decisions affecting their care and 100% stated they felt satisfied with the service overall.
- The bereavement services team carried out a bereavement services customer care audit. The Freeman hospital results were positive showing that 47% of responders strongly agreed that they were treated with dignity and respect, 30% agreed, 5%



# End of life care

neither agreed nor disagreed and 15% did not know. 42% felt strongly that staff were helpful and they were well informed, 33% agreed, 6% neither agreed nor disagreed.

- We saw some examples of outstanding practice by the chaplaincy. One example included the communication made by the chaplain at the Freeman Hospital to Malaysia airlines to advise of the urgency to bring the relative of a terminally ill patient to Newcastle as soon as possible.
- The chaplaincy held a range of memorial services throughout the year including the children's heart unit, haematology, motor neurone disease and we saw positive feedback following these services.
- We visited four wards. Staff were aware of patients who were receiving end of life care. They were able to discuss their needs and the support that they required. They showed a good understanding and demonstrated compassion and respect.
- We saw information readily available offering advice for relatives with guidance on viewing arrangements, how to register a death, organ and tissue donation, funeral arrangements and a list of advice and support organisations and how to contact them.
- During our inspection, we visited the mortuary and spoke with the mortuary staff. Staff went the extra mile and we saw several examples of outstanding care. On discussion, staff were able to demonstrate compassion, respect and an understanding of preserving the dignity and privacy of patients following death.

## Understanding and involvement of patients and those close to them

- We saw that clinical staff spoke with patients about their care so that they could understand and be involved in decisions being made.
- There was evidence of patients and/or their relatives being involved in the development of their care plans.
- We saw that the 'Caring for the Dying Patient' document used by the trust included prompts to assist staff with patients and their relatives to ensure holistically planned care. Families were encouraged to participate in care and provide feedback through surveys.
- We saw that bereavement packs were available in the ward areas with information about access to support.
- Information was available for patients and their relatives around different aspects of care at the end of life. This included what to expect and coping with bereavement.

## Emotional support

- During our inspection, we visited patients who were in receipt of end of life care. Patients spoke positively about the way they were being supported with their care requirements.
- Throughout our inspection, we saw that all staff were responsive to the emotional needs of patients and their visitors.
- The chaplain was able to refer families and patients directly to counselling services.
- Staff were able to access counselling support through the staff welfare scheme. We saw posters in the staff rooms offering counselling courses for staff.
- We saw evidence of links to specialist nurses to support patients with respiratory problems, breast cancer, transplantation and dementia.
- The senior leads told us that two band 2 staff had been recruited to join the end of life team. The purpose of these staff was to spend quality time with patients to provide emotional support, which may not always be possible on busy acute wards.

## Are end of life care services responsive?

Good



We rated responsive as good because:

- Ward and SPCT staff responded to patients' individual needs in a timely and co-ordinated manner. The trust worked effectively with key stakeholders to improve quality standards for end of life care.
- There were purpose built rooms available in the Northern Centre for Cancer Care. Facilities were newly designed and were sympathetic to the needs and requirements of patients.
- Fast track discharges were managed efficiently. Patients received support out of hours.
- We saw that the trust was supporting the increasing numbers of non-cancer referrals.
- We saw evidence of learning following complaints and feedback provided to staff following issues and concerns.

However



# End of life care

- Although some audit did take place, the trust did not formally collate data on preferred place of death but acknowledged that future audits would identify this.

## Service planning and delivery to meet the needs of local people

- Newcastle Clinical Commissioning Group had commissioned the Clinical Standards Care project, funded for one year, commencing October 2015. It would facilitate primary care teams in implementing Newcastle Primary Care Palliative Care standards. These local standards were underpinned by the 'NICE: Quality standard for end of life care for adults (2013)', the five Priorities of Care identified in 'One Chance to Get It Right (2014)', and the five assessment domains which were the focus for the Care Quality Commission.
- The trust participated in a number of quality improvement projects. The Nursing home project involved 10 care homes and was aimed at supporting care homes to deliver excellent end of life care.
- The SPCT was working with the Trust Education Group (TEG) to scope and develop education initiatives around palliative and end of life care.
- The spiritual and religious care group met on a regular basis and were chaired by a non-executive board member. The chaplains represented a diverse group of faiths
- Joint working between the trust and Marie Curie had enabled the appointment of two Nurse Practitioners. These nurses with enhanced skills worked alongside two of the hospital teams to develop a robust partnership approach and promote seamless care between the two organisations.

## Meeting people's individual needs

- The trust had introduced a Specialist Palliative Care Rapid Assessment Team (SPRAT) for patients who had an identified palliative care diagnosis with specialist needs. Medical practitioners and community nurses could make referrals.
- Nursing staff told us they could access specialist nurses relating to dementia and learning disabilities to ensure specialist knowledge.
- We saw a designated ambulance service specific to end of life care for patients requiring urgent discharge home or for complex patients who required admission to hospital or hospice for symptom management. The

response time was one hour and the service was offered seven days a week including bank holidays. Services were based within the emergency assessment suite within the hospital and available in the community. An emergency care technician led crew who had undergone palliative care training operated the ambulance.

- The wards had a relaxed visiting policy for relatives to visit patients who were at the end of life. Family members who wished to stay with their relatives were encouraged to do so.
- Ward staff offered side rooms to families and relatives.
- Comfort packs and refreshments were provided to relatives and friends wishing to stay with patients.
- Interpreters were available within the trust and we saw information relating to these services.
- The trust recently commenced the distribution of the family's voice to patient's friends and family. The family's voice is a voluntary diary, which families and health professionals maintain during a patient's end of life care.
- We saw leaflets, which were produced for patients and their families regarding the SPCT, bereavement office and mortuary.
- The mortuary at the Freeman hospital offered viewings from 9am–9pm but accommodated requests outside of these times.
- The mortuary at the RVI was the only facility in the region, which offered a ritual washroom, and this was available for patients using the Freeman Hospital.

## Access and flow

- The SPCT were available Monday to Friday from 9:00am to 5:00pm. This meant they were able to respond to requests to see patients in a timely way. The community SPCT ran a weekend on-call service until 5pm. After 5pm, a hospice advice line ran by St Oswald's Hospice, offered patients and staff support.
- The trust did not formally capture preferred place of death as they felt patients 'changed their minds' and therefore the data would not be accurate. However, we saw some audit activity, which demonstrated that Allied Health Professionals (AHP) had started to record this information. The data showed that 76% of patients seen by the SPC AHP team were discharged to their preferred place of death
- Ward staff told us they knew how to access the SPCT and that the team were responsive to the needs of patients.

# End of life care

- The SPCT told us that all referrals were actioned within 48 hours; we saw many were actioned within 24 hours.
- There were no delays to discharge patients requiring end of life care at home. However, staff told us that there was a lack of social care in the community, which could prevent patients receiving care at home.
- Between January and December 2015, there were 1990 adult hospital deaths. The number of non-cancer patients referred to the SPCT was 643 (18%) between April 2014-March 2015. The number of cancer patients was 2,834 (82%) referred to the SPCT during the same period.
- Excluding The Northern Centre for Cancer Care the percentage of non – cancer referrals had increased from 12% to 26% in the last 4 years.
- There was a robust referral system, which ensured that the most complex cases were seen by the service quickly. The trust offered a rapid discharge service for patients who expressed the wish to die at home. The Specialist Palliative Care Team (SPRAT) provided rapid assessment (within 1 hour). This was offered to patients at home or in a care home. This service had the capacity to work within the emergency department and facilitate rapid discharge home again if required. Between April 2014 and March 2015 referrals to rapid response seen within one hour was 100%.
- Between April 2014 and March 2015 outpatient referrals seen within 24 hours within the Northern Centre for Cancer Care was 89%.
- The trust had introduced a patient flagging system called RAPA. A RAPA alert was a notification of the patient's admission. The aim of this alert was to make end of life staff aware that a patient may require services from the team.

## Learning from complaints and concerns

- Information was available in the hospital to inform patients and relatives about how to make a complaint.
- Staff were aware of their responsibility in supporting patients and families who wished to make a complaint.
- Ward staff told us they received very few complaints regarding end of life care.
- We saw specific data relating to complaints relating to end of life showing concerns relating to poor communication and responsiveness relating to end of life planning. Staff told us that feedback was always given following complaints and staff felt there was an honest and open culture within the service.

- The lead clinical nurse would generally investigate complaints relating to end of life.

## Are end of life care services well-led?

Requires improvement



We rated well-led as requires improvement because

- The Caring for the Dying Patient document to replace the Liverpool Care pathway although fully embedded in the community had only been piloted on a small number of wards in the acute hospitals with ward-based training being prioritised according to the number of patients at the end of life. In total 16 wards had received this training by February 2016. Interim guidance was available for ward staff, which outlined initial and subsequent assessments, regular documentation of care delivered, interventions and care after death. Plans were in place to roll out training for the new documentation across all wards but there were no formal timescales to specify this at the time of inspection.
- Although risks were identified in the End of Life and Palliative Care update reports to the Board, there was no end of life care risk register used to identify and monitor risks.
- Whilst ward staff were engaged in the provision of end of life care there appeared to be a lack of understanding of the strategies and priorities for end of life care by ward staff. The trust had taken steps to engage with staff to increase awareness of the strategy.
- Although there was some audit for monitoring if, patients achieved their wish for their preferred place of death this was limited and was not routinely identified. The trust acknowledged that future audits would include this.

However

- The trust had an approved Palliative and End of Life Care Strategy 2015 – 2018. It included strategic aims, core values of the service and key outcomes.
- Patient safety and quality was addressed through governance processes and there was evidence of improvement.

# End of life care

- Staff felt proud of the quality of care that they gave to patients at the end of life, and there was positive feedback from nursing and medical staff for the support they received from the SPCT. There was an open and honest culture.
- Views of patients and relatives were included in data collection processes and used to improve the quality of care.

## Vision and strategy for this service

- The trust had an approved Palliative and End of Life Care Strategy for 2015 – 2018. This included strategic aims, core values for the service and key outcomes. Although ward staff were clear about the core values of the care of the dying there appeared to be a lack of understanding of the strategies and priorities for end of life care. The trust had taken steps to proactively engage with staff and increase awareness of the strategy.
- We saw discussions regarding end of life care at board level. These took place at regular intervals and covered a broad range of topics.

## Governance, risk management and quality measurement

- Specialist palliative care team meetings were held daily to discuss patient progress and care. The palliative care consultant led these.
- Patient safety and quality was addressed at the end of life strategy group meetings. We saw minutes of these meetings which included improving patient experience, reviewing DNACPR data, palliative care funding, national and internal audits and on-going priorities.
- We saw the end of life incident log and saw action was taken and learning following incidents.
- The trust participated in the End of Life Care - Dying in Hospital audit. The results for 2016 showed that the trust met all clinical indicators with some areas scoring 100%, and achieved seven of the eight organisational indicators.
- Risk were identified in, the End of Life and Palliative Care update reports to the Board. This included funding to continue the Allied Health Professionals project and the completed roll out of the Caring for the Dying Patient documentation, however, there was no end of life care risk register so it was not clear how risks were identified and continuously monitored.

- Although there was some audit for monitoring if, patients achieved their wish for their preferred place of death this was limited and was not routinely identified, the trust acknowledged that future audits would include this.

## Leadership of service

- The Director of Nursing and Patient Services was the nominal Executive lead for end of life care at Trust Board level, and the Deputy Director of Nursing and Patient Services was in practice the lead.
- The SPCT was interdisciplinary and included consultants in palliative medicine and nurse specialists. There was a lead consultant in palliative medicine and a lead nurse for end of life care. In addition, there was an advanced Macmillan specialist Occupational Therapist as part of a four year funded project based at the RVI and Freeman hospitals.
- Specialist palliative care line management was divided between cancer services directorate (medical staff) and the patient services directorate (all other staff).
- Staff we spoke with told us that team leads were visible and that they felt well supported.

## Culture within the service

- Staff at ward level told us end of life care delivery was part of their daily role. They spoke positively of the involvement of the SPCT.
- There was evidence that ward staff felt proud of the care that they were able to give and there was positive feedback from the nursing and care staff as to the level of support they received from the SPCT.
- Nursing staff told us they felt valued and part of a team that 'listened'.
- Staff were open about reporting incidents and concerns and felt there was a 'no blame culture'.

## Public engagement

- We saw that the trust gathered views and opinions of patients and relatives. The trust participated in the National Care of the Dying in Hospital audit and had recently commenced the distribution of the family voice to patient's friends and family. The family's voice is a voluntary diary, which families and health professionals maintain during a patient's end of life care.

# End of life care

- Allied Health Care Professionals carried out a postcard survey of patient and carer views. The survey was conducted over three months, with a finish date of 31 March 2016. Return rates were less than 10% but comments were generally positive.
- The SPCT patient and carer satisfaction survey 2015, evaluated three areas, which included communication and information, personal treatment by staff and patient involvement in care. The sample size was small with 20 patient and 13 carer questionnaires returned, although 100% of patients expressed overall satisfaction with the service.
- The team was one of the 11 pilot sites nationally to participate in the Public Health England National Palliative Care Clinical data set pilot. The pilot introduces a suite of measures in line with palliative care funding and validated outcome measures, including patient and carer views on care and support.
- Following a successful pilot in 2015, the end of life team secured Macmillan funding for three Macmillan health care assistants who provided an individualised service to patients and families across the acute settings regardless of diagnosis.
- There was an integrated model of care, working with the Cardiothoracic Transplant Team. Specialist palliative care had worked alongside patients with advanced disease including those waiting for transplant and those with ventricular assist devices. This service innovation resulted in presentations at national conferences (Association of Cardiothoracic Anaesthetists/Society of Cardiothoracic Surgeons national conference, as well as a national palliative care meeting) and publications.


## Staff engagement

- We observed the SPCT morning team meeting. All staff, except community, attended this. We saw the meeting gave the opportunity for all members of staff to raise items on the agenda. Staff felt confident to raise issues that were relevant to their role.
- Trainee paramedics attended SPCT morning meetings from Teesside. Trainees spend time in both acute and community settings. Staff members of the SPCT told us they attended ward level meetings regularly. Additionally, they had been involved in regional forums, which were attended by key partners within the region.
- The AHP team following the publication of an article in the Occupational Therapy News were asked to present at the National HIV/ Aids, Oncology and Palliative Care Conference.
- We saw effective communication between the SPCT and ward nurses in relation to patient care.

## Innovation, improvement and sustainability

- The Allied Health Professionals part of the service had been shortlisted for the third year in a row for the National Macmillan Achievement Awards.
- An innovative service development with the Respiratory Team working with Cystic Fibrosis patients was shortlisted for an award and gained national interest. The service had a part funded consultant post from the Transplant Institute which allowed development of Specialist Palliative Care Service to work alongside patients undergoing heart, lung and liver transplant. The trust had funded a Senior Nurse Band 8 full time post and two programmed activities for a consultant dedicated to end of life care.

# Outpatients and diagnostic imaging

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

## Information about the service

The Patients Services directorate managed outpatients and they provided 834,122 outpatient appointments at the Freeman Hospital in the year before our inspection they provided outpatient services with up to 2700 clinics per week across all sites and a range of specialties including general medicine, general surgery, cardiology and thoracic medicine, renal and urology, with separate clinics for ENT. The Northern Centre for Cancer Care (NCCC) at the Freeman Hospital site offered outpatient services for cancer diagnosis and treatment.

The Radiology Directorate Freeman Hospital provided outpatient services between 8am and 8pm Monday to Friday with some clinics held to reduce waiting lists on Saturdays. Fracture clinics were open every day, including weekends and bank holidays, across the main sites of RVI and the Freeman Hospital.

The Radiology Directorate managed diagnostic imaging (x-ray) departments, screening and diagnostic services including radiology (where staff carried out x-rays and other related studies), therapy, and pathology for the people of Newcastle upon Tyne and further afield including the north east of England and Cumbria. Diagnostic imaging services offered x-ray and scanning facilities and provided 587,294 diagnostic imaging appointments across all sites in the trust. An average of 7,000 scans was carried out each month and these included CT, MRI, and ultrasound scans. The Nuclear medicine department within the NCCC provided specialist scans and treatments using radiation via a wider range of modalities and systems.

Pathology (laboratory testing) services were provided from laboratories and at the point of care for patients from all services across the trust. The trust processed 3,082,496 laboratory requests across all sites in 2014/15.

We inspected outpatient and diagnostic imaging services at Freeman hospital including the NCCC.

We spoke with 21 patients and three people close to them, 35 members of staff and looked at 13 patient records.

# Outpatients and diagnostic imaging

## Summary of findings

We rated outpatient and diagnostic imaging at Freeman Hospital 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.
- There were sufficient staff of all specialties and grades to provide a good standard of care in all departments we visited. The departments were clean and hygiene standards were good. Staff had enough personal protective equipment in all the areas we inspected and staff knew how to dispose of items safely and within guidelines. Staff ensured equipment was clean and well maintained.
- Staff and managers had a vision for the future of their departments and followed systems and processes to monitor risks and gather information about patient experiences. Staff felt supported by management and encouraged to discuss and learn from incidents and complaints and to improve their practice.
- Management supported staff who wanted to work more efficiently, develop new ideas and carry out research projects.
- Communication was effective between senior management and staff, and there was good overall leadership of staff to provide good patient outcomes in the outpatients and diagnostic imaging departments. There were well-organised systems for organising clinics. The departments were well led, proactive and all staff worked in teams 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

- Diagnostic imaging reporting turnaround times for inpatients and A&E patients did not match national best practice guidance.



# Outpatients and diagnostic imaging

## Are outpatient and diagnostic imaging services safe?

Good



We rated safe as good because:

- There was sufficient staff of all specialties and grades to provide a good standard of care in all departments we visited.
- The departments used an electronic system to report incidents. All the staff we spoke with knew how to use the system. Managers and governance leads investigated incidents and shared lessons learned with staff.
- The departments were clean and hygiene standards were good. Staff had enough personal protective equipment in all the areas we inspected and staff knew how to dispose of items safely and within guidelines. Staff ensured equipment was clean and well maintained, so patients received the treatment they needed safely.
- Medical records were stored electronically and transported securely. Records showed patient notes were ready for patients attending clinics 99.1% of the time.
- Staff in all departments knew actions to take if a patient's condition deteriorated while in each department and at each site. They carried out risk assessments to check patient conditions, were able to call for help and transfer a patient to the Accident and Emergency Department. They knew the actions to take in case of a major incident.

### Incidents

- The departments had robust systems to report, learn from incidents and reduce the risk of harm to patients. Staff told us that the culture was one of honest reporting and a positive move towards change.
- The trust used an electronic programme to record incidents and near misses. Staff we spoke with knew how to use the programme and report incidents. Staff could give examples of incidents that had occurred and investigations that had resulted in positive changes in practice.

- Managers told us that the incident reporting procedures allowed staff at all levels and across multidisciplinary teams to reflect on practice. The matron gave feedback in monthly safety briefing meetings to all staff.
- Staff gave examples of learning from incidents. For example, a child had removed the mould from their hearing aid and swallowed it. Audiology teams were working together to produce a better design that could not be dismantled.
- There had been no serious incidents in the previous 12 months. There had been 183 incidents, of which 30 were classed as moderate and three major incidents, reported in the four month period from June to September 2015 across all outpatient departments and sites at the trust. Themes included patient information errors, clinic waiting times including delays due to staff shortages and overbooking.
- Staff understood their responsibilities of the recently introduced Duty of Candour regulations and all staff described an open and honest culture. Staff described this as a critical element of how people learn from mistakes, improve and move on. Directors and managers told us that there was a very positive culture of support amongst staff. Department staff gave examples of how they had informed patients immediately when minor errors had occurred.

### Diagnostic Imaging:

- There were 142 incidents across all services within radiology across the sites, none of which were classed as major. There had been nine near-miss radiological incidents, eight of which involved duplicate requests for procedures, which were all identified by staff before imaging was carried out and unnecessary procedures were cancelled.
- There had been 15 radiological incidents reported under ionising radiation medical exposure regulations (IR(Me)R) during the period 01/04/15 to 30/09/2015 in comparison to 13 reported in the same period of the previous year. These were all low level and included referrer-initiated errors; duplicate requests for investigations. There were a small number of wrong-site investigations, or wrong patient requests. A small number of overexposure incidents were related to Image Guided Radiotherapy (IGRT), which required verification scanning prior to treatment. If the image field needed to be amended slightly then a repeat scan

# Outpatients and diagnostic imaging

would be taken. Radiologists told us these incidents were clinically insignificant when considering the amount of scans and exposure the patient would undergo in their total radiotherapy treatment.

- Staff gave an example of learning from incidents when the department had developed a safety check following a Medicines and Healthcare Products Regulatory Agency (MHRA) alert from an incident at another trust. This was to ensure the correct injection fluid was used in imaging rooms when the lights were dimmed. A simple system was developed where a bung was fitted to the end of the syringe to ensure staff had time to pause and check.
- The radiation protection committee had reported that the frequency and severity of incidents were within national norms for a trust of this size. There was evidence to show staff had checked all radiological incidents, taken appropriate action, and had learned from them.
- Consultants and reporting radiographers discussed radiology discrepancy incidents by case review. Staff took the opportunity to learn, worked as a wider team to undertake root cause analysis and liaised with the specialty medical teams across the trust. Managers told us that some very positive learning had arisen from these events.

## Cleanliness, infection control and hygiene

- Staff carried out daily and weekly cleaning regimes and nursing staff adhered to procedures for setting up and clearing each clinic.
- Staff measured compliance with knowledge and practice around environmental cleanliness, infection prevention and control and uploaded results from all departments to the Clinical Assurance Tool (CAT) that showed consistently high compliance rates at 100% during our inspection and 93% or above for the past six months. Staff received infection control information at meetings and collated data for the Infection prevention team, departmental managers and outpatient's department infection control link nurse.
- 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

- Equipment in the departments was calibrated, maintained and the medical electronics department managed maintenance contracts.
- The trust provided single sex and disabled toilets and these areas were clean.
- All patient areas were spacious and bright. Staff ensured that consulting, treatment and testing rooms were well stocked.
- We found that resuscitation trolleys for adults and equipment including suction and oxygen lines were locked and tagged and staff made regular checks of contents and their expiry dates. No drugs had exceeded expiry dates.
- Reception areas were open plan and spacious. 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 outpatient 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.

## Diagnostic Imaging:

- The design of the environment within diagnostic imaging kept patients safe. There were radiation-warning signs outside any areas 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.
- Staff wore dosimeters (small badges to measure radiation) and lead aprons in diagnostic imaging areas

# Outpatients and diagnostic imaging

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 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.
- There were three radiation protection advisors (RPAs). An RPA is a professional Health Physicist whose competence has been accredited by the Health and Safety Executive (HSE) as meeting the criteria for appointment under the Ionising Radiation Regulations. The RPA's provided advice on the restrictions of exposure to radiation and the controls, procedures and equipment that ensure limited exposures to radiation. The RPA would advise on radiological training schemes, hazard assessments and contingency planning.
- A radiation waste advisor (RWA) was appointed in October 2015. The role of the RWA included ensuring that systems were in place for the safeguarding of radioactive materials, for the safe disposal of radioactive waste and ensuring all requirements of the Radioactive Substances (Basic Safety Standards) Regulations 2000 were satisfied.
- Radiation Protection Supervisors (RPS) carried out risk assessments across all modalities with ongoing safety indicators for all radiological equipment and its use by staff. These were easily accessible to all diagnostic imaging staff. The role of the RPS included supervising work-involving radiation and ensuring it was done within 'local rules'. The list of trained RPS staff was up to date. The Radiation Protection Advisors (RPA) had risk-assessed ionising radiation equipment to ensure the safety of staff and patients. Specific testing and reporting had taken place during the previous 12 months on all equipment including radiographic tubes and generators, ultrasound, CT, MRI and image intensifiers.
- Staff in diagnostic imaging demonstrated safe working methods to record patient doses for radiation.

## Medicines

- We checked the storage of medicines and found staff managed them well. No controlled drugs were stored in

the main outpatient 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 procedure for the safe use and security of prescription pads. All pads were logged and empty pads were destroyed.
- In the diagnostic imaging and breast screening departments, some patients having interventional procedures would need sedation and pain relief and these included controlled drugs. Medical staff prescribed controlled drugs and nursing staff stored them securely. They maintained and audited records and logs appropriately and according to trust standards.

## Diagnostic Imaging:

- Patient group directions (written instructions for the supply or administration of medicines) for radiological contrasts and drugs used in MRI, CT and nuclear medicine were in date, completed and reviewed.

## Records

- Records in the outpatient departments 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, and personal information, medical, nursing, and allied healthcare professional interventions. Records had been unified in 2007 but some historical case notes were still in use. A patient with multiple conditions may have several separate sets of medical records (up to 12 specialties had separate notes). Managers told us that letters and results being available to all clinicians electronically mitigated any risk of missing information at an appointment. The only notes that might be missing would be handwritten notes and letters. Staff told us this system was not ideal but was well managed and notes were logged and rarely unavailable for clinics.
- The medical records department had begun using a gun reading system to locate patient records in any department. Staff told us that this system had reduced the occurrence of missing notes. In the latest audit

# Outpatients and diagnostic imaging

carried out in November 2015, 98.6% of all full patient notes were available in clinics. Some further areas for improvement had been identified. However, no action plans had been documented.

- Referral letters and discharge summaries were stored electronically and provided back up when patients' notes were unavailable.
- Staff managed records and their preparation for clinics in outpatients and, in the latest audit carried out in November 2015, 98.6% of all full patient notes were available in clinics. Some areas for improvement had been identified. However, no action plans had been documented.
- Records were stored securely at outpatient reception areas in preparation for outpatient clinics. Patient notes were kept on open shelves at each clinic suite but staff assured us that no patients were unaccompanied or waited in clinic areas so staff were confident that records were safe and confidential until the point of need.
- We reviewed 13 patient records that were completed with no obvious omissions.

## Diagnostic Imaging:

- Patient information, pathology reports, diagnostic images and reports were stored electronically and available to doctors through Picture Archiving and Communications System (PACS) and Radiology Information System (RIS).
- Staff used electronic 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. Staff gave examples of putting safeguarding procedures into practice for concerns around vulnerable adults and children. They knew they could ask for support if they needed it or they had a query.
- The incident reporting system provided a reminder for staff to follow the trust safeguarding policy and procedure and refer patients at risk of harm or abuse.
- There was designated safeguarding lead for the outpatient departments and senior staff were involved with the trust safeguarding committee.

- Information provided by the trust showed that 100% of applicable staff in outpatients had completed all safeguarding adults and children modules.
- Between 85% and 100% of staff across radiology had completed safeguarding adult's level 1 and level 2 training. Between 50% and 100% of staff had completed safeguarding children level two training as part of their mandatory training. The trust target was 95% 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 a range of e-learning modules. Staff used e-learning as an accepted method of learning. Modules included patient handling, infection prevention and control, basic life support, prevention of patient falls and safeguarding adults and children.
- Managers in the outpatient 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 was 100% for all staff groups. Staff were very proud of this result.
- In diagnostic imaging, the training compliance rate measured in June 2015 was 87.4%. Current figures held by the manager showed similar results. The trust target was 95% and managers showed us plans for staff to attend training so that targets would be met by the end of March 2016.

## Assessing and responding to patient risk

- Outpatients and diagnostic imaging staff completed risk assessments including national early warning score (NEWS), pre-assessment for procedures and pain assessments when required. Nurses recorded these in patient records and escalated any concerns to medical staff in clinics.

# Outpatients and diagnostic imaging

- 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 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 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 cardiac catheter suites used the WHO safer surgical checklist for all interventional procedures. Checklists were audited and changes made in line with good practice where processes were different.

## Diagnostic Imaging:

- 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.
- Diagnostic imaging policies and procedures were written in line with the Ionising Radiation (Medical Exposure) 2000 regulations IR(ME)R.
- Named and certified radiation protection supervisors (RPS) provided advice when needed to ensure patient safety. The trust had radiation protection supervisors (and liaised with the radiation protection advisor (RPA)).
- Arrangements had been agreed for radiation risks and incidents defined within the comprehensive local rules. Local rules are the way diagnostics and diagnostic imaging work to national guidance and vary depending on the setting. Staff ensured policies and processes were written and agreed to identify and deal with risks. This met with (IR(ME)R 2000).
- Radiology 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 fetus. 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.
- Radiology staff had undergone training with paediatric nurses on how best to address questions around possible pregnancy with young girls and women. They had organised raising awareness sessions with radiographers to improve confidence when asking questions of girls aged between 11 and 19.
- 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.

## Nursing and allied health professional staffing

- We looked at the staffing levels in each of the outpatient areas.
- There were no departments with significant vacancies. Managers told us that staff retention was high. Managers, doctors and nurses told us there were enough staff to meet service and patient needs and they had time to give to patients.
- Clinical nurse specialists led their own clinics and supported clinics throughout the outpatient departments.
- All department managers told us that staff were flexible to ensure they provided cover for each clinic and department. Managers could adjust the number and skill mix of staff covering clinics to help those that were busy or where patients had greater needs.
- Outpatient departments used some trust bank staff and ensured they received local induction. However, some staff were used regularly and were encouraged to apply for permanent posts when vacancies arose.
- Managers compiled rotas based upon activity within the departments and staff regularly volunteered to work overtime to provide support at extra clinics arranged to prevent extended patient waiting times.
- Managers told us staff sickness rates in outpatients were measured in June 2015 and the directorate's sickness absence rate was 3.15%, this was better than the national average of 3.4% but marginally higher than the trust's target of 3%. Over the previous 12 months, there has been a slowly improving trend in absence. This was due to a number of long-term sickness absences having ended.



# Outpatients and diagnostic imaging

- Breast clinic senior staff had carried out an audit of staff working hours because of an increasing number of instances where patients may have additional needs and require a longer appointment time. Staff had developed a formal rostering system to identify those working a later shift and to reduce overtime hours.

## Diagnostic Imaging:

- There were vacancies for radiographers in CT, MRI and ultrasound. Managers reported that staff were being recruited, including some sonographers from overseas and the departments openly encouraged training and development into new roles. Locums had been used to backfill staff who were undergoing training. The department were planning to expand the sonographer role to do more interventional work and employ a consultant sonographer. A regional ultrasound manager post had been established.
- The diagnostic imaging department had experienced some staffing difficulties due to sickness in MRI and ultrasound. The manager had organised increased staffing of the service gap by agency radiographers. This included providing seven-day service cover where possible. They had recruited new staff, including some sonographers from abroad, and identified existing staff interested in sonographer training.
- Eight specialist radiology nurses 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. Some interventional procedures were carried out entirely by nurses for example peripherally inserted central lines. There were currently two nurse vacancies and the trust nurse bank had recruited one new radiology nurse who had recently retired from their main post.
- There were seven reporting radiographers and an additional two in training. They reported plain film x-rays and were supported by radiologists.

## Pathology:

- In the last year, three large acute pathology facilities had merged to form a new pathology service at Gateshead, a neighbouring NHS Trust. Staff from all over the region had moved to the new facility and all other local trusts felt the loss of staff on top of national shortages of qualified and experienced lab staff. However, the

laboratory had managed staffing and the trust, maintained full United Kingdom Accreditation Service (UKAS) clinical pathology accreditation (CPA), and was Medicines and Healthcare Products Regulatory Agency (MHRA) compliant for its transfusion service.

## Medical staffing

- Medical staffing was provided to the outpatient department by the various specialties that ran clinics. Medical staff undertaking clinics were of all grades; there were consultants on duty to support lower grade staff when clinics were running. Some specialist trainee doctors had their own caseloads and delivered outpatient clinics when consultants were away. Staff would adjust clinic formats accordingly.
- Consultants told us that there was good succession planning in specialties with specialist registrars experiencing good training and choosing to stay at the trust.

## Diagnostic Imaging:

- There was a national shortage of radiologists. However, the trust had no vacancies and was able to recruit to new posts in the previous 12 months. There were three paediatric radiologists and 20 specialist registrars in post. There were 40 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 capacity requirements.
- Trust radiologists carried out diagnostic imaging reporting. However, some reporting was outsourced to manage reporting backlogs. The trust aimed to use these services as little as possible. The clinical director and business manager assured us that images for urgent cases and cancer pathway patients were filtered out of the system efficiently. There were service level agreements in place and staff audited quality and timeliness of reporting appropriately.

## Pathology:

- The department had consultant vacancies in microbiology and histology. Managers told us that there were additional recruitment difficulties because other providers were attracting staff.



# Outpatients and diagnostic imaging

- The department were developing advanced practitioner posts to extend roles and address the shortage of consultant histopathologists. Some triaged and non-urgent histopathology work was outsourced in order to meet trust-reporting standards.

## Major incident awareness and training

- Major incident plans were in place and last reviewed and updated in April 2014 with a review due in 2017. Maintenance of the plan was the responsibility of the major incident steering committee and reviewed annually.
- There was a major incident policy and staff understood their roles in case of an incident.
- There was a lockdown policy in place approved by the Resilience and Response Strategy group. The policy enabled the lockdown of buildings and sites owned by the trust in response to an anticipated or presenting threat or hazard. Processes were in place for monitoring compliance with the policy.
- 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. Potential risks were taken into account when planning services and consideration given regarding seasonal fluctuations in demand, the impact of adverse weather, and any disruption to staffing levels. Staff discussed action plans and implemented them as necessary.

## 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.
- Staff in the departments and across trust sites were competent and multidisciplinary teams met regularly across a range of services and specialties and included both medical and non-medical staff. Staff at all levels

felt supported by their line managers, who encouraged them to develop and improve their practice. The departments supported staff who wanted to work more efficiently, be innovative, and try new services and treatments.

- 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.
- Diagnostic imaging provided services for inpatients seven days a week and services offered were increasing and continuously improving in line with new technologies.
- Staff undertook regular departmental and clinical audits to check practice against national standards. They also developed and checked action plans regularly to improve working practices when necessary.

## Evidence-based care and treatment

- Senior staff 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.
- Staff followed national guidelines for example for pulmonary hypertension and collated results for a national database. Staff met nurses and pharmacists from other centres and held teleconferences to share good practice.
- There were identified leads within each 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.

## Diagnostic Imaging:

- We saw reviews against IR(ME)R regulations and learning shared with staff through team meetings and training.

# Outpatients and diagnostic imaging

- 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.
- Staff followed procedures to ensure the diagnostic imaging department were following NICE guidance to meet major trauma imaging timescales and to prevent contrast induced acute kidney injury. We noted that 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.
- Staff carried out audits throughout the outpatients department. Audits included a clinical assurance tool carried out monthly and themes on patient letters, pharmacy, bereavement, and health records including patient assessments in line with NICE guidance. The cardiology department provided rapid access chest pain clinics and audit results showed that they had been 100% compliant in meeting national standards for patients who attended with chest pain.
- Staff carried out an audit of 19 outpatient areas across the trust using the 15 Step Challenge Audit tool in April 2015. This was a peer review, carried out by outpatient staff, who recorded the findings and recommendations for each area. Some recommendations included improving customer care skills, using televisions in waiting areas to take attention away from patients booking in at reception desks and encouraging patients to use hand gel. We saw some of these in the departments such as clocks in waiting areas and tidy information boards.
- Pulmonary hypertension clinic staff carried out an audit on prostaglandin infusion patients where staff had taught patients to make up their infusions daily. Results showed that infection rates had started to rise so staff organised home visits to teach patients good infection control principles on a bimonthly basis and then annually. This audit had won an award for sharing best practice.

## Pain relief

- Outpatient 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.
- Outpatient staff assessed pain relief for patients undergoing a range of treatments and procedures in clinics such as biopsies (removal of a small piece of tissue for testing) and some minor surgical procedures.

## Diagnostic Imaging:

- Diagnostic imaging and outpatient staff carried out pre-assessment checks on patients before carrying out interventional procedures.

## 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.
- Staff had access to food and drinks for patients who required them as part of their treatment or for those who were vulnerable.

## Patient outcomes

## Diagnostic Imaging:

- 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.
- Diagnostic imaging staff did not have an established audit programme. However, they had plans to develop an audit team to take on new roles to include monitoring of patient outcomes. In addition they planned to implement a database of projects as a reference to relevant audits, some of which may be derived from audit live (the Royal College of Radiologists audit templates) and suggested timeline for re-audit.

# Outpatients and diagnostic imaging

## Competent staff

- 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, and appraisal.
- Healthcare assistants completed a competency framework. This included trust wide information and specific skills undertaken in the outpatient setting. Senior staff signed off competencies as they were achieved.
- Students were welcomed in all departments and information from students showed they felt supported. The trust had received letters of thanks from students and the universities, in particular, for providing mentors to students.
- The trust carried out medical revalidation for all consultants.
- Senior staff supported registered nurses for revalidation in 2016. All staff had prepared professional portfolios. The outpatient department sisters had planned a study day in April 2016 for outpatient the Northern Centre for Cancer Care (NCCC) staff.
- Staff kept resource files and each member of the team took responsibility for a relevant subject and updating regularly. Staff shared learning in monthly staff meetings. Link nurses were identified for diabetes, infection control, education and practice placement, moving and handling, risk assessment including a control of substances that are hazardous to health (COSSH) assessor and real-time patient feedback. There were also dignity and dementia champions.

## Diagnostic imaging:

- An IRMER e-learning training package was directed at and made available to staff within the Northern Centre for Cancer Care (NCCC). Essential radiation protection training was included within the local induction programme for all junior medical staff.
- Radiology had designed an IR(ME)R assurance course. It had raised awareness that not all non-medical referrers had successfully undertaken the online IRMER course, accessed via e Learning, which was required by the trust

in order to practice as a non-medical referrer. The first sessions were fully attended and the course was advertised on the intranet to ensure continued attendance at future sessions.

- In outpatients and radiology, 100% of staff had undertaken formal appraisals. In all departments, staff were encouraged to discuss development needs at appraisal and as opportunities arose.
- Managers had created extra trainee sonographer positions to train existing staff and improve skills. These posts had been introduced to improve ultrasound capacity and provide opportunities for current staff to extend their skills.
- Staff in radiology and outpatients completed trust and local induction that was specific to their roles.
- Diagnostic imaging staff completed specific modality training and competencies. Radiation protection supervisors undertook annual training updates.
- Nominated key staff led on specialist information and guidance on areas such as radiation protection and education.

## Multidisciplinary working

- There was evidence of wide ranging multidisciplinary team (MDT) working in the outpatients and diagnostic imaging departments. For example, nurses and medical staff ran several joint clinics and specialist nurses ran clinics alongside consultant-led clinics. Specialist radiographers, nurses and Macmillan nurses worked together in the breast clinic to share good practice and provide a cohesive service for patients.
- The trust provided clinics on different sites, including satellite and outreach clinics, throughout the trust and staff worked flexibly and as a trust-wide team to provide a coordinated service to patients.
- Staff communicated with a range of other departments such as diagnostic imaging, the emergency department, and community staff about patients.
- We saw the departments had links with other organisations involved in patient journeys such as GPs, community services, 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 a large number of specialist consultants.

# Outpatients and diagnostic imaging

- Staff worked towards common goals, asked questions, and supported each other to provide the best care and experience for patients.
- Managers and senior staff in all outpatient and diagnostic imaging departments held regular staff meetings. All members of the MDT teams 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.

## Diagnostic Imaging:

- Medical staff could contact a 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 discussed referral requests for patients with complex or specialist needs into the trust regional specialist services.

## Seven-day services

- Outpatient managers had developed seven day working within the outpatient setting for trauma clinics. The majority of staff were all employed with seven-day working terms and conditions. The department supported the delivery of outpatient's clinics over a six-day service including Saturdays and evenings as demand occurred. Such demand was mostly for extra capacity to support waiting list initiatives requested by specialties to help address shortfalls in capacity.

## Diagnostic Imaging:

- Diagnostic imaging provided services seven days a week. The trust provided a 24 hours a day, seven days a week service for emergency plain x-ray imaging, emergency CT, MRI, out of hours portable images and emergency theatre imaging.
- The diagnostic imaging department provided general radiography, CT, MRI, ultrasound scanning, fluoroscopy (study of moving body structures) and nuclear medicine 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.

## 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:

- 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 to meet internal and regulator standards. The diagnostic imaging department kept an electronic list of approved referrers and practitioners. Internal and external vetted staff against the protocol for the type of requests they were authorised to make.
- There were systems to flag up urgent unexpected findings to GPs and medical staff. This met the Royal College of Radiologist guidelines.

## Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- 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).
- 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.

## Diagnostic Imaging:

- 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.
- Patients told us that staff were good at explaining what was happening to them before asking for consent to carry out procedures or examinations.

# Outpatients and diagnostic imaging

## 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. Staff spent time with patients and those close to them to give explanations about their care and encouraged them to ask questions.
- Patients gave positive responses in the outpatient satisfaction surveys.
- Staff respected patients' privacy, dignity, and confidentiality at all times.
- There were services to provide emotional support for patients and their families. Staff were trained to identify when people needed emotional support with their care. Staff reacted compassionately to patient discomfort or distress and to suit individual needs. Staff involved patients, their carers, and families by discussing and planning their treatment and patients could make informed decisions about the treatment they received.
- Staff involved patients by discussing and planning their treatment. Patients could make informed decisions about the treatment they received.
- Staff behaved positively and autonomously to provide the best possible care for their patients. Individuals and staff groups applied a caring approach to all aspects of their service and consistently considered their patients' experiences.

However:

- In diagnostic imaging, we saw inpatients waiting on trolleys in the reception area in full view of staff and patients.

### Compassionate care

- 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 within main outpatients 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.
- Reception areas were spacious and the main reception desks allowed space for patients to hold conversations with receptionists that could not be overheard by others.
- Staff followed a trust chaperone policy. This was available to all staff in hard copy and on the trust intranet.
- We spoke with 21 patients and three people close to them and all said that staff were friendly with a caring attitude. Patients were grateful for the standard of care they received visit after visit and from staff in all departments from clinics to diagnostics and back again, often within the same visit.
- Results from the national Friends and Family test showed that during July 2015, 87.5% of patients who attended outpatients at Freeman Hospital would recommend the trust to others (lower than the England average of 92%). However, 100% of patients who attended Radiology at Freeman Hospital would recommend the trust to others.
- The outpatients department carried out their own patient satisfaction survey and used feedback kiosks for patients to give their opinions. Results showed that 95% of patients who completed the survey at the Freeman Hospital had experienced kindness and compassion by staff.
- Clinic reception staff from different sites had received personal touch awards from management for their kindness and compassion shown to patients.

### Diagnostic Imaging:

- In radiology, we saw inpatients waiting on trolleys in the reception area in full view of staff and patients. One patient was not properly covered by a blanket, which had slipped from their legs. This did not show respect for the patient's dignity. We later observed the nurse covering them when they noticed the blanket had slipped.

### Understanding and involvement of patients and those close to them



# Outpatients and diagnostic imaging

- 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 and answering patients' questions.
- Staff told us they would invite families into the consulting room if possible as long as the patient agreed.

## Emotional support

- Patients told us they felt supported by the staff in the departments. They reported that, if they had any concerns, they were given the time to ask questions.
- Staff made sure that patients understood 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.
- Specialist nurses worked throughout the department in all specialist areas. These specialist staff provided support and care to patients and those close to them throughout their visit.
- Outpatient staff controlled clinic room use and could make best use of rooms for each clinic for instance when an additional room was needed for breaking bad news or for patients with additional needs.
- A manager told us they were very proud of their team and the care they offered vulnerable people.

## Are outpatient and diagnostic imaging services responsive?

Good



We rated responsive as good because:

- The trust had regularly achieved the referral to treatment targets (RTT) for national two-week cancer waiting times for a first outpatient appointment and six-week diagnostic imaging targets were met for the majority of x-ray appointments.
- Between January and December 2015, the percentage of cancelled clinics within six weeks of an outpatient appointment was 0.5%, which, was within the average (6%) for Trusts in England.
- Routine appointments were booked within acceptable timescales.
- 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 departments recorded concerns and complaints, which they reviewed and acted on to improve patient experience. The trust provided a very wide range of specialist clinics and cancer screening services for patients in the North East, North Cumbria and some patients travelled from all over England and Scotland.

However:

- The diagnostic imaging department inpatient and emergency image reporting turnaround times did not meet nationally recognised best practice standards or trust targets. The trust had taken a number of actions to mitigate the risks and work towards a resolution.
- The service had breached six-week, wait targets for outpatients in specialist MRI services. The trust had taken action, outsourced the performance of MRI scans, and purchased a new MRI scanner, which would enable the trust to meet the demand and reflect national guidelines.
- Results of a recent audit of waiting times within clinics showed that 35% of patients had experienced delays of more than 30 minutes.

## Service planning and delivery to meet the needs of local people

- Multiple specialist services offered one-stop clinic appointments to enable patients to attend on one day for consultation and investigations.
- Some departments had re-organised clinics so that specialist services and tests could be performed at the same site and on the same day.



# Outpatients and diagnostic imaging

- The outpatient department flexed capacity and staffing to meet demand and managers regularly met with doctors to organise extra clinics.
- Staff held informal daily meetings and formal, minuted, weekly meetings to plan for the days and weeks ahead. They discussed each specialty and the clinics taking place.
- Managers told us the trust were continually exploring options to move more outpatient sessions from the hospital to community to bring care closer to the patient's home. The trust had opened a new outpatient satellite site at a nearby shopping centre in October 2015 and used some local primary care centres for outreach clinics.
- The diagnostic imaging department were able to accept urgent referrals and arranged extra scanning sessions to meet patient and service needs.
- The pathology department provided a wide range of blood and tissue tests. Staff used a vacuum system to transport specimens speedily and direct to the labs and porters made regular hourly collections throughout the day.

## Access and flow

- The trust held 2,700 outpatient clinics each week across all sites.
- The previous 12 months' appointments showed the Freeman Hospital outpatient departments booked 834,122 appointments with a new to review ratio of 1:2.7 (the number of new appointments compared to the number of reviews) for all appointments which was similar to the England average.
- Between January 2015 and December 2015 the percentage of clinics cancelled where the notice period was less than six weeks was 0.5%. The percentage of clinics where the notice period was more than six weeks was 6.9%. These were within national averages. The main reasons given for cancellations were annual leave, on-call changes, and sickness. However, some patients told us, and there was evidence from written complaints, that appointments had been cancelled and rearranged several times.
- The 'did not attend' (DNA) rate for the trust was 7.6%, which was slightly worse than the England average of 7%. There were written trust policies for managing DNAs and a recently implemented appointment reminder and confirmation system. Managers had extended the use of the confirmation service for a further six months after initial results had shown some improvements in DNA rates. This system enabled the appointments team to use empty clinic slots more efficiently and invite other patients to attend. The trust had received positive messages from patients about the appointment reminder texts. Staff followed a DNA policy, which prompted a referral back to the patient's GP if they DNA 3 times.
- The trust had achieved the 2-week cancer waiting times for a first outpatient appointment in all specialties. Results for the previous 12 months ranged between 95.5% and 96.5%, better than the England average.
- The trust had met the overall referral to treatment targets (RTTs) of patients admitted for treatment within 18 weeks of referral up to September 2015 except for trauma and orthopaedics, which achieved a rate of 85.9%. The overall rate for the trust for the 6-month period prior to our inspection ranged between 95% and 96%, slightly better than the England standard of 95%. However, for the six-month period prior to that, the trust had achieved lower results ranging between 91.5% and 95%.
- The percentage of patients with incomplete care pathways who started their consultant-led treatment ranged between 92% and 94.7%. The operational standard in England is 92%. This rate had rapidly improved in the first six months of 2015 and the trust had maintained its performance above the England average.
- The trust was performing consistently similar to or better 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. Between 84% and 89% of patients were seen within 62 days in 2015.
- We heard staff tell patients about delays and the reasons for them. Staff displayed delay times on TV screens that were clear and positioned for patients to see.
- Outpatient staff did not have a waiting time escalation procedure to follow in the event of clinics running late.
- Staff had audited Freeman hospital outpatient waits from the time patients booked in at reception until a doctor saw them. Out of 25 clinics audited and 368 patients from different services over a 2-week period, 35% of patients had experienced delays of more than 30 minutes. This was a much smaller sample than an audit carried out at the RVI, which had collected results similar to the figure (8.9%), submitted to the inspection

# Outpatients and diagnostic imaging

team for the year. Staff had identified reasons for delays and the most common causes were “clinics running slowly (unknown reason)”, “previous appointment overran”, “clinic overbooked”, and “patient delayed returning from diagnostic tests”. Staff were working together to consider changes to help reduce delays.

- The recent junior doctors’ strike had resulted in cancelled clinics and staff had volunteered to work some evenings to cover extra clinics to clear this backlog.

## Diagnostic Imaging:

- Trust reporting standards for plain film reporting times were provided and showed that the requirements were A&E – 3 working days, inpatients – 3 working days, GP – 3 working days and outpatients – 15 working days. The trust set the standard that 95% of examinations would be reported by target dates. The Royal College of Radiologists (RCR) best practice on reporting times state that imaging services should provide all inpatient diagnostic imaging reports within one working day and A&E plain films within 24 hours. Therefore, trust standards did not match best practice. Unreported examinations carry a number of serious clinical risks including the possibility that findings necessitating urgent intervention may be unnoticed, as well as the risk of patient harm from an inaccurate preliminary interpretation by a non-expert reader.
- Data provided by the trust showed that accident and emergency imaging rates for 24 hour reporting in April 2015 was as low as 29.7% and the best rate was 50.2% in May 2015. Between April and September 2015 an average of 54.2% of in-patient, reporting was completed within 24 hours of imaging and reporting within a week for the same time ranged between 84.6% and 92.7%. This data showed that neither trust standards nor best practice guidelines were met for these patient categories.
- The trust was aware of the challenges in relation to plain film reporting times and had taken a number of steps to mitigate the risks and work towards a resolution. This included the training of more reporting radiographers (two members of staff had completed their training to date with more to follow), prioritising GP, CT, ultrasound and MR imaging reporting and ensuring that clinicians could contact the radiology team for any urgent reporting 27 hours a day, 7 days a week.
- Radiology managers told us that they met national requirements for reporting turnaround times of urgent radiology reports for general scans and suspected stroke patients. Image reporting for GP and outpatients (including the breast unit) met trust standard reporting times.
- In diagnostic imaging, staff recorded the arrival time of every patient and explained any unexpected delays to individuals.
- The radiology administrators checked referral letters and radiology requests and forwarded to consultants, radiographers or sonographers for triage depending on the test requested. Staff entered radiology requests onto the electronic patient administration system.
- Diagnostic imaging waiting times for all departments and from all urgent and non-urgent referrals met national targets of 99%. These were consistently better than the England average. Managers had set out temporary and long-term measures to address targets in the ultrasound department, which had experienced severe staff shortages in 2015, which led to patients waiting longer for their scans. The department had recruited staff for sonographer posts and identified staff interested in commencing sonographer training. 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 within sessions to provide more urgent diagnostic imaging requests as necessary.
- In the diagnostic imaging department, 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 when targets were in danger of being breached. Managers and radiologists were working hard towards keeping all reporting internal to the trust.
- Patients who cancelled diagnostic imaging appointments were re-booked to attend within the national target of 6 weeks of their original appointment date.

## Meeting people’s individual needs

- Clinics were organised to meet patients’ needs. Teams worked together and some specialist clinics were

# Outpatients and diagnostic imaging

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.
- The outpatient department manager sat on the learning disabilities steering group and worked with patient user groups for vulnerable people including visual and hearing-impaired individuals as well as those with dementia and learning disabilities.
- Several specialist 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 followed recognised care pathways for patients with learning difficulties. These included prompts for staff and information about patient needs, their communication needs, family and social history relevant to their care, how they made decisions about their own treatment and how they managed any pain.
- There was bariatric furniture and equipment available in several departments (for people who were larger or heavier and could not use standard furniture). However, some outpatient areas did not have specialist furniture for larger patients. Most newly procured equipment was chosen with larger patients in mind.
- Staff knew how to support people living with dementia and had completed the trust training programme. They understood the condition and how 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. The trust learning disabilities lead liaised with staff to provide information and support when treating patients with additional or complex needs and electronic patient records included information on patient needs and preferences.
- 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 were hoists 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 comprehensive information leaflets.
- There had been a recent introduction of a telehealth clinic in renal services. This was a trial with plans to extend it if it proved successful. Telemedicine in cardiology included remote monitoring of pacemakers and defibrillators via Bluetooth technology. There had been a lower demand for this service because other local acute hospitals offered the same service but the department were planning to extend the service to include remote monitoring of arrhythmias.
- The bookings teams organised interpreter services for patients who did not speak or understand English. However, booking staff had to rely on GPs and hospital informing them about a patient's individual needs. Staff did not allow family members to act as interpreters, thus upholding the trust safeguarding policy.

## Diagnostic Imaging:

- The department had purchased a new high-speed, low-dose CT scanner that was useful for paediatric cases because it reduced the need for children to undergo a general anaesthetic. Paediatric nurses accompanied children to use distraction and calming techniques and scans were completed quickly.

## 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 clinic waiting times and car parking, and a few were about appointments. Staff had encouraged patients to use the feedback kiosks but some patients told us that if they wanted to raise a concern they had to navigate through 50 screens to input all the information the system asked for. However, patients could also access the patient advice and liaison service (PALS) team to raise concerns face to face. We saw patients using the service throughout our inspection to ask for information or advice. They told us that staff had listened and dealt with their concerns and, where possible, taken action to address the problem.
- Staff understood the local complaints procedure and were confident in dealing with concerns and complaints

# Outpatients and diagnostic imaging

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. We saw evidence that data about patients' complaints and concerns had been analysed and recorded. Staff responded appropriately to complaints and concerns and we saw action plans that departments had written following investigations into practice.

- None of the patients we spoke with had ever wanted or needed to make a formal complaint. Overall, they were happy with the experience they received from the departments.
- Staff managed complaints in diagnostic imaging and showed us evidence of actions they had taken to address concerns, complaints, and their outcomes. Very few formal complaints were received and in some months, the department received none at all.

## 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, knew the risks, and challenges the service faced. Directors and managers told us that there was a very positive culture of support amongst staff. Staff we spoke with felt supported by their local team leaders and managers, who encouraged them to develop and improve their practice.
- Staff worked well together as a productive team and had a positive and motivated attitude. Teams were involved in planning improvements for departments and services. Staff and managers had a clear vision for the future of the service and they knew the risks and challenges the service faced.
- There was an open and supportive culture where staff discussed incidents and complaints, lessons learned and practice changed. All staff were encouraged to raise concerns. There were effective and comprehensive governance processes to identify, understand, monitor, and address current and future risks. These were proactively reviewed.

- There were systems and processes for gathering and responding to patient experiences and the results were well publicised throughout the departments.
- Staff we spoke with at all levels felt supported by their line managers, who encouraged them to develop and improve their practice. The departments supported staff who wanted to work more efficiently, be innovative and try new services and treatments. Trust management supported research and development ideas, projects and ventures, and staff valued the interest shown and finances provided for them.
- The departments supported staff who wanted to work more efficiently, be innovative, and try new services and treatments. Staff had received nominations and awards for innovation and changes in practice. Staff were proud to work in the hospital and its departments.

However:

- Although staff told us that local leadership was strong, there was evidence in outpatients and diagnostic imaging of targets not being met.
- Trust policy for diagnostic imaging reporting times did not reflect national guidelines and best practice. Performance for reporting times for inpatients and emergency patients fell short of trust targets.

## Vision and strategy for this service

- Staff told us managers involved them in strategic planning. There was a clear strategy with a vision to meet the needs of the specialties as well as local people.
- The trust vision was displayed in staff areas and discussed amongst teams. Staff had worked together to agree local ideas about providing the best possible service for patients.
- The trust provided outpatient services in community settings and planned to add more clinics at these locations.
- Cardiology staff expected that, due to improvements in diagnostics and treatments available, in future more inpatients would be treated as day cases and day case patients would be treated in outpatients. Therefore, there would be a greater demand and a bigger role for outpatient services.

Diagnostic imaging:

- Radiology staff had produced a trust wide overarching imaging strategy for the future delivery of diagnostic

# Outpatients and diagnostic imaging

services with strategic goals and objectives. This incorporated all major imaging equipment including plans and costs attached, opportunities to develop the service with business cases, plans to improve efficiency, accuracy, flexibility and to strive for excellence.

- Radiologists had implemented tele-reporting as a means of reporting images from any site. This improved flexibility of staffing across trust sites.

## **Governance, risk management and quality measurement**

- Staff reported on risk, incidents, and complaints. They discussed incidents at departmental meetings, led by the department managers and clinicians attended to discuss trends and serious incidents.
- Department managers held and controlled risk registers and staff could influence what risks were included. The clinical governance and quality committee met monthly to discuss risks and disseminate learning across the whole organisation through directorate manager and clinical leaders meetings, communications group, staff meetings, bulletins and emails. Audiology staff had reported the need for repairs and unsuitability of treatment rooms. These items were both on the risk register and plans had been drawn up to address them. The department manager was confident that changes would be made.
- The Radiation Protection Committee reported to the trust board in annual and six-monthly reports with information and recommendations on all aspects of radiation safety.
- 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 advisors provided support and guidance in all aspects of risk assessment.
- Managers held monthly meetings where staff raised, discussed and actioned risks identified within the department and agreed higher-level risks they would forward to the patient safety and quality review panel.
- The organisation checked up to date NICE guidance to make sure they put relevant guidance into practice and carried out compliance audits.
- The trust board had oversight of staff groups and committees, which measured and checked performance against national targets where managers presented

finance, performance, and operational performance dashboards. Department managers, matrons, clinical leads, finance and patient safety team's attended and key risks were fed up to the executive team.

## **Leadership of service**

- Managers were strong and positive, leading by example with a calm and confident manner.
- 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 and told us they were 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 managers expected of them and of the department. Staff at all levels were involved in planning positive changes and continual improvement.
- 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, who encouraged and 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 told us that the trust cared about its patients and staff. 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

- 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.
- Clinicians told us that they felt the trust provided a safe environment to work in, fabulous teaching facilities with excellent staff teams who worked collaboratively and were all prepared to go the extra mile to provide a good service for patients.
- Clinicians told us that if they wanted to trial new technology, ideas or make suggestions, these were always well received by the chief executive and when requests were accompanied with a strong business plan, no requests had been refused.

## Public engagement

- The trust recruited volunteers following trust policies and procedures. Volunteers provided support to patients and staff throughout outpatient areas and showed patients and relatives to waiting areas.
- 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, learning disabilities group, deaf and blind patient user groups.
- Patients told us that they were encouraged to give feedback on their experiences through questionnaires, comment cards and new patient feedback kiosks. Staff had supported them to use the kiosks.
- The trust involved patients from charitable organisations in deciding how to make improvements to patient services and environments.

## 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.
- Staff felt involved in decision-making and future service planning, including best use of facilities.

## Innovation, improvement and sustainability

- Outpatient managers had worked hard to implement a work placement programme for young adults with learning difficulties. Following successful work

placements, the trust had employed three young people. Project Choice had won the Workforce Award at the 2015 HSJ Awards and the programme had had a positive effect on staff.

- Outpatient staff had carried out an audit with the commercial pharmacy who provided trust medicines. Patients had reported delays in collecting their prescribed medicines. The problem had been solved by the pharmacy delivering medicines to the patients' local pharmacy or direct to their homes.
- Senior clinical staff held national college and development group roles and regularly implemented new practice from national and international projects.
- NCCC staff had developed an in-house data system where staff could formally audit waiting times and display times on patient-facing screens.
- Booking teams used a call centre system to monitor and handle incoming telephone calls. Staff told us this had made improvements to the service and had reduced complaints. It allowed managers to flex staffing to suit patient need. For example, on the first working day after New Year the department received 500 calls. All 10 staff handled calls and queues were minimal.

## Diagnostic Imaging:

- The department were working with an old patient administration system that had been due to be replaced but the lead-time had been extended. This was causing extra work and some lack of IT support from the existing service but staff were managing this well day to day and there were clear plans in place for implementing the new system.
- A recent drive had taken place to carry out post mortems under MRI or CT, which enabled the trust to begin to move away from the current surgical post mortems. This was being trialled in the Northern Cancer Care Centre (NCCC) based on the Freeman Hospital site, in the short term with specialist staff undertaking the radiographic work.
- The nuclear medicine department was working hard to implement the latest developments within the discipline. They worked closely with the local university to develop new techniques and therapeutic tools such as radioisotope injections to destroy liver tumours and sentinel node identification.
- Radiology staff told us of the excellent relationship with the chief executive officer in terms of appreciation of the need to constantly move forward, develop and increase



# Outpatients and diagnostic imaging

the opportunities for up to date, fast and effective technologies. These included PET-CT (a system using a single machine to carry out a CT scan to show the structures of the body and, at the same time, a PET (positron emission tomography) scan using a mildly radioactive drug to show up any areas where the cells are more active than normal.)

- The trust had made recent investments into making radiology facilities more suitable to those with specific needs such as dementia or learning disabilities and for children such as distraction aids and mood lighting to enable patients to relax.
- Radiology and nuclear medicine staff had designed tools to use when imaging patients with scoliosis and for children undergoing kidney and bladder function imaging. Staff had designed prototypes and the medical devices engineers had supported them to build them.
- Radiology senior managers aspired to ISAS accreditation but the trust was not in a position to consider this due to the ongoing PACS/RIS project.
- Radiologists had won a BMJ award in 2014 for junior radiologist intervention training in endovascular radiology. They used a life size simulator and could print 3D models for practicing techniques.

# Outstanding practice and areas for improvement

## Outstanding practice

- There was an integrated model of care between the Specialist Palliative Care Team and the Cardiothoracic Transplant Team. The teams worked alongside patients with advanced disease including those waiting for transplant and those with ventricular assist devices.
- A sleep checklist was developed for patients in critical care to optimise sleep. This included measures such as environmental factors, noise, temperature and light in patient areas.
- Hydrotherapy rehabilitation after critical illness had been developed for patients who were ventilated which enabled them to move their limbs supported by water. This gave psychological support to patients and helped them engage with their rehabilitation programme.
- Radiology facilities were adapted to meet the needs of patients with dementia or learning difficulties. This included distraction aids and mood lighting to help patients relax.
- The trust Falls and Syncope Service was the largest of its kind in Europe and undertook research and treatment for patients presenting with a range of problems such as balance disorders, dizziness, low blood pressure, balance problems or unspecified lack of co-ordination and falls.
- The Northern Centre for Cancer Care (NCCC) in partnership with Macmillan was providing chemotherapy in three community health centres enabling access for non-complex treatments closer to home. Chemotherapy nurses from the NCCC ran this service.
- The Perioperative care team at the Freeman were national leaders in pre-operative assessment, cardiopulmonary exercise testing after major intra-abdominal surgery (including shared decision making in the pre-operative counselling process).
- The pancreatic service had developed a remote care service to assist clinicians in outlying hospitals to manage their patients. This was to avoid transferring ill patients to Newcastle when they could be managed at their base hospital. This service was coordinated by a nurse specialist and saved patients being unnecessarily transferred to Newcastle. It also ensured that those patients who may require specialist care were transferred at the correct time.

## Areas for improvement

### Action the hospital MUST take to improve

#### Action the hospital MUST take to improve

- Ensure that care documentation in the Emergency Care Department and on some wards are fully completed to reflect accurately the treatment, care and support given to patients, and is subject to clinical audit.

### Action the hospital SHOULD take to improve

#### Action the hospital SHOULD take to improve

- Ensure processes are in place to meet national best practice guidelines for diagnostic imaging reporting turnaround times for inpatients and patients attending the Emergency Care Department.
- Ensure that all groups of staff complete mandatory training in line with trust policy particularly safeguarding and resuscitation training. Ensure that all staff are up to date with their annual appraisals.
- Ensure that the departmental risk register in End of Life Care accurately reflects the current clinical and non-clinical risks faced by the service.
- Ensure that all housekeeping staff who undertake mattress contamination audits are aware of the trust policy relating to mattress cleanliness and the criteria for when to condemn a mattress.
- Ensure staff follow the systems and processes for the safe storage of medicine and the recording and checking of resuscitation equipment.

# Outstanding practice and areas for improvement

- Ensure that the storage of patient records is safe to avoid potential breaches of confidentiality.
- Ensure that arrangements are robust to enable patients to transfer safely with continuity of syringe drivers in place from hospital to the community to avoid the risk of breakthrough pain being encountered.
- Ensure that the Care for the Dying Patient documentation is fully implemented and embedded

This section is primarily information for the provider

## Requirement notices

### Action we have told the provider to take

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

Regulated activity	Regulation
Treatment of disease, disorder or injury	<p>Regulation 17 HSCA (RA) Regulations 2014 Good governance</p> <p>Systems or processes must be established and operated effectively to :</p> <p>(c) maintain securely an accurate, complete and contemporaneous record in respect of each service user, including a record of the care and treatment provided to the service user and of decisions taken in relation to the care and treatment.</p>