The Newcastle-upon-Tyne Hospitals NHS Foundation Trust

Royal Victoria Infirmary

Quality Report

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Date of inspection visit: 19 – 22 January 2016 and 5 February 2016
Date of publication: 06/06/2016

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

Ratings

Overall rating for this hospital	Outstanding ☆
Urgent and emergency services	Good ●
Medical care (including older people's care)	Good ●
Surgery	Outstanding ☆
Critical care	Outstanding ☆
Maternity and gynaecology	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 the CQC's comprehensive inspection programme.

We included the following locations as part of the inspection:

- Royal Victoria Infirmary incorporating the Great North Childrens Hospital
- Centre for Ageing and Vitality

We inspected the following core services:

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

Overall, we rated the Royal Victoria Infirmary, 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. However, there were some infection control issues in the Emergency Care Department.
- 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 staffing in the neonatal unit and 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 trust was effectively meeting its four-hour waiting time targets in the Emergency Care Department.
- 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.

Summary of findings

- Information written in clinical notes about the care patients received in the Emergency Department was minimal and not subject to frequent local clinical audit carried out by staff within the department. The sister in the department confirmed to us that local audit of nursing records did not take place.
- Although improvements had been made to ensure patients received antibiotics within one hour to treat sepsis, the latest audit showed a compliance of 55%, which was still low.
- There were some issues with the environment and facilities in critical care (ward 38) at the RVI. This was highlighted in the critical care risk register and in a trust gap analysis report to the Trust Board in 2015. However, the service was managing risks consistently well in this area to ensure safe care.
- 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.
- 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:

- The home ventilation service delivered care to around 500 patients in their own home. The service led the way for patients who needed total management of their respiratory failure at home with carers. The team offered diagnostics, extensive training and patient support. The team had written the national curriculum for specialist consultant training. The domiciliary visits covered the whole of the North of England, up to the Scottish border, West Coast and Teesside.
- The liaison team from the bone marrow transplant unit had developed an open access pathway so post-transplant patients could access urgent care quickly and safely. Children and young people presented their unique passport upon arrival in A&E, which included all information about their condition and any ongoing treatment. The team had worked with other trusts across the country, as many patients lived outside of the local area, to ensure a smooth transition. Feedback from families about the passport was very positive.
- The Allied Health Professionals (AHP) Specialist Palliative Care Service was a four-year project currently funded by Macmillan, which embedded AHPs into the existing Acute Specialist Palliative Care Service. The primary outcomes being to improve patient experience, manage symptoms, maximise and increase well-being and quality of life.
- There was an integrated model where palliative specialists joined the cystic fibrosis team to provide palliative care in parallel with standard care. Specialist palliative care staff saw all patients with advanced disease including those on the transplant waiting lists.

Summary of findings

- The trust had an Older Peoples Medicine Specialist Nurse led in-reach service into the emergency department. In addition, there was an Elderly Assessment Team at weekends in the department, which included a social worker and specialist nurse.
- The critical care pressure ulcer surveillance and prevention group had developed a critical care dashboard for pressure ulcer incidence. A new pressure ulcer assessment tool was developed and implemented this had led to a major reduction in pressure injury.
- The Newcastle Breast Centre was at the forefront of treating breast cancer. The trust was the first unit in the UK to offer 'iodine seed localisation' in breast conservation surgery. Many breast cancer patients were given the chance to take part in national and international breast cancer treatment trials, as well as reconstruction studies.
- In cardiology, the service had developed a new pathway for patients requiring urgent cardiac pacing. This was a 24/7 consultant led service and reduced patients length of stay.
- Eye clinic liaison staff had worked with the Action for Blind People charity to improve links between medical and social care. Studies showed that there had been a reduction in patient falls and consultations.

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

Importantly, the trust MUST:

- 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.
- Continue to develop plans to ensure that staffing levels in the neonatal unit meet the British Association of Perinatal Medicine guidelines.
- 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.
- Continue to develop processes to improve compliance for patients to receive antibiotics within one hour of sepsis identification.
- Ensure that Emergency Care Department display boards in waiting rooms are updated regularly and accurately reflect the current patient waiting times.
- Ensure that the departmental risk register in the Emergency Care Department and End of Life Care accurately reflects the current clinical and non-clinical risks faced by the directorates.
- 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 the maternity service implement the maternity dashboard, with appropriate thresholds to measure clinical performance and governance.
- 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	Rating	Why have we given this rating?
Urgent and emergency services	Good 	Overall we rated the emergency department as good with safe rated as requires improvement because: The department was not meeting the trust's expected target for mandatory training. Nursing records did not always contain enough information about the care patients had received, some equipment was not identified as soiled and there were some gaps in records to show that checks of equipment and medication had taken place. There was enough medical and nursing staff. Staff followed safeguarding processes to protect vulnerable adults and children from abuse. The department followed evidence-based policies and procedures relating to care. There was evidence of different kinds of staff working well together throughout the department. Staff provided good care to patients. They maintained patients' privacy and dignity and dealt with people in a kind and compassionate way. Patient's individual needs were met. The department was meeting the target for patients to be admitted or treated and discharged within four hours, although this was a challenge. The trust was performing better than the England average for a number of other performance measures regarding the flow of patients. Managers had plans in place to ensure the sustainability of the department. There were effective governance, risk management and quality measurement processes to enhance patient outcomes. There were many examples of innovative ways of working in the department.
Medical care (including older people's care)	Good 	
Surgery	Outstanding 	Overall we rated surgery as outstanding because: Performance in surgery showed a very good record of accomplishment 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.
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.
Leaders had an inspiring shared purpose and strived to deliver and motivate staff to succeed. Rigorous and constructive challenge was welcomed and seen as a way of holding services to account.

Critical care

Outstanding ☆

We rated critical care as outstanding for safe, effective, caring, and well led and good for responsive.
Standards for infection prevention and control were good and rates of infections were better than national averages. Ward 18 was a large purpose built critical care unit with excellent facilities, in contrast to the inadequate environment of ward 38, although staff reduced risks and ensured patients received safe care.
Care was led 24 hours a day, seven days a week by a consultant in intensive care medicine. With the exception of pharmacist cover and consultant to patient ratios out of hours, staffing was in line with the Core Standards for Intensive Care (2013).
Critical care services were very well led. A genuine culture of listening, learning and improvement was evident amongst all staff.
Patients and their families had access to a range of support services. It was clear that patients were at the centre of decisions. There were many examples of compassionate care.
The critical care unit performed within or above national averages in governance and performance areas.

Summary of findings

Maternity and gynaecology

Outstanding ☆

We rated maternity and gynaecology services as outstanding overall with the safe and responsive domains rated as good because:
We observed and were given examples by staff and patients of areas of good practice in the care and treatment of women.
The service provided safe and effective care in accordance with national guidance. Staff monitored outcomes for women continually and took action where improvements were necessary.
Resources, including equipment and staffing, were sufficient to meet women's needs. Staff had the correct skills, knowledge and experience to do their job.
Staff took women's individual needs in planning the level of support they needed throughout their pregnancy. Staff treated women with kindness, dignity and respect. The service took account of complaints and concerns and took action to improve the quality of care.
A highly committed, enthusiastic team, each sharing a passion and responsibility for delivering a high-quality service, led the women's health directorate, which included maternity and gynaecology services.
Governance arrangements at all levels, enabled managers to identify and monitor risks effectively, and review progress on action plans. Engagement with patients and staff was strong. There was evidence of innovation and a proactive approach to managing performance improvement.

Services for children and young people

Outstanding ☆

Overall, we rated services for children, young people and families at the Great North Children's Hospital as outstanding with safe as requires improvement because:
Although managers planned, implemented and reviewed staffing levels regularly, some wards and units reported staff shortages. Senior nurses and medical staff were taking appropriate steps to mitigate the risk and keep children and young people safe.
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.

Summary of findings

Families were very positive about the service they received. They described staff as being very caring, compassionate, understanding and supportive.
The care and treatment of children and young people achieved good outcomes and promoted a good quality of life.
Staff protected children and young people from avoidable harm and abuse. Managers and staff discussed incidents daily.
The wards, clinics and departments were clean. Staff managed medicines safely and the quality of healthcare records was good.

End of life care

Good

Overall we rated end of life care as good with well-led as requiring 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.
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 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.
The Specialist Palliative Care Team and End of Life Care Team were highly visible and accessible. Medical and nursing staff were very positive about the advice and support they received from these teams. Patients received compassionate care and their privacy and dignity was respected.

Summary of findings

Outpatients and diagnostic imaging

Good 

Overall we rated outpatient and diagnostic imaging as good because:
The service had met national targets for urgent and routine appointment waiting times.
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.

Royal Victoria Infirmary

Detailed findings

Services we looked at

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

Detailed findings

Contents

Background to Royal Victoria Infirmary

The Royal Victoria Infirmary (RVI) has been providing healthcare to communities in Newcastle and the North East for over 250 years. Several of the departments at the RVI are designated regional centres of expertise, including the major trauma centre, with national reputations.

The RVI offered in-patient care for those requiring general, specialist medical and surgical services, and critical care.

Services for children and young people at the RVI are located within the Great North Children's Hospital (GNCH) one of the largest children's hospitals in the UK. The RVI also offered an extensive range of maternity services for women and families based in this hospital and the community. The service was the specialist referral centre for maternity services in the North East of England and Cumbria.

There was a large range of outpatient and diagnostic services. Nursing and medical staff throughout RVI delivered end of life care.

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.

Detailed findings

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

- Between July 2014 and June 2015, the urgent and emergency care department had 185,126 attendances. Of these, 71.4% were aged 17 or over (145,139) and 21.6% (39,987) were under 17.
- Compared to all trusts in England, the Newcastle upon Tyne Hospitals surgical spells were the highest at 76,629 with 37.9 % of those spells dealt with by RVI surgical service
- The RVI accounted for 38,600 admissions across 12 medical in-patient wards.
- In the year before our inspection, the RVI provided 1,454,375 outpatient appointments across a vast range of specialties.
- Between July 2014 and June 2015, children and young people services at RVI had 29,137 spells.
- The maternity service at RVI delivered 5,283 babies between April 2015 and December 2016, 1,123 babies born in the Newcastle Birthing Centre (midwifery led service) and 4,159 babies born in the Newcastle Delivery Suite (consultant led unit).
- The total number of in-patient deaths between July 2014 and June 2015 was 2,063.

Our ratings for this hospital

Our ratings for this hospital are:

Detailed findings

	Safe	Effective	Caring	Responsive	Well-led	Overall
Urgent and emergency services	Requires improvement	Good	Good	Good	Good	Good
Medical care	Good	☆ Outstanding	Good	Good	Good	Good
Surgery	Good	Good	☆ Outstanding	☆ Outstanding	☆ Outstanding	☆ Outstanding
Critical care	☆ Outstanding	☆ Outstanding	☆ Outstanding	Good	☆ Outstanding	☆ Outstanding
Maternity and gynaecology	Good	☆ Outstanding	☆ Outstanding	Good	☆ Outstanding	☆ Outstanding
Services for children and young people	Requires improvement	☆ 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	Requires improvement	☆ Outstanding	☆ Outstanding	☆ Outstanding	☆ Outstanding	☆ Outstanding

Notes

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

Urgent and emergency services

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

Information about the service

The emergency department (also known as accident and emergency, A&E or ED) is at the Royal Victoria Infirmary (RVI), on the outskirts of Newcastle upon Tyne town centre. It is a major trauma centre, which means that it can treat patients with a very wide range of illnesses and injuries, including those who have been involved in serious accidents and incidents. Patients can arrive on foot, by road or by air ambulance landing on the helipad on the roof of the hospital. Patients who arrive by helicopter are escorted to the department by a dedicated team of staff. Within the department, there are three distinct areas where patients are treated. The minors department can treat patients with minor injuries such as simple fractures; the paediatric emergency department treats patients under 17 with all types of illnesses and injuries; and the majors department treats patients with more serious illnesses or injuries. The trust also has an eye casualty department open five days a week where patients with eye injuries are treated.

A wide range of experienced consultants, middle grade and junior doctors, GPs, emergency nurse practitioners, nurses and healthcare assistants staff the department, seven days a week, 24 hours a day.

According to the trust, between July 2014 and June 2015 the department had 185,126 attendances. Of these, 71.4% were aged 17 or over (145,139) and 21.6% (39,987) were under 17.

We spoke with staff including doctors, receptionists, nursing assistants, nurses of all grades, domestic and housekeeping staff and paramedics. We also spoke with 31 patients and their relatives. We looked at the records of 27 patients and reviewed information about the service provided by external stakeholders and the trust.

Urgent and emergency services

Summary of findings

Overall, we rated the emergency department at this hospital as good because:

- There were enough medical and nursing staff employed by the department and staffing levels were acceptable. Staff followed safeguarding processes to protect vulnerable adults and children from abuse and referred suspected cases of abuse to the proper authority in a timely way. Staff were up to date with annual appraisals.
- The department had evidence-based policies and procedures relating to care, which were easily accessible to staff and were audited to ensure that staff were following relevant clinical pathways. Information about patients (such as test results) was readily accessible. There was evidence of different kinds of staff working well together throughout the department. The department offered services round the clock every day. Staff understood their responsibilities in relation to patients giving consent to treatment and the principles of the Mental Capacity Act 2005 that applied where a patient's capacity to consent was in doubt.
- Staff provided good care to patients. They maintained patients' privacy and dignity and dealt with people in a kind and compassionate way. Staff treated patients as individuals and the care they provided met people's physical and mental health needs. Patients and relatives were involved in decisions about their care and staff gave them emotional support in difficult situations. Results from national and local surveys and questionnaires about the care patients received were consistently good.
- Patients who visited the department had their individual needs met. Interpreters were available and there were facilities available to assist disabled patients and those with specific needs. Staff gave patients pain relief, food and drinks when they needed them. The department was meeting the target for patients to be admitted or treated and discharged within four hours, although this was a challenge. The trust was performing better than the England average for a number of other performance measures relating to the flow of patients.
- The vision and strategy of the trust were embedded in practice. Managers had plans in place to ensure the sustainability of the department for the future. There were robust governance, risk management and quality measurement processes to enhance patient outcomes. The views and opinions of patients were important.
- Staff felt that there was good leadership not only in the department but also within the trust. There was an inclusive, learning and supportive culture in the department and staff felt appreciated by their colleagues and managers. The culture in the department supported staff to deliver good patient care. Staff were encouraged and supported to be innovative and we saw many examples of innovative ways of working.

However

- The department was not meeting the trust's expected compliance rate for mandatory training. Nursing records did not always contain enough information about the care patients had received, some equipment had not been identified as soiled and there were gaps in evidence to show that some checks of equipment and medication had taken place.

Urgent and emergency services

Are urgent and emergency services safe?

Requires improvement

We rated safe as requires improvement because:

- We found recording was a problem that applied to nurse records, fridge temperature records and resuscitation equipment records.
- We also found some soiled mattresses that should have been condemned and replaced.

- Staff mandatory training figures were below the trust standard for a number of subjects however, an action plan was in place to ensure that by 31 March 2016, all staff would be fully up to date with their mandatory training.
- The environment of the department was clean, hygienic and well maintained. There were adequate staffing levels to provide safe care to patients. Medication was stored and dispensed safely and records were stored securely.
- Staff reported incidents of harm or risk of harm as common practice throughout the department and they told us of examples of staff learning from incidents, near misses and errors. The department had processes for identifying patients at risk of harm and for monitoring and escalating the care of patients if they began to deteriorate.
- Staff were well rehearsed in their roles and responsibilities when major traumas came to the department. They worked efficiently and cohesively. Staff received regular major incident training and were well rehearsed in their roles and responsibilities.

Incidents

- Between June 2015 and September 2015, there were four serious incidents or incidents that must be reported to STEIS (Strategic Executive Information System). STEIS is a national register that records the number of a specific list of serious incidents. All related to patient falls after patients were told not to mobilise. There were no never events reported by the department.
- Between June and September 2015, there were 246 incidents in the emergency department. Of the 246 incidents, 33 were graded as insignificant, 200 as minor, 11 as moderate and 2 as major. We looked at a selection of root cause analysis reports following incidents. These were of good quality and where appropriate, there were actions to improve patient care.
- The three most commonly reported categories of incidents were abusive or violent behaviour from a patient (42), pressure ulcers (98) and staff or visitor accident or incident (15).
- There was evidence that the trust took action to learn lessons and informed patients when there had been errors or potential harm. This demonstrated that staff were aware of the Duty of Candour regulations and actively informing patients or their relatives when required to. Staff demonstrated this through the information they provided when completing incidents on the electronic incident reporting system. Staff gave examples of changes made because of incidents, such as installing staff release exit buttons, collapsible curtain rails and placing patients who were admitted with alcohol or substance misuse on trolleys that had been lowered to reduce the risk of injury if the patient attempted to leave the bed.
- The National Staff Survey 2014 showed that 71% of staff thought when near misses or incidents were reported, the organisation took action to ensure that they did not happen again for example by adding extra security measures for people leaving treatment areas.
- Mortality and Morbidity meetings took place regularly across the trust and staff from the department routinely attended and reported any findings or lessons learned at departmental meetings.

Cleanliness, infection control and hygiene

- Since June 2015, there had been no incidents of MRSA (Methicillin Resistant Staphylococcus Aureus) or Clostridium Difficile in the ED.
- When we visited the department, we found it to be visibly clean. Patient rooms were cleaned in between patients and waiting area floors and seating were well maintained. Patient toilets were clean.
- There were cleaning schedules in place but we found that staff did not always complete paperwork confirming that cleaning occurred. We did however see staff completing the required tasks in line with schedules. This was not so much of an issue in minors as cleaning records had much fewer gaps.

- The annual cleaning audit was completed on 13th January 2016. The department was 100% compliant with standards measured by the audit.
- The ED scored 100% for cleanliness in the matron's monthly check for December 2015.
- Staff could call cleaners to the department 'out of hours' if required however, health care assistants were responsible for general cleaning and wiping of patient equipment such as blood pressure machines. We witnessed staff carrying out cleaning of equipment between patients.
- There was ample personal protective equipment (PPE) such as aprons and masks available to staff. We routinely saw staff using this equipment during our inspection. Patients also told us that staff washed their hands and used gloves and aprons.
- The trust routinely monitored staff hand hygiene procedures and compliance at the time of inspection was 100%.
- The department had a policy in place to ensure the safe isolation of patients who needed to be isolated. Patients who attended with potentially contagious conditions were safely in cubicles with solid walls and doors. We saw examples of this during our inspection.
- We looked at the areas where equipment was cleaned and these were visibly clean and there were cleaning schedules in place for all equipment.
- Mattress checks were carried out by housekeeping staff on a weekly basis. We checked 13 mattresses and found that 11 were soiled inside their protective cover. Staff had not identified these mattresses and condemned them in line with trust policy. Trust policy states that any mattress stained under the protective cover should be condemned and replaced, therefore housekeeping staff were not following trust policy. We pointed out the missed mattresses to the ward sister who immediately arranged for the mattresses to be replaced in line with trust policy.

Environment and equipment

- The waiting area used by patients was well lit and had enough seating.
- Consulting and treatment rooms were an acceptable size and contained the necessary patient equipment. As rooms had doors, privacy was maintained.
- We found that equipment in the department had been safety tested. All of the equipment we looked at had up to date tests.
- Servicing and maintenance of equipment was in line with manufacturer's guidelines. The medical electronics team co-ordinated equipment servicing and repairs throughout the trust. To ensure accuracy the medical electronics team also ensured that equipment was regularly calibrated.
- We saw that there were ample supplies of all equipment. This meant that if one suffered a mechanical breakdown, a spare machine was available.
- Staff told us that resuscitation trolleys were checked regularly. We checked the resuscitation trolleys and found that documentation in bays two, five and six did not support that they were checked in line with the trust's policy. There were gaps on the checklist that should be completed each time the trolley was checked.

Medicines

- Medication was stored securely in the department. Where medication was stored outside of national guidelines, this had been risk assessed and was checked regularly. There was sound rationale as to why the medication was stored in this way based on the type of drugs and how quickly they were needed in an emergency.
- Controlled drugs were stored in line with national and trust policy and stock checks were routinely completed.
- Staff from the pharmacy department completed regular checks of medication stocks held in the department and there was a system to make sure that any stock close to expiry was removed.
- Fridge temperatures were checked, however records to show this was done were not regularly completed, or completed correctly. This was the same for the main department and the paediatric department. We saw an example when fridge temperatures appeared to be outside of acceptable parameters but there was no evidence that staff had taken any action to rectify the problem or check that the medication was still safe to use. At our unannounced inspection, we saw that documentation had not been completed for nine days for the main department drugs fridge.
- Patient group directives (PGDs - specific written instructions for the supply and administration of medicines to specific groups of patients) were used in the department. They were up to date. We saw that staff had signed to say that they understood them and were working within their guidance.

Urgent and emergency services

Records

- We looked at the records of 18 patients in the majors department. We found that the records completed by medical staff showed a clear history, action plan and treatment plan. However, we had concerns about the standard of nursing records. This was because there was little information recorded. For example, none of the records had information to show that risk assessments such as falls, skin pressure care or nutrition and hydration had been considered. The one patient who attended with a fractured hip did not have the pathway document in their records, in the emergency department, or once transferred to the ward.
- On the electronic record, we saw that there was clear information about patients' presenting condition; however, we noted that due to the system in place, this was not added at the time of streaming, but after the patient had been directed to the correct department and had registered. The paper record was returned to the triage nurse to put on to the electronic record.
- The records we looked at did not show that nursing care, such as supporting patients to eat, or take comfort breaks had taken place. We did however see that this support was offered to patients, but it had not been documented.
- Medication and pain scores were completed and the records demonstrated clear medical treatment plans.
- Patients had observations taken. All of the records we looked at contained the necessary information about the patients' National Early Warning Score (NEWS).
- We discussed record keeping audits with the management team of the department. They told us that regular monthly record keeping audits did not take place. They were unable to assure us of the quality of record keeping although they were aware that record keeping needed to improve.

Safeguarding

- We looked at the processes and policies the trust had for safeguarding vulnerable adults and children. They provided staff with good, detailed information about the action they should take if they had concerns about any patients who attended the department.
- We spoke with a number of staff from all disciplines about the action they would take if they were concerned about the safety and welfare of patients. They demonstrated good working knowledge.
- There were referrals for vulnerable adults and children. Information was routinely sent to health visitors about all children who attended the department.
- Safeguarding training included specific training about safeguarding topics such as sexual exploitation, people trafficking and female genital mutilation (FGM). Staff in the paediatric department knew the signs to look for. Staff in the other areas were less confident about these topics.
- The IT system used by the department routinely displayed the number of attendances patients had made during the previous 12 months. Where there were concerns about patients' welfare, the system also displayed an alert to staff that gave specific details about any risks to the patient or to staff.
- Safeguarding training in the year to date, up to September was below the trust expected standard of 95%. Training figures showed compliance as follows: Safeguarding adult's level one 74%, safeguarding adults level two, 26%, safeguarding children level two, 23% and safeguarding children level three, 36%. There was a schedule in place to ensure that the service would meet the trust target by 31st March 2016.

Mandatory training

- Staff told us they had accessed most mandatory training on the intranet. They reported few problems accessing e-learning (training courses on the intranet) other than the occasional shortage of free computers.
- None of the staff groups were meeting the target of 95% for any mandatory training. The matron was aware of this and there was a plan in place to improve mandatory training by March 2016.
- According to the information sent to us, no staff had undergone paediatric basic life support refresher training since April 2015. Additionally, not all staff (Medical staff 43% and nursing staff 33%) had undergone basic adult life support refresher training since April 2015. We discussed levels of training with managers and staff who informed us that there was an action plan in place to ensure that levels of staff training improved and that all staff would be compliant by 31st March 2016.

Assessing and responding to patient risk

- Patients were triaged on attending the department and staff based their decisions about whether the patient should be treated in the minors, majors, paediatric emergency department or eye casualty.
- Of the seven records we looked at in majors, six showed that patients were routinely seen within 15 minutes of attending the department. One patient waited 17 minutes to be seen.
- Patients with allergies wore a red wristband to ensure that they were easily identifiable. Staff recorded known patient allergies in patient records.
- Patients had their observations taken regularly and the department used the national early warning score (NEWS) or paediatric early warning score (PEWS) to assist in identifying patients whose condition was deteriorating. Staff were fully aware of the action they should take if patients deteriorated and there was a process in place for staff to follow. All of the patient records we looked at had NEWS or PEWS recorded.
- There was emergency medical equipment in the department and staff were experienced at dealing with very sick patients. There were senior staff on hand to support less experienced staff 24 hours a day.

Nursing staffing

- We found that the staffing levels and skill mix within the department were appropriate to meet the needs of patients who attended. Although the department did not formally use an acuity tool, staffing levels were reassessed on a six monthly basis to take in to consideration changes in workload. Staff and managers told us staffing levels were frequently monitored to ensure that staffing levels matched the demand for services.
- There were qualified members of the nursing team who worked in advanced roles as emergency nurse practitioners, treating patients with minor injuries and illnesses.
- According to information provided to us by the trust, between April 2014 and March 2015, there was a staff turnover rate of 3.51% for band five and six staff and 15.79% for band seven to eight (A) staff (three staff).
- The sickness rate for nursing staff was around 2%, which was better than England averages.
- Information sent to us by the trust showed that there were six whole time equivalent (WTE) nursing vacancies in the department, which was confirmed by the departmental management team. The matron told us about the action the department was taking to recruit new staff to the emergency department such as running a recruitment campaign and working with local universities.
- The number of nurses actually working and the number expected and planned to be working were displayed in the department and updated on a daily basis. We looked at the rotas for nursing staffing for previous weeks between November 2014 and January 2016. There were no significant gaps. The senior sister made a clinical judgement based on the experience of staff about whether, when there was a gap, bank or overtime was needed.
- Staff absences and annual leave were managed using overtime and internal bank staff.
- Information sent to us by the trust showed that there was no agency use in the ED and low levels of bank use. From April 2014 to March 2015, bank use ranged from 1.9% to 4.2% with an average over the year of 3.2%.
- We observed handovers between senior nurses and between staff nurses and saw that staff effectively communicated information about why patients were attending and care needs of patients to colleagues starting the new shift or taking over responsibility for care.

Medical staffing

- Doctors staffed the department 24 hours a day seven days a week. Emergency department consultant presence was also on site 24 hours a day, seven days a week.
- There were 17 whole time equivalent consultants employed by the department.
- In comparison with the national average, the department had more consultants (40% compared to 23%) and fewer junior doctors (17% compared to 24%).
- The department employed three experienced staff grade doctors and a range of trust grade, training grade and junior doctors.
- The senior management team and senior medical staff told us that it was difficult to recruit doctors in to the emergency department and that this was a recognised national problem. In order to attract staff to the department, the trust offered research opportunities and linked with the local medical school. This had proved to be successful and meant that locum use was limited. The department had eight clinical fellows.

- Senior medical staff told us that locum use was minimal and that the trust used a number of regular locums to fill gaps in rotas. Between April 2014 and March 2015, locum use varied from 0.4% to 11.6% with the average across the year being 4.3%.
- We observed doctors discussing patients and handing over relevant information to colleagues. We had no concerns about this process.
- The trust employed GPs to work in the department between 6pm and midnight to deal with some children who attended, or patients who had minor illnesses in the minors department.
- Specialist ophthalmology medical staff were present in the eye casualty department and support was available by the ophthalmology ward if needed.
- The trust reported to us that medical staff were fully up to date with revalidation requirements.

Major incident awareness and training

- The emergency department at the RVI was a major trauma centre. This meant that in the event of a major incident in the region, patients attended the RVI. The department received patients who had been involved in serious accidents and incidents. Patients were brought to the department both by road and by air ambulance.
- We checked the equipment the department held, which would be used in the event of a major incident. We found that this was stored securely, organised and appropriately accessible. We found that the department had an ample supply of high visibility clothing, hard hats, torches and radiation detection equipment.
- Staff in the department were aware of the role they would play if there were a major incident in the region. We also observed that staff worked as an organised and cohesive team when responding to trauma patients brought into the department. Each staff member, nurse, doctor and others were clearly identifiable and each person knew exactly what their role was in supporting and treating patients.
- We observed the initial care and treatment of patients brought to the department as emergencies, both by road and by air ambulance. We saw that the processes for receiving such patients were smooth and clearly well rehearsed. Staff told us that such patients were a regular occurrence to the department.
- The department had a policy in place to manage patients presenting with suspected Ebola. There was sufficient equipment and a designated area of the department. Staff were aware of their roles and responsibilities in the event of a possible presentation and had previously put this in to practice very effectively.
- Staff received refresher training about major incidents approximately every three months.
- The department had business continuity plans in place, in the event of system failures.
- The department had plans to manage increased demand on the service, such as over the winter period.
- Security staff were based in the department and were easily accessible if required.
- The department could be locked down easily to ensure the safety of patients should the need arise. Staff were aware of their roles and responsibilities in such a situation.

Are urgent and emergency services effective?

(for example, treatment is effective)

Good

We rated effective as good because:

- There were policies and procedures and these were evidence based. Audits took place to ensure staff were following relevant clinical pathways. The trust was taking part in local and national audits and monitoring patient outcomes. The trust had identified a need to improve some audit results where they had outcomes worse than the England average and action was taken to make this happen.
- Staff were able to access information about clinical guidelines. Information about patients such as test results were readily accessible.
- Patients were offered pain relief on arrival at the department and regularly during their stay; however, this was not always recorded. Paediatric pain scores were not recorded and although pain relief was administered, re-evaluation of patient pain levels were not always carried out.
- Patient and relative's nutrition and hydration needs were managed and we saw patients being offered drinks and food whilst we were inspecting the department. Patients also confirmed that they were offered food and drinks.

- There was evidence of multi-disciplinary and multi-agency working throughout the department and the department offered a full seven-day service.

Evidence-based care and treatment

- There was a wide range of departmental policies and guidelines for the treatment of both children and adults.
- Departmental policies were based upon the National Institute for Health and Clinical Excellence (NICE) and Royal College guidelines. We looked at a reference tool available to staff and found that guidelines reflected recent updates to NICE guidance.
- We saw evidence that the department followed NICE guidance for a number of conditions such as sepsis, head injury and stroke. Where patients presented to the emergency department with these conditions, pathways were commenced. The department had introduced a sticker to in patient notes as a response to poor sepsis audit compliance.
- A recent audit had been undertaken to assess compliance with the delivery of the Sepsis 6 within the ED for patients who had 'Red Flag Sepsis'. The results were encouraging and showed a significant improvement on the base line data. However, there was still much room for improvement and the cycle of audit and review will need to continue to improve compliance further. For example, the introduction of the 'ED Sepsis Sticker' showed that it was only used in 31% of cases. Although the sample was too small to assess the impact of the sticker, 4 out of 5 patients with a sticker had all aspects of the 'Sepsis 6' completed in full and within the 60-minute target. These results would be fed back to the ED team and a repeat audit undertaken within the next 6 months.
- Care was provided in line with 'Clinical Standards for Emergency Departments' guidelines and there were audits in place to ensure compliance. Staff acknowledged that results to some audits were poor due to record keeping but were keen to stress that patients received the appropriate care and treatment for their conditions in a timely manner and in line with guidance. During the inspection, we tracked one patient who had attended with a fractured hip. The pathway documentation had not been completed. However, the patient had received appropriate and timely treatment.
- Local audit activity demonstrated that audit, re-audit took place in the department, and there was evidence of changes implemented as a result. For example, the introduction of paediatric early warning scores (PEWS) for children with asthma, and work to introduce a psychiatry liaison team in to the department to support patients who presented with mental health conditions.

Pain relief

- We saw that patients were asked if they required pain relief as part of the triage process and it was recorded if patients refused. Patients were checked regularly to see whether they needed further pain relief. Patients we spoke with confirmed that they were offered pain relief.
- We saw nurses giving patients pain relief such as paracetamol and ibuprofen using PGDs.
- CQC's national 'A&E survey 2014' showed that the trust performed worse than other similar trusts for the time patients waited to receive pain medication after requesting it. As a response to this, PGDs (patient group directives) had been introduced that meant nursing staff could prescribe simple pain relief quickly, at initial assessment. We saw patients being offered pain relief at triage and periodically throughout their stay.
- In the same survey, the trust performed worse than other similar trusts when patients were asked whether staff did everything, they could to control people's pain.
- Of the 12 sets of notes reviewed in the paediatric emergency department, none had pain scores recorded although records showed that those patients who needed pain relief received it in a timely manner. The same records showed there had been no reassessment documented however further pain relief had been administered.
- In December 2015, the department undertook a clinical audit of pain management of patients presenting to the ED. The re-audit showed an improvement in recording of pain scores, in the number of patients receiving the appropriate pain relief within 60 minutes, the number of patients having their pain relief re-evaluated within 120 minutes and documenting of reasons for not administering pain relief as per protocol. However, the department was falling short of Royal College of Emergency Medicine standards and a further re-audit was planned for April 2016 to ensure further improvements.

Nutrition and hydration

- CQC's national A&E survey 2014 showed that the trust performed 'about the same' as other similar trusts for the ability of patients to access food and drinks whilst in the ED Department.
- Staff told us that sandwiches, hot meals and beverages were available to patients. We overheard staff asking patients if they wanted drinks or snacks and we saw patients being offered drinks and being brought hot and cold meals.
- There were vending machines present in the department that relatives and carers could access and the hospital had a number of shops, cafes and places to eat.

Patient outcomes

- The department took part in Royal College of Emergency Medicine (RCEM) audits. The results of some audits showed that the department needed to improve compliance with RCEM guidelines. We saw that re-audits had taken place to ensure results had improved because of changes made, such as the sepsis pathway and the introduction of new documentation as well as the introduction of a lead nurse and consultant for management of sepsis. Paediatric early warning scores had been introduced to ensure that patient vital signs were recorded for children with asthma. Work was also ongoing with local psychiatry services to ensure a more timely response to referrals from ED staff to psychiatry services.
- The department had no CQUIN (Commissioning for Quality and Innovation) targets for 2014/2015 or for 2015/2016.
- Trauma Audit Research Network (TARN) information showed that when the trauma team was activated, 99% of patients with a head or spinal injury and 98% of patients with a chest or abdomen injury were seen by a consultant within five minutes of arrival.

Competent staff

- According to information provided by the trust, between April 2015 and October 2015 75% of band two to four, 92% of band five and six and 82% of band seven to eight had undergone annual appraisal. Within the medical staff, 75% of consultants and 67% of middle and trainee grade staff has undergone an annual appraisal.
- We spoke with staff about whether they were able to access support and supervision. Staff told us that the department managers supported them to develop their roles. Staff felt well supported and able to discuss clinical issues openly with colleagues and managers.
- The department required that all newly employed staff had at least six months experience before joining the department. Recently qualified staff were given preceptorship (mentoring and support) and newly employed staff shadowed existing staff prior to being counted as a member of the team for staffing purposes.
- We saw that there was a local induction in place for all new staff including temporary staff. The senior nurse in charge had to sign to say they were happy with the competencies of any bank staff used.
- The practice education nurse worked with staff to ensure that they were competent. Senior members of staff informally monitored staff competencies throughout the year and managers told us that action was taken to address any concerns about staff competencies. This applied to both medical and nursing staff.
- All staff were part of the revalidation scheme and we identified no concerns about compliance within the department.

Multidisciplinary working

- The emergency department teams worked effectively with other specialty teams within the trust, for example by seeking advice and discussing patients, as well as making joint decisions about where patients should be admitted. There were close links with the ambulatory care department and the assessment suite.
- There was good access to mental health clinicians within the department with 24-hour telephone access to psychiatric liaison staff. The aim was to have a psychiatry liaison team based in the department in the future.
- There was a substance and alcohol misuse liaison team available by telephone to support patients and staff treating them.
- Allied health professionals such as physiotherapists and occupational therapists attended the department. This meant that patients who needed therapy input or assessment prior to discharge could be seen quickly and efficiently.

- The department worked closely with the ambulance trust, local GPs and the out of hours service to ensure that unnecessary attendances and admissions to the department were avoided.
- We saw that medical and nursing staff worked well together and communicated clearly and effectively about patients.

Seven-day services

- The emergency department offered a seven-day service staffed 24 hours a day, seven days a week by medical and nursing staff. Staff could access support from consultants throughout the 24-hour period.
- There was 24-hour seven-day access to diagnostic blood tests. The department had some point of care testing which meant that some blood tests could be carried out in the department. Radiology tests such as x-rays and scans were carried out as and when needed and were available 24 hours every day.

Access to information

- Staff were able to access patient information using the electronic system and using paper records. This included information such as previous clinic letters, test results and x-rays.
- Patients transferred to other services or sites took copies of their medical records with them. Additionally, the referring clinician gave a verbal handover to the receiving department to ensure that important details were captured.
- Clinical guidelines and policies were available on the trust intranet.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- We spoke with staff about the Mental Capacity Act (MCA) 2005 and Deprivation of Liberty Safeguards. Most staff understood the basic principles of the Act and were able to explain how the principles worked in practice in the department.
- We saw staff put in to practice their knowledge around the Mental Health Act and actions to take if patients needed to be detained under the Act.
- Training figures for MCA training were at 53% for nursing staff and 13% for medical staff. The trust target was 95%.
- Staff we spoke with understood the need to obtain consent from patients to carry out tests and treatments. Staff told us that they implied consent when the patient agreed to a procedure and we saw evidence of staff explaining procedures to patients and patients agreeing to them.

Are urgent and emergency services caring?

Good

We rated caring as good because:

- Patient feedback for the department was positive. We saw patients supported and receiving good treatment. Amongst staff, there was a patient-centred culture. All staff delivered individualised care to patients. Patients were involved in decisions about their care and treatment and diagnoses were explained in ways that patients could understand.
- Staff recognised people's physical and mental health needs and offered support. Staff had a holistic approach to the treatment of patients who presented with both physical and mental health needs.
- Emotional support was present for patients and their relatives and wider support mechanisms were in place as required by patients and their relatives. People's social needs were considered by staff and were a part of their care and treatment.

Compassionate care

- During our inspection, we spoke with 31 patients who were very happy with the care they received.
- Patients described to us how all staff treated them with dignity and respect. Relatives told us they chose to bring family members to this department because of the way they would be treated. Some patients told us that the department had a good reputation and did not mind waiting to be seen.
- Results from the 2014 A&E survey showed that the trust scored about the same as other similar trusts when patients were asked if they felt they were treated with respect and dignity in the department.
- Results of the 2014 A&E survey showed that the department performed about the same as similar trusts in five of the eight questions relating to care and

treatment and worse than other trusts for the remaining three, reassurance when distressed, time to receive pain relief and feeling as though everything was being done to control pain.

- When we discussed care of patients with staff, there was a consistent message that staff wanted the patients to feel as though they were being well cared for.
- Parents of children attending the department told us that staff were, "Fantastic, they are lovely I cannot fault them", "Fantastic…I cannot fault them", "and they are all good", "Staff have been very helpful" and "Staff are all very nice". .
- The trust performed about the same as other trusts in 23 of the 24 compassionate care questions in the '2014 Accident and Emergency survey'. The trust scored worse than other trusts for one question, whether patients felt staff reassured them if they were feeling distressed in the department.
- The National Friends and Family test showed that 91% of patients who used the department between August 2014 and August 2015 would recommend this department compared to a national average of 88%.

Understanding and involvement of patients and those close to them

- According to the 2014 A&E Survey, the department scored about the same as other trusts for questions relating to understanding and involvement.
- Patients were happy with the amount of information they received when visiting the department.
- Patients and relatives told us that staff explained patient literature to them and gave them time to ask questions.
- Staff delivered patient diagnoses in a calm and sensitive manner and in language and terms, which patients and their relatives understood.
- Patients and relatives told us that staff were responsive to their questions and before they left the department, made sure they understood their care or treatment pathways and next steps.
- When patients needed to be transferred to another part of the hospital, we saw staff explain why this needed to happen, how it would happen and what would take place once the patient arrived at their new destination

Emotional support

- Staff understood how important it was to ensure that patients had emotional support as well as medical treatment.
- Staff told us about how they would support patients who were distressed, by chatting to them and trying to distract them.
- Staff told us they made sure patients received the support they needed. Patients we spoke with said that they would feel reassured if they needed extra support to know someone was there for them.
- We observed all staff talking with patients and relatives in a calm way and offering reassurance to both concerned patients and their family members.
- Staff offered support and gave information about support services if this was required.
- Staff could refer patients who presented with alcohol or drug problems (regardless of their age) to support services available through the alcohol liaison nurse.
- Staff were observed delivering news in a sensitive and compassionate manner.
- There was pastoral support available for patients of all or no religious belief.

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

(for example, to feedback?)

Good

We rated responsive as good because:

- The department delivered services to patients who attended from around the region as well as the local population. To ensure that services met people's needs, external stakeholders, organisations and the local community were involved in how services were planned. The department was part of a Vanguard project to improve the provision of urgent and emergency care for patients across the region.
- Patients who visited the department had their individual needs met. Interpreters were available and there were facilities available to assist patients with disabilities or specific needs.
- Ambulance handovers to the department were efficient and there had been no excessive patient trolley waits. The average patient wait between April and October was less than four hours in 95% of cases. In January

2016 this was 92.2% compared to an England average of 88.7%. For all performance measures relating to the flow of patients, the trust was performing in line with or better than the England average.
- The trust actively managed patient complaints in line with the trust's policy. Lessons were learned and where applicable, feedback was given to staff.

Service planning and delivery to meet the needs of local people

- Senior staff told us that there had been a period of crisis management rather than service planning when demand took a sudden increase, however that period was managed and although workload was still increasing, there was no longer a need for crisis management.
- The department was working with the local 111 service, North East Ambulance service, GPs and community services to look at ways to ensure that patients attended the most appropriate service to manage their conditions, such as specialist community services rather than attend hospital unnecessarily. The department was part of a Vanguard project to look at the urgent and emergency health economy.
- GPs worked in the department each evening between 6pm and midnight and over the weekend from 10am to midnight to ease the pressure on the main ED and ensure that the most appropriate clinician saw patients quickly.
- Managers were aware of the type of patients who attended the department and the potential major incidents that could occur locally and had ensured that the department had the necessary equipment and trained staff to manage such situations.
- The department had acknowledged the mental health needs of the local population and had good access to mental health services. There was work in progress to have psychiatric liaison services based in ED. This would improve the experience for mental health patients and ensure that they received the most appropriate care as quickly as possible.

Meeting people's individual needs

- The waiting room and triage rooms were large and spacious. This meant that the department was easily accessible to patients who used wheelchairs. Additionally there were dedicated disabled toilets available.
- On average, 22% of patients that attended the department were under the age of 17. There was a dedicated paediatric emergency department and treatment rooms for children were decorated with age appropriate murals and wall art. This was open 24 hours a day. This meant that young people were away from the adult waiting and treatment rooms at all times.
- There were facilities, such as beds and wheelchairs, for bariatric patients.
- The trust had access to interpreting services for people whose first language was not English. Staff told us that in an emergency they may use a family member in the very first instance, but would try to access an interpreter as quickly as possible. The trust could also access telephone interpreters if necessary. We noted that the department had received a written complaint in October 2014 regarding the delay in an interpreter being used. The complaint also stated that staff used the patient's partner to interpret because they thought that the partner had a good standard of English, rather than the telephone interpreting service that was available. Staff were reminded to use professional interpreting services at the earliest possible time.
- The trust had access to British sign language interpreters however general feedback from deaf people was that this was not always available and that there was a general lack of understanding from staff about how to support people with hearing loss.
- Most patient information was available in different formats such as large print, audio, CD, braille and languages other than English on request.
- There were private areas for relatives to wait whilst patients were being treated. There were relatives' rooms as well as a viewing room where people who were recently bereaved were given support and could see their family member. They could wait in privacy. The room was comfortable and tastefully decorated. There were advice leaflets available for relatives.
- The trust had a dementia strategy and within the department, there were designated dementia leads for nurses and doctors.
- The staff we spoke with about patients living with dementia, or a learning disability all told us that they would treat patients as individuals but would try to find out about them in order to make a decision about whether they needed any extra support such as to be

seated in a private area. Staff told us that whenever possible, people with dementia or a learning disability were seen as quickly as possible in order to minimise distress for the patient.

- Some patients with learning disabilities had patient passports. When the patient or carer presented this at the department, staff used the information to assist them in making decisions about patient needs and wishes.
- If patients had specific needs, such as a learning disability, were living with dementia, or had mental health problems, alerts were also put on to the electronic record system to alert staff. The electronic records system had a built in alert system that highlighted any patients attending the department who were at risk of self-harm, or harming others. This made sure that staff were aware of safety risks to patients and to themselves. Security staff in the department were informed for the safety of patients and staff.
- Information about expected waiting times was clearly visible however this was not updated regularly. We spoke with clinical and reception staff about who had responsibility to update waiting time information but neither group of staff was clear about where responsibility lay. This meant that patients were not always clear about how long they could expect to be in the department.
- For patients and relatives of all faiths or none there was 24-hour access to chaplaincy services.
- Patients with purely mental health needs were supported to wait in a designated room that had two exits, panic button and CCTV. The trust had access to the psychiatric liaison team by telephone and was working towards having the team based in the department in the near future.
- The paediatric emergency department employed play specialists who worked with children who attended to department.
- The trust offered accommodation to the relatives of major trauma patients so that relatives could stay close to their family member.

Access and flow

- Ambulance staff told us that they had no concerns about the handover time within the department. They told us that handovers were usually quick. Between July 2015 and October 2015, 11 patients waited longer than 30 minutes to be handed over from ambulance staff to hospital staff. No patients waited longer than 60 minutes to be handed over. This means that there were no black breaches. We saw evidence that the trust carried out investigations when this happened.
- Between April and October 2015 95.3% of patients were seen within four hours of arrival. However, three of those months, the 95% target was not met (April, June and September). The management team met regularly to discuss this and manage the situation.
- Between April 2014 and October 2015, no patients waited on a trolley in the department for more than 12 hours before being either discharged or moved to a ward.
- The unplanned re-attendance rate for the department was 1.8% average between April and October 2015.
- 4.8% of patients left the department without being seen between July 2014 and December 2015. The rate for the eye casualty department across the same period was 0.3%
- From our observations and discussions with patients and staff, patients were triaged and assessed quickly. Few people we spoke with expressed concerns about excessive waiting times.
- We looked at the clinical records of seven patients who had attended the emergency department during our inspection. Five patients waited less than 10 minutes for their initial assessment, one waited under 20 minutes and one under 30 minutes.
- The department used rapid access and treatment to triage patients where a nurse and consultant worked together to assess patients and plan diagnostic needs such as order tests. This was aimed at improving the flow of patients through the department at busy times.
- The minors and paediatric departments used GPs at certain times of the day to deal with minor illnesses and injuries to ease the pressure within the department. This also helped ensure that patients were seen by the most appropriate person to treat them.

Learning from complaints and concerns

- Patients and relatives we spoke with were confident about how to make a complaint to the trust although none of the people we spoke with had made a complaint about the department.
- There was information about how to raise concerns about ED or the trust as a whole on display in the department and there were leaflets available for patients to take away with them.

Urgent and emergency services

- Staff were able to describe to us the action they would take if a patient or relative complained to them.
- Between October 2014 and October 2015, the trust received 29 complaints about the ED, two complaints about the paediatric ED and one complaint about eye casualty.
- The most common cause for complaints was 'All aspects of clinical treatment'. There were some themes running through the complaints such as attitude of staff and lack of communication with patients.
- Information provided by the trust showed that feedback was given to staff when they were part of a complaint. Additional training and counselling was offered as a way of supporting staff.

Are urgent and emergency services well-led?

Good

We rated well-led as good because:

- The vision and strategy of the trust was embedded in clinical practice. Staff felt that there was good leadership not only in the department but also within the trust. Staff were inspired to ensure that they delivered good patient care and were supported to do so. Staff were proud to work for the organisation and the department. There was an inclusive, learning and supportive culture in the department and staff felt appreciated.
- There were proactively managed governance and quality measurement processes to monitor and manage performance and patient outcomes. However, the departmental risk register did not reflect all of the clinical risks in the department.
- The opinions of patients were important and there were a number of initiatives within the trust designed to ensure that the opinions of patients were heard and influenced the delivery of services.
- Staff were encouraged and supported to be innovative and we saw many examples of innovative ways of working within the department and with other organisations such as the introduction of MERIT (medical emergency response incident team) bikes and haemorrhage packs to deal with major traumas.

Vision and strategy for this service

- The hospital had a vision and five core values as well as five strategic goals. Staff we spoke with demonstrated these values, putting patient's first, pride in what they did, being professional at all times and working in partnership with colleagues and others. The department was also innovative, demonstrating pioneering approaches to service delivery. Staff demonstrated through their actions that patients were at the centre of everything they did.
- The trust had a vision for the service and it was working with local clinical commissioning groups, GPs and service providers to develop urgent and emergency care services. The department was part of a Vanguard project looking at the health economy of urgent and emergency care in the region. Vanguard projects are supported by NHS England to improve the effectiveness and efficiency of health care services in England.
- Managers in the department were aware of the changing demands and the types of patients accessing the department. Work was continually underway to ensure demand was managed appropriately and safely.
- Managers had succession planned. For example, they had looked at the age and skill mix of staff and identified the future staffing levels and training needs of the department. They had developed a training and education programme for staff to ensure that if staff left, the department would remain functioning and safe.

Governance, risk management and quality measurement

- A robust clinical governance system was in place across the department. Staff were able to attend clinical governance, patient safety and clinical audit meetings.
- There was a robust process to ensure that all relevant NICE guidance and drug alerts were implemented and that staff were aware of any changes.
- The staff we spoke with were clear about the challenges the department faced.
- There was a robust process for ensuring that the results of radiology investigations were followed up to ensure that any "missed abnormality" was followed up in a timely way. Where abnormalities had been missed, staff involved were informed and offered support and training to ensure that the risk of future errors was minimised. We saw documented evidence that this happened.

Urgent and emergency services

- When we spoke with the senior management team, they were able to tell us clearly about the risks posed to the department and how these were being addressed. For example, relating to workload and staff recruitment.
- The trust provided us with a risk register for the department. There was only one risk on the register. We asked the trust to ensure that this was the only risk register for the department and they confirmed it was. We had concerns about this because this suggested that the department were not aware of any clinical risks within the department other than pressure to meet the national four hour waiting time standard. It also contradicted the discussions we had with the management team about the risks the department faced.
- Managers discussed waiting time breaches weekly to identify any themes and were able to take actions to address issues, such as bed shortages across the trust.

Leadership of service

- We found that the leadership in the department was strong. During our inspection, senior managers were visible within the department and readily available to support staff. Staff confirmed that this was the case.
- Staff told us that members of the executive team occasionally visited the department. Staff were complimentary about the senior management of the trust. According to the NHS staff survey 2014, 88% of staff knew who their senior managers were. This was better than the national average of 84%.
- Staff felt that their hard work was recognised and they felt appreciated.
- Nursing staff told us that they felt well-led at a local level and that they had no concerns with their line managers. They felt that they could raise concerns and be confident that they would be resolved quickly. They told us that the management team was open, approachable and provided good leadership.
- In the 'NHS 2014 staff survey', 50% of staff believed that staff who were involved in an incident, error or near miss were treated fairly. This was better than the national average of 47%. 48% of staff said they agreed or strongly agreed that they received feedback about changes made in response to incidents, errors, or near misses. The national average was 44%.

Culture within the service

- The department had a patient oriented culture. The atmosphere in the department showed that staff focus was on treating patients in a compassionate and professional way. Staff felt supported to be able to deliver good care for patients.
- The way we saw staff interact with each other demonstrated that there was an open and respectful culture. Staff showed great teamwork and supported each other to ensure that patients received good care.
- Staff told us that they supported each other to learn from incidents. We saw evidence of this through the incident reports we looked at. Staff were encouraged to take responsibility and reflect on incidents in a positive way.
- The department scored better than the national average for fairness and effectiveness of procedures for reporting errors, near misses and incidents at 3.59 (out of 5) compared to the national average of 3.54.
- Staff told us they valued their colleagues, managers and the trust. The national NHS staff survey showed that 79% of staff were satisfied or very satisfied with the support they received from colleagues. This was similar to other acute trusts.
- Overall, staff told us they were proud to work for the hospital and in particular this department. One member of staff told us, "It always feels good to say that I work in this department in this trust because it has such a good reputation around here".
- The team appeared to be efficient, and the concept of teamwork was clear from our observations at the inspection. Staff worked naturally well with each other, particularly in high pressured, potentially stressful situations such as when major traumas were brought to the department.

Public engagement

- The trust took part in the national Friends and Family initiative (FFT) and used volunteers in the department to try to encourage patients to reply.
- The trust had a member of staff employed specifically to encourage patient engagement. They worked with patient groups to get patient feedback about services.
- The department carried out local surveys, comment cards, text messages and questionnaires and regularly checked NHS Choices for patient feedback. Results from the FFT and local questionnaires were very positive about the department.

Urgent and emergency services

Staff engagement

- We saw that regular staff meetings took place for both medical and nursing staff.
- The staff survey showed that people wanted to work for this trust and were proud to do so.
- The National Staff Survey of 2014 showed that the trust had a better response rate than other similar hospitals.
- As a whole the trust scored better than other similar trusts for staff feeling work pressures, receiving job relevant training, receiving appraisals, which were well structured, suffering work related stress and witnessing potential harmful errors, near misses or incidents. There were no specific results for the emergency department.
- The National Staff 2014 Survey also showed that the trust as a whole was performing better than other similar trusts in: staff reporting good communication between staff and managers, staff being able to contribute to improvements at work, staff recommending the trust as a place to work, staff believing that there were equal opportunities to progress and overall engagement.
- Staff told us that they were kept informed about changes within the department as well as opportunities to progress through emails and team meetings

Innovation, improvement and sustainability

- The department was working with nursing and care homes when beds were under pressure to ensure that patients, who were medically fit for discharge, but needed social care support, did not have to remain in hospital.
- The staff in walk in centres were able to speak to consultants using a video phone if they needed advice about a patient. This meant that advice was based on visual information as well as verbal information.
- There was point of care testing in place within the department. This meant that staff could carry out some blood tests quickly without the need to wait for the laboratories to process the results. Each cubicle also had an ultrasound machine in place. This meant that ultrasound could be carried out without waiting for the radiology department. Staff had been trained to use the ultrasound equipment.
- The department had developed a major haemorrhage pack and fresh plasma was kept in the department. This was shown to decrease the number of patient deaths and improved outcomes for patients. Blood bikes were used by the trust. Blood bikes took blood to roadside incidents when patients needed urgent blood transfusions. This again was shown to improve patient outcomes.
- The Blood on Board scheme ensured that the air ambulance carried blood supplies that could be used to give patients' blood transfusions at the scene of their accident or incident.
- The trust used MERIT bikes. These were used when a patient needed a surgical team to attend them at the scene of an accident, or in the event of a major incident. Staff were taken to the site of the incident to deliver treatment before the patient was transferred to the A&E department.
- The department had developed a chest trauma management pathway in conjunction with the critical care team to ensure that any patient with chest injuries was assessed immediately and treated appropriately.
- The department worked closely with the critical care, general surgery and orthopaedics teams to run major trauma simulation courses bi-monthly. This made sure that staff delivered consistently safe and well-co-ordinated care to patients.
- Children with chronic conditions were issued with a passport that identified their condition and lead consultant. This meant that such patients were seen quickly by the most appropriate person and received their treatment more quickly.
- A number of senior staff were involved in research within the department looking at a wide range of topics including how many patients had alcohol in their system when they attended the department. Some of this meant that new procedures and pathways were used in the department to improve patient care.
- Staff told us that innovation was encouraged, with patient safety paramount. Staff were encouraged to look at new ways of working and becoming more effective and efficient.

Medical care (including older people's care)

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

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. In 2014-15, the medical directorate recorded almost 25,000 new outpatient appointments and in excess of 56,000 review appointments.

With almost half of directorate beds across its 12 medical in-patient wards, the Royal Victoria Infirmary ("the RVI") situated in the heart of Newcastle's City Centre accounted for 38,600 of these admissions. The RVI offers in-patient care for those requiring general and specialist medical services in dermatology, neurology, infectious diseases, respiratory care, diabetes, endocrinology, stroke medicine and cardiology. The RVI also houses the trust assessment suite.

During our inspection, we spent time at the RVI visiting wards, the assessment suite and the endoscopy unit. We also attended the stroke rehabilitation ward at the Centre for Aging and Vitality (CAV) based on the old Newcastle General Hospital site. We spoke with 63 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 25 patients and relatives and were able to observe shift handovers, multi-disciplinary team meetings (MDT) and care delivery 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 good overall because:

- There was a good track record 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 good evidence of joint and effective multi-disciplinary team working.
- 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. Care of patients was the top priority with governance arrangements set up to effectively identify, manage and plan actions to mitigate risks affecting 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 confidently reported such incidents. There were some lessons learnt and changes made following incident review.
- Safety thermometer data showed performance consistently better than national target. The service showed steps taken to address particular concerns surrounding pressure ulcer care and falls.
- 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.
- Overall, record keeping and the storage of medical notes was good. Staff administered medications in accordance with guidelines.
- Staff had an awareness of safeguarding procedures. There was 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 throughout the service. To reinforce, Safer Nursing Care Tool (SNCT) findings, senior staff used professional judgement 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 directorate was achieving staffing fill rates over 90% which showed effective staff cover. Senior staff closed beds when safe staffing levels could not be achieved.

However

- Staff were not always given protected time to complete some aspects of their mandatory training causing conflict with working shifts and ward duties.
- Some resuscitation trolley medications were not securely stored and equipment checks not recorded.
- On some wards, clinical records were not stored securely and there was inconsistency in recording.

- Although improvements had been made to ensure patients received antibiotics within one hour to treat sepsis, the latest audit showed compliance of 55%, which was still low.

Incidents

- The service reported incidents through the trust electronic reporting system.
- Between June and September 2015, there were 2,627 medical care incidents reported, of which 1,332 originated from RVI.
- From the 2,627 total, four (0.1%) 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 RVI reported 1 '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, medicine 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). Incidents meeting the SI criteria accounted for six (16%) of the total. These trends related 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 those they would report. This included any incidences of falls, pressure ulcers, near misses and medication errors. Staff graded such 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.
- There were no never events in the service between August 2014 and July 2015.
- Staff we spoke with explained that they received feedback on incident outcomes by e-mail, at team meetings, and through informal supervision to inform learning and improvements in care.
- Staff identified that feedback from non-serious incidents was less structured in contrast to feedback from more serious incidents.
- Ward 19 held a daily morning safety briefing to discuss incidents. Ward 41 produced a monthly newsletter to share learning outcomes from reported incidents.
- Ward 52 introduced a safety checklist for patients who administered their own intravenous (IV) antibiotics. This followed an incident in which a patient developed a portacath infection. A portacath is a small tube implanted under the skin to allow frequent or continuous medication to be given directly into a vein.
- Staff reported all PUs irrespective of grade or classification and tissue viability nurses (TVNs) responded 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 confirmed their understanding 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.
- Staff discussed learning from incidents in 1:1 reviews, appraisals and ward meetings. Heads of Units, Ward Managers and Matrons also discussed incidents at their regular meetings. The trust 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 cascaded to ward staff and relevant others during safety briefings and by 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 CUTI's (urine infections in patients with a catheter). 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 TVNs recorded 89 trust acquired categorised PUs across all wards at the RVI, 7 (7.9%) as category 1, 76 (85.4%) as category 2 and 6 (6.7%) 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 200 falls at the RVI, 98% of which were 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 RVI from 54.9% to 79.2%. Of 29 records reviewed, we noted staff completed 27 VTE risk assessments, one was pending and one could not be located. Of the 27 completed, all except two were completed within the first 24 hours of admission. This showed compliance of 93.1%. All patients identified as requiring VTE prophylaxis had this prescribed.
- Of 29 records reviewed, we noted staff completed 28 pressure ulcer risk assessments using the Braden Scale (tool used to predict pressure sore risk) within 6 hours of admission. The timing of the remaining risk assessment was unclear.
- The trust was using this data to drive down PU incidence and was targeting a 50% reduction overall. A number of medical wards were involved in a regional working group, which was auditing pressure ulcer incidence and documentation.
- Of 29 records reviewed, all patients had a falls risk assessment on admission and included within their care plan. Two records showed staff had not signed one falls risk assessment or reviewed another where risk had changed.
- The trust has 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 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.
- The service supported the trust's agenda to ensure effective prevention and control of healthcare associated infections (HCAI) including CUTI's with projects and initiatives to "Prevent CAUTI/UTI" through aseptic non-touch technique (ANTT) training and antibiotic review.
- The service displayed safety thermometer data differently on wards we visited. The majority of wards displayed a graph showing the percentage of patients who had received harm free care by month. The service did not breakdown the individual incidence of pressure ulcers, falls, or CUTIs and present this in a user-friendly format. Ward 19 and ward 43 did not have this information on display and on ward 5; the information was out of date. Staff told us that the trust were in the process of changing the way safety thermometer information was displayed and commented that they did not feel as though the patients or relatives paid any attention to it.

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.
- We observed that personal protective equipment (PPE) such as disposable gloves and gowns were available to staff.
- We observed staff caring for patients requiring isolation nursing in side rooms. Staff used appropriate signage advising staff and visitors not to enter without appropriate protective clothing. We observed staff using appropriate protection when entering the room and disposing of the same appropriately when they left.
- Hand sanitizing gel was available on the entrance to all the wards we visited. We did not observe any clear

instruction or signposting to encourage visitors to sanitize their hands on entering clinical areas. We observed some visitors attending wards without sanitizing their hands.

- We observed staff carrying out hand washing prior to and after patient contact. Staff followed the "5 Moments for Hand Hygiene" and "Bare below the Elbow" protocols.
- The trust provided us with results from a rolling annual cleanliness audit, completed at various times during 2015 by senior members of the nursing, catering, estates and hotel services team. Senior staff audited wards 19, 30, 31, 48, 51 and 52. The results varied with ward 19 achieving 100% compliance and wards 30, 31 and 48 achieving between 94% and 96% compliance. Wards 51 and 52 scored lower with 88% and 76% respectively. Comments on the audit confirmed that refurbishment of the wards would be necessary in order to increase some scores.
- In the Matron's monthly check for December 2015, the service 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 measured performance against key criteria such as environmental cleanliness, hand hygiene, infection prevention and control (IPC) practice and encompassed the matron's monthly check. In December 2015, the service recorded 100% against hand hygiene opportunity, hand hygiene technique, 98.4% under IPC practice and 97.6% for environmental cleanliness. IPC knowledge was 85.7% for the same period.
- Urinary catheter care, invasive device insertion and invasive device care was monitored by the CAT scheme. In December 2015, the service scores were 100%, 100% and 99% respectively.
- The CAT assessed staff knowledge surrounding infection control. The service scored consistently above 80% from August to December 2015.
- Ward 19, The North of England's Infection and Tropical Medicine Service was located at the RVI. The unit provided care for patients with infectious and contagious illnesses and tropical diseases. The unit also provided care for patients diagnosed with HIV and AIDS. The unit had ten isolation rooms all with anterooms allowing staff to remove and dispose of PPE and wash their hands before returning to the ward area. We observed staff using PPE appropriately when interacting with patients. The unit recently underwent significant building work to create four high-level isolation suites and a Trexler Isolation Unit housing two Trexler isolators (plastic cover on a frame isolating the bed and whole bed space) in response to the Ebola outbreak.
- The service was able to care for patients with Ebola, Viral Haemorrhagic Fever and hazard group 4 pathogens (agents that cause severe human disease where community spread is likely and where there is usually no effective prophylaxis or treatment available).
- The Regional Cystic Fibrosis unit had six side rooms with bathrooms facilities. Staff kept doors closed to reduce the risk of infection to patients and we observed staff using and disposing of PPE appropriately.
- Wards 30, 41 and 52 had side rooms to isolate patients but no bathroom facilities. Patients used commodes in their room and staff wheeled these to the sluice for emptying. This could potentially increase the spread of infection.
- Ward 41 only had two side rooms to isolate patients. The ward manager told us that if no side rooms were available, patients with MRSA would be isolated in the bay. The ward had recorded no cases of MRSA or C. difficile from May – October 2015.
- 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 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 gastroenterology M&M meeting. Staff identified there needed to be further engagement with the departmental quarterly review of antibiotic prescribing. The audit team did not consider it necessary to re-audit the ward going forward. The audit did not include a formal action plan to monitor compliance and progress against these recommendations.

- 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 recorded 36 C. difficile cases (against target of 77 for year-end).

Environment and equipment

- The trust designed wards in a way to make optimum use of space to deliver patient care.
- Wards 31 and 48 had PLACE assessments carried out in May 2015 and received generally positive comments. The RVI received overall scores that were better than the national average in all the above categories.
- Matron's monthly check in December 2015 reviewed key ward equipment across the service. The service scored 100% in meeting key criteria for patient bed space, hospedia 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, commodes score 93.8%, and locked medicine fridges recorded 85.7%.
- We checked the resuscitation trollies on all the wards we visited. The majority of these were appropriately sealed and all contained the correct medicines and equipment. Three 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. Staff told us they checked resuscitation equipment on a daily basis. We saw that each resuscitation trolley had a log attached to it for staff to complete. We saw that there was inconsistent checking of the trollies. 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.
- Most of the wards we visited had adequate space for the storage of equipment. Ward 51 did have some clutter on the corridors (e.g. boxes of food supplies, a box containing a fridge and a microwave). The trust identified ward 51needed refurbishment to help with these issues and planned work to begin shortly after our inspection.
- Some wards we visited lacked storage. On the assessment suite, we observed equipment obstructing a fire exit.
- On some wards, nurses could not see side rooms from the nurse's station. Staff risk assessed patients suitable for these rooms taking into consideration clinical need and patient safety.
- Staff told us the medical devices department coordinated the monitoring of equipment and calibration checks where necessary. All equipment we checked had testing stickers in date.
- 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 were stored securely in appropriately locked rooms and fridges.
- Staff appropriately refrigerated medications that could not be stored at room temperature. We saw that staff completed the majority of daily checks required to monitor fridge temperatures. There was a small number of days where temperatures had not been recorded on the wards we visited (for example, on the assessment suite fridge temperature had been recorded on eight of ten days)
- We saw that staff proactively raised issues with pharmacy when fridge temperatures were outside of permitted ranges. We observed an example of this on the assessment suite where staff had raised concerns and taken advice from the pharmacy team to reduce the fridge temperature.
- We checked the storage of controlled drugs. Staff stored controlled drugs appropriately in a locked cupboard and recorded dispensing in a controlled drugs book.
- On ward 51, we saw staff securely lock away waste products from cytotoxic medications awaiting disposal by pharmacy.

- Patient Group Directives (PGD's) are written instructions for the supply or administration of medicines to groups of patients who may not be individually identified before presentation for treatment. We checked the PGD's in use on ward 51, the Planned Investigation Unit. We found that these were past their review date, with the majority being due for review in 2007. We raised this issue with the ward sister, who explained that a Consultant Endocrinologist had checked the PGD's and they were satisfied that the advice contained within the PGD's was still current. No formal review and update of the PGD's had taken place in conjunction with the pharmacy department.
- We reviewed 10 electronic prescription charts. Staff showed us the prescriber's name and date of the prescription on the screen. All prescription charts had patient allergies recorded, two of which had annotated 'n/a'. Staff had not entered an omission code on one chart and the electronic prescribing system had highlighted this as an 'overdue task' to have the omission explained.

Records

- We observed differing practices for the storage of records on the wards we visited. On some wards, records were stored in 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. Although visible from the nursing station, on ward 30 we found notes stored in an unlocked trolley situated in the main ward corridor. Staff had not secured the notes leading to a potential risk of confidential patient information not appropriately protected.
- We reviewed 29 sets of medical records (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, diagnosis and treatment plans. The team documented their discussions into care and discharge planning however, some notes had no recorded entries showing discussions with family where this was expected or appropriate.
- We found nursing records to be up-to-date with evidence of regular care review. Entries in the nursing records were not always legible and were not always clear whom the name/grade of nurse was making the entry. We found staff completed all appropriate risk assessments, in particular surrounding falls and pressure ulcers 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.

Safeguarding

- Staff we spoke with knew how to raise safeguarding concerns through the safeguarding team. Staff provided us with examples of when they had contacted the safeguarding team for support and said that they received timely and appropriate advice.
- Data provided by the trust showed that staff on the medical wards at the RVI had achieved on average 90% compliance with safeguarding adults and children level 1, training and 38% compliance with safeguarding adults level two training. This was against a trust target of 95%. However, there were plans to ensure staff received training by the end of the financial year.
- 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.
- All staff we spoke with (on ward 50 and 52) had completed safeguarding training using an electronic learning system.

Mandatory training

- On average, at the time of our inspection and partway through the training calendar, staff on the medical wards at the RVI had achieved 80% compliance with mandatory training modules. This was against a trust target of 95%.
- Training modules included 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 mandatory training sessions, which was sent to staff. Some ward managers also kept an internal ward level list of key mandatory training dates.

- Staff we spoke with said they were up to date with mandatory training requirements. Staff accessed some mandatory training modules by an electronic learning system. This allowed them to monitor what training was due when they logged onto the system.
- Staff explained they completed the majority of mandatory training around their daily work commitments and 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.

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 RVI had achieved on average 90% compliance with falls training against a trust target of 95%.
- The service highlighted fall prevalence to be a risk for medicine. 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 low beds, fall sensors and footwear assessment for patients.
- The trust audited compliance in providing the sepsis six bundle (a package of care to treat sepsis) within one hour of sepsis identification. This included information provided by medical wards. The initial audit between October 2014 and January 2015 looked at compliance with three elements, including the provision of antibiotics within the hour. The audit showed that 41.7% of patients received antibiotics within the hour, with the mean time to antibiotics being administered was 165 minutes. The audit findings recommended improvements for presentation at patient safety briefings. A re-audit took place between July and August 2015. This showed compliance had risen to 55.1% and the mean time had reduced to 95 minutes. Staff identified further recommendations for improvement including making the issue a clinical governance priority for additional training and resources. The audit did not include a formal action plan to monitor compliance and progress against these recommendations.
- 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.
- 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.
- All staff we spoke with knew how to contact the 'crash team' (a specialist emergency team who attend urgently to deal with patients who suffer cardiorespiratory arrest) and were confident in knowing how to access emergency support.
- The RVI provided level two (those requiring more intense monitoring) and level three (those requiring advanced respiratory monitoring/organ support) care on site

Nursing staffing

- The trust used the 'Safer Nursing Care Tool' (SNCT) to measure patient dependency and determine the number of staff required to care for those patients. On a day-to-day basis, 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.
- 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.
- The service displayed planned and actual staff numbers on boards on each ward.

Medical care (including older people's care)

- The service had an overall vacancy rate of 9.6% and there were issues with staff shortages. However, 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 followed NICE guidance and staff had an awareness of 'red flag' indicators to trigger escalation steps.
- Having identified nurse staffing as an issue, senior nursing staff proactively managed shortfalls to meet patient acuity and achieved overall fill rates in excess of 90%. However, we looked at nursing fill rate trends from October – December 2015, this showed all wards, with the exception of ward 5 and ward 51, falling short for daytime registered nurses. Ward 41 reported average fill rates for daytime registered nurses across this period to be 73.2%. Night-time registered nurse fill rates for the same period were better with half of the wards at the RVI meeting or exceeding 100%.
- Unregistered nurse fill rates for both day and night time at the RVI was variable but most wards recording figures in excess of 90%.
- At the time of our inspection, trust data showed that there were some nurse and other clinical staffing vacancies across medical wards at the RVI. In total, data showed that the trust was 37.52 whole-time equivalent (WTE) nurses down on establishment levels. The bulk of these vacancies came on general medical wards (19.02 WTE).
- Data also showed that the trust was 5.34 WTE down on establishment for other clinical staff such as health care assistants. Again, the bulk of these vacancies arose in general medical wards (4.05 WTE).
- Nurse staffing turnover and staff sickness, averaged 14% and 5.3% respectively.
- The trust provided us with data on the use of bank nursing staff between April 2014 and March 2015. At the RVI, this showed that the average use of bank staff during this period was 6.9%. The assessment suite showed the lowest bank staff usage (1.5%) and wards 51 the highest (31.8%). The service only used agency staff for 1:1 care where existing staff and resource could not meet this need.
- Staff on some wards felt frustrated by the staffing shortfalls when they had to move to other ward areas to help with a shortfall or when losing their own staff to another ward then having to reassess resource left behind to manage their clinical area.
- We looked at staff rotas from a number of wards, which confirmed actual numbers of staff on duty for given shifts. Historic rotas also showed additional staff had been requested to compliment shortfalls to meet demand.
- 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. Staff raised no concerns about unsafe staffing levels or patient risk.
- British Thoracic Society Guidelines confirm patients receiving non-invasive ventilation (NIV) require 1:2 staffing in the first 24 hours. Ward 52 confirmed an average number of patients requiring NIV to be approximately six per week. Staff allocated patients requiring this intensity of care to areas of the ward providing the safest staffing ratio. The ward manager escalated concerns with staffing thresholds to the matron and ITU to ensure patients received the care required in the most appropriately staffed location.
- Ward 41 was a 26 bedded acute stroke unit. The British Association of Stroke Physicians and NICE provide guidance on staffing stroke units where specialist care/ thrombolysis is provided. The Sentinel Stroke National Audit Programme (SSNAP) looks at patient centred and team centred key indicator levels including thrombolysis. The trust performed well with an overall SSNAP level of B (where A is best and E is worst) in April – June 2015. The ward manager on the stroke unit felt there was enough staff to meet the patient's needs when they had their planned staffing numbers.
- The service closed beds or wards for short periods with unsafe staffing levels.
- The trust was actively recruiting nursing staff by way of social media advertisements and pool interviews. The service had filled a number of vacancies.

Medical staffing

- 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 clinical directors confirmed there were overall no issues 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 addition 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 RVI, this showed that the average use of medical locums was around 7.2%. Some of the lowest usage was in dermatology and in the dermatology waiting list (1.7% and 0% respectively), whilst the 'chronic pain' team recorded the highest usage (50.1%).

Major incident awareness and training

- The service had appropriate policies 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.
- Staff we spoke with knew how to access the major incident policy for guidance on the trust intranet.
- The service considered seasonal risks when planning medical beds within the trust. We were told that specific medical winter pressure beds were routinely opened in ward 44 (12 medical beds) to help meet the extra demand from winter pressures.

Are medical care services effective?

Outstanding ☆

We rated effective as outstanding because:

- The service was actively involved in local, national and international audit activity and followed recognised guidance that provided a strong evidence base for care and treatment.
- The patient outcomes from the stroke, heart failure, diabetes and myocardial infarction (heart attacks) audits were all better than national averages.
- Patients were comfortable on the wards and said they were satisfied with the standard of food.
- Staff had access to internal and external learning opportunities with wards developing their own specialism-specific competencies. Ward-based learning in the form of mentorship and preceptorship for junior staff was very good.
- We found effective team working; thorough 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 when caring for patients and received mandatory training in the Mental Capacity Act and Deprivation of Liberty Safeguards.

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 across the service were variable.

Evidence-based care and treatment

- Staff referred to a number of guidelines, quality standards, Royal College, best practice guidelines in support of their provision of care and treatment. Local policies were accessible on the ward and on the trust intranet and reflected up-to-date clinical guidelines.
- The service was actively involved in local, national and international audit programmes using evidence to monitor and improve care and treatment. There was an annual clinical audit programme, showing a range of completed, planned and ongoing evidence-based reviews.
- In accordance with NICE Quality Standards, the service was involved in data collection activity for heart failure, diabetes, acute coronary syndromes, and falls and the fragility fracture audit programme (including hip fractures), gastrointestinal bleeding and renal registry.
- There was 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.
- The service had reflected on National Audit Report findings and developed action plans to support evidence-based care and treatment. For example, in respiratory medicine staff reviewed evidence on exercise plans, muscle strength testing and pulmonary rehabilitation.

- Quality measures were monitored to ensure patients had their needs assessed, care planned and delivered in accordance with recognised standards and best practice such as matron monthly audits and clinical assurance toolkit (CAT) measures.
- Staff we spoke with were aware of Mental Health Act issues relevant to the delivery of care and treatment.

Pain relief

- Patients received pain relief as prescribed and as required.
- Patients confirmed that staff asked if they were comfortable and if pain relief was required.
- In the endoscopy suite, staff sedated patients or gave them throat spray to minimise discomfort.
- 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.
- The service called on a specialist pain team when needed.

Nutrition and hydration

- Of 29 records reviewed, we observed that all patients had received a nutritional/malnutrition (MUST) risk assessment. Staff created care plans for patients who needed support and help with eating and drinking.
- Staff told us that they could access support from the speech and language therapy service (SALT). SALT staff saw patients on the day of referral during the week. Staff told us that there was no access to SALT at weekends.
- 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 trust-wide, scores were at a four-year high for staff knowledge and documentation in dealing with nutritional issues, and 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 following nutritional policies. Staff developed action plans to improve compliance.
- Patients had protected meal times but if they needed support to eat or drink, family members could be there to help.
- Staff used red jugs to identify patients at risk of dehydration or those who needed help with drinking.
- We received variable comments from patients regarding food quality and menu choice with most confirming food was of an adequate standard but repetitive when hospitalised for a longer period.

Patient outcomes

- The RVI stroke service performed well in the Sentinel Stroke National Audit Programme (SSNAP) recording 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 2013-2014 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 RVI 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 RVI 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 RVI 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 regarding Nursing and Midwifery Council (NMC) revalidation.
- Staff confirmed that 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 confirmed they and their managers identified learning and training needs during annual appraisals and 1:1 sessions. Appraisal rates between April and October 2015 were variable from ward to ward and across different staff groups. 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 told us the trust supported them with further study. Many senior staff told us they could access additional training and development, with many matrons studying Masters Degrees and one physiotherapist completing a doctorate.
- 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.
- Staff acknowledged mentoring and clinical supervision on the wards was very good and that considerable learning took place in the ward environment through sharing best practice.
- The trust had developed an integrated stroke clinical and research service where all stroke physicians and stroke specialist nursing staff were research active.
- Staff on the stroke unit told us they were able to access additional training and had completed specific stroke training competencies (STAR training); the ward received good support from the clinical education team.
- Staff on the respiratory ward told us they had access to specialist training. Staff could attend tracheostomy, chest drain and laryngectomy study days. Staff had to work on the ward for a year before completing this training due to staff turnover.
- We spoke with the staff nurse working in the cystic fibrosis unit who was newly qualified and had not completed any specialist training or competencies. They felt confident in looking after the patient and well supported from other members of the team.
- Staff used the trust Tissue Viability Nurses (TVN) for training and support. 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. The TVN team also ran an annual event – STOP Pressure Ulcer Day every November and over 200 staff from wards attended.
- 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%.
- Junior medical staff informed us access to formal and informal training was good.

Multidisciplinary working

- We observed multidisciplinary working (MDT) throughout our visit to the RVI.
- 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.
- We observed a MDT meeting on ward 30 attended by physiotherapists, an occupational therapist, doctors, nursing staff and a social worker. Staff shared their specialist knowledge of each individual patients need, social circumstances and risk such as falls and infection. Staff discussed referrals to other teams such as chiropody, psychiatry, speech and language therapy and the palliative care team. The team also discussed discharge plans for patients.

Medical care (including older people's care)

- We observed the MDT process continuing throughout the stroke care pathway at the Centre for Ageing and Vitality where patients received MDT involvement on the stroke rehabilitation unit.
- 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.
- Pharmacists were accessible and present on the assessment unit to support the team with prescribing of medicines.
- The endoscopy unit occasionally found problems whereby wards had failed to starve patients long enough prior to the procedure or others starved for longer periods than was required. This caused inconvenience and distress to some patients. The endoscopy team were setting up ward visits by endoscopy nurses to improve MDT working.

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 and frequently outside this window.
- Non-resident on-call consultant level cover was available in all specialisms, diabetes (1:5), endocrinology (1:4), gastroenterology (1:8) and infectious diseases/stroke medicine (1:5).
- Daily consultant ward rounds occurred seven days a week with additional review of patients causing concern.
- A senior grade physician was present 24/7 and many specialist units within the medical directorate provided senior grade physician cover OOH.
- 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 operated the service and took calls for medical support. Staff triaged calls for clinical or advanced nurse practitioner input ensuring patients received care at the right level for their need.
- Diagnostic testing and reporting was available at all times subject to the needs of the respective patient.
- The service provided endoscopy facilities out of hours in theatre as opposed to the endoscopy suite.
- 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 need summaries for each individual patient discussed during the team handover.
- Medical handovers at shift changes was comprehensive with detailed and relevant information shared. These 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 respective wards.
- We observed staff moving patients to specialist wards following initial assessment and the handover of relevant patient information shared between the holding ward and the receiving ward prior to the transfer.
- Medical staff informed us they received investigation results in a timely manner.
- Staff informed us discharge considerations and planning for care started on admission.
- Staff informed GPs of a patient discharge in writing by way of a discharge summary, which followed the patient on the day of discharge.
- Staff discussed patients requiring community services or on-going care needs with the relevant service ahead of the discharge.
- 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 the delivery of care or any procedures.

Medical care (including older people's care)

- 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 were aware of the Mental Capacity Act and DoLS. Staff provided us with examples of when DoLS applied and could explain the steps they would take to identify and seek support for patients who may not have the capacity to consent.
- Staff with concerns could contact the Safeguarding Team.
- 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.
- There was access to trust specialist nurses with expertise in dealing with vulnerable groups such as learning disabilities and those living with dementia.

Are medical care services caring?

Good

We rated caring as good because:

- Patients felt safe and received good care with privacy and dignity being maintained. Staff gave patients time to ask questions and to check understanding of the treatment plan. Patients felt communication was good.
- 98% ofpatients at the RVI would recommend the service. The trust performed well in the CQC In-Patient Survey.
- All patients had core care plans identifying care needs. We found a holistic approach to the assessment of physical, emotional and social aspects of health and well-being, however with varying levels of patient involvement in care and treatment planning.

Compassionate care

- At RVI, the adult in-patient response rate to the NHS Friends and Family Test (FFT) was 25.1% (compared to 33.7% nationally).
- 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. The majority of medical wards at the RVI mirrored these findings with only two wards receiving a recommendation rate of less than 90% in October – December 2015. On the assessment suite and wards 31, 41 and 51, all patients said they would recommend the trust.
- 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.
- We observed nursing and medical staff interacting with patients in a caring manner. This included addressing patients by name and coming to the patient's level when patients were in beds and chairs.
- Of the 25 patients and relatives we spoke to, the consensus was care received was good. Patients felt safe and commented that nurses "were always checking up on you". Patients told us that nurses responded to requests and 'buzzers' as quickly as they could but were very busy. We observed that 'buzzers' were not always immediately accessible to a number of patients who were in bed.
- Patients told us staff maintained their privacy and dignity and always informed them in advance of any treatment.
- Patients felt informed and stated that communication from the nurses and the doctors was good.
- Staff informed us that they took personal, cultural and religious needs into account when assessing patient's needs and in planning care.
- Wards we visited had set visiting times (2pm to 4pm and 6pm to 8pm). We observed staff speaking with relatives to accommodate alternate visiting where this was necessary. This included agreeing to earlier visiting for the family of an acutely unwell patient. The patient was in a cubicle and we saw that staff considered the benefits to the patients, as well as the impact on other patients, in allowing earlier visiting.
- Staff enjoyed sharing positive feedback received from patients and family members and most wards we visited displayed 'thank you' cards.

Medical care (including older people's care)

Understanding and involvement of patients and those close to them

- The trust performed better than other trusts nationally 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 core care plan and of those reviewed, the majority were appropriately individualised from core standards to the needs of the patient concerned.
- Patients informed us they felt involved to varying degrees in their care and treatment.
- Staff informed us patients could manage their own medications if deemed safe to do so. Patients on the cystic fibrosis 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. This followed learning from a concern where a carer felt that they could not adequately input into the care of a relative with dementia.
- We observed doctors requesting a private room for a patient who was hard of hearing to discuss their diagnosis in a confidential environment.
- The trust had produced a leaflet for patients concerning discharge - 'Leaving Hospital: what to expect'. This provided information to patients on the discharge process, what to expect from the trust in relation to discharge, medication, follow up and help at home. It also set out expectations the trust had of patients, such as being involved in the discharge process and arranging transport home if the patient did not have a medical need for hospital transport.

Emotional support

- Staff explained to us when caring for a patient that they took into account all aspects of their particular needs from physical to emotional and social elements that may affect their holistic well-being.
- Staff provided emotional support to patients from a variety of sources. Staff told us they had a chaplaincy service that was available at any time for patients and carers. Additionally, staff often found that patients gained emotional support from interactions with wider ward based staff such as the housekeeper and the domestic.
- 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.
- Staff on the coronary care unit (CCU) told us relatives of patients who were at the end of their life could stay overnight.
- 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.
- The Macmillan nursing team offered counselling and support to patients and staff on the respiratory ward.

Are medical care services responsive?

Good

We rated responsive as good because:

- Services were planned in conjunction with stakeholder input, to meet the needs of the local and wider UK population with a number of specialist services offered.
- Bed occupancy rates in the service were high and length of stay for elective and non-elective admissions was higher than the national average.
- Ambulatory care services had developed to implement care pathways for specific medical conditions under strict criteria, so avoiding the need for hospitalisation and inpatient treatment.
- The service provided reasonable adjustments for vulnerable patient groups such as those living with dementia and those with additional needs due to learning disabilities.
- The service used the trust complaint policy. There was information about how to make a complaint for patients and relatives on the wards.

However

- Due to patients being referred from a wider geography, staff confirmed discharge planning had become more complex due to some unfamiliar and differing community discharge pathways.
- Demands had seen a number of patients boarded out to non-medical specialism wards but, there was a good tracking system and care remained medical consultant led.

Medical care (including older people's care)

Service planning and delivery to meet the needs of local people

- To plan and improve services for local people, management staff attended meetings with local clinical commissioning groups (CCGs) to feed into the local health network. Staff informed us of a recent engagement meeting with local GPs to consider how the current assessment suite provision affected patient care.
- Management staff were aware of issues about delays in the repatriation of patients back to their local authority/ hospital. Senior staff informed us they worked closely with local agencies, commissioners and the NHS Newcastle Gateshead CCG Vanguard to review integrated community home based care services.
- The assessment suite had identified that there could be delays in patients being transported home by the North East Ambulance Service (NEAS). To address the increased winter pressures, the assessment suite had commissioned two private ambulances to help facilitate discharges home.
- The service provided ambulatory care services, which accepted patients from the assessment suite and the emergency department. The unit was open 8.30am to 8.00pm, Monday to Friday. The unit also helped to facilitate the discharge of patients who may still require intravenous (IV) antibiotics. They offered a home visit service or the option for patients to attend ambulatory care to receive this treatment.
- 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, a number of specialist nurses and clinical educators were appointed across the site to support ward provision and to meet the needs of patients requiring specialist care.

Access and flow

- Medicine at the RVI had approximately 38,600 admissions to its service between July 2014 and July 2015. Admissions were broken down into day case (55%) emergency admissions (43%) and elective care (25%). The majority of admissions (42%) were to general medicine.
- Staff told us due to bed pressures patients were transferred to non-medical wards. In December 2015 there was an average of 25 medical patients each day (range 9 to 36 patients) receiving care on non-medical wards ("Boarders") at the RVI. Senior staff were aware of this issue 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 outlier numbers reduced following new patient flow processes.
- Senior staff informed us there would be an expectation that a clinician from the relevant specialism would see each outlying patient at least once per day. 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.
- Some junior medical staff we spoke with during our inspection found the management of boarders to be a challenge when located elsewhere within the trust on non-specialist wards.
- Senior staff and ward managers received a daily email advising on the number of boarders. The email detailed patient admission date, the date when the boarding occurred, the treating physician and the base ward that the service would like the patient returned to. When beds became available, the decision to return the patient followed.
- We visited the stroke ward and saw they had 18 medical outliers. Staff told us they had a good relationship with the bed managers and this was not having an impact on patient flow for patients on the stroke pathway.
- Staff on the wards and bed management identified delays in patient repatriation to other areas when they had attended the trust for treatment. At the time of our inspection, around 22 patients were waiting for repatriation to their home areas.
- As of September 2015, the trust was better than its operational standard 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. 100% of patients were referred within 18 weeks in general medicine, geriatric medicine and gastroenterology.
- The average length of stay at the RVI for elective and non-elective patients was higher than the England average. For elective patients this was 4.1 days (compared to 3.8 days) and for non-elective patients 8.2 days (compared to 6.8 days). There were exceptions to

this trend, for example, the average length of stay for elective general medicine patients was 4.3 days compared to an England average of 4.7 days and non-elective cardiology patients had an average length of stay of 4.1 days compared to an England average of 5.6 days.

- 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 medical directorate 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 wards.
- The service 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 suitable for ambulatory care without hospitalisation.
- Staff on the dermatology ward told us the ward had some urgent assessment beds where GP's could refer directly giving prompter specialist assessment and care planning.
- Staff on the stroke ward told us they received direct patient admissions into their assessment bay. Specialist stroke nurses operated the assessment bay, Monday to Friday from 9am to 9pm. Staff admitted patients who required thrombolysis directly to these beds. Staff told us they used an agreed checklist when taking the referral from the ambulance staff. They had a good relationship with the radiology department and they had emergency slots for carotid Doppler investigations and head CT scans. Outside of these hours, patients flowed through the accident and emergency department.
- We visited the chest pain assessment area (4 beds situated within the emergency department). These beds were available 24/7 and staffed by coronary care staff that were advance life support trained. The beds were initially for thrombolysis monitoring but had since evolved into chest pain assessment beds.
- Overall, the relative risk of readmission for elective patients at the RVI was below the England average for the period between June 2014 and May 2015 (91 at the RVI compared to 100 England average). The relative risk of readmission for patients undergoing non-elective care was greater than the England average during this period at 114 at the RVI compared to the 100 England average.
- Between October 2014 and September 2015 the trust reported that of 147,645 inpatients admitted to the RVI, 72% had not been required to move ward during their admission, 22% on one occasion, 5% on two occasions, 1% on three occasions and less than 1% on four or more occasions.
- During April – September 2015 at the RVI the number of patients moving ward after 10pm in September totalled 1207 across all services. Over half came from the medical services with 357 recorded against the assessment suite.
- Staff on the stroke unit 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 plan process.
- Staff considered discharge plans on admission and reviewed as an on-going concern throughout the patients stay. Daily board rounds and MDT reviews specifically considered discharge planning. At the Centre for Ageing and Vitality, we observed multi-agency working to align care packages for individual patient needs and planned discharge dates.
- 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.
- Staff informed us discharges were often complex with patients having multiple needs. Staff said this led to longer patient stays in hospital while services planned to ensure the safe transition from hospital into the community.
- Day to day discharge problems were referred to the Patient Services Co-Ordinators who liaised with the relevant services to address any delays or obstructions allowing the patient to be discharged as planned and to free the bed.

Meeting people's individual needs

Medical care (including older people's care)

- At the time of our inspection, on average 39% of ward staff at the RVI 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. Those patients with LD had a 'passport', which was owned by the patient and detailed personal preferences, likes/dislikes, anxiety triggers and interventions, which are helpful in supporting during difficult periods. The LD nurse specialist identified when a patient admission occurred and attended the ward to liaise with clinical staff, the patient and family to see what reasonable adjustments were required to support the patient while in hospital. Staff allowed family members to stay.
- We did not see any foreign language patient information leaflets or posters on display on the wards we visited. Staff we spoke to did not know how to access leaflets in foreign languages.
- The majority of staff explained that translation services were available by telephone interpretation. Some staff members explained that they would routinely ask for English speaking friends or family members to interpret for the patient. This led to a difficult situation if discussing sensitive medical needs.
- The trust provided documents in large print for those patients with visual impairment and the same was available in braille. Interpreters trained in British Sign Language (BSL) were available when required.
- Staff we spoke with explained that they could easily access bariatric equipment from the moving and handling team. 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. Families and carers completed this for staff.
- 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 at the RVI 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.
- As part of the cognitive care pathway, staff assessed patients with known or possible dementia, cognitive impairment or delirium. Staff monitored compliance against these assessment measures. Step 1 Dementia Awareness Reporting for September 2015 was 92.4%; 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.

Learning from complaints and concerns

- The medicine directorate generated 36% of the complaints reported 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.
- Staff located the complaints policy and explained the advice they would provide to signpost patients to Patient Advice and Liaison Services (PALS) and the complaints service. Staff indicated they would deal with and resolve any concerns immediately at ward level.
- 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.

Are medical care services well-led?

Good

We rated well-led to be good because:

- The service had a clear strategy and vision with patients at the heart.

- Governance arrangements enabled the effective identification of risks, which the service monitored against agreed action plans. There was evidence that controls were in place to mitigate such risks.
- Staff informed us of a culture of openness and honesty. Senior medical and nursing staff were visible and accessible. Local ward managers and matrons were approachable and supportive.
- Senior staff felt part of and fully integrated into service delivery.
- 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.

However

- Some junior members of staff did not always feel valued by the management.

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.'
- The service had a clear and planned strategy to help it 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 that they felt proud to work for the organisation and without exception believed that, patients were at the heart of everything the trust endeavoured to do.

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, the service provided us 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 to ensure the continual monitoring of performance, quality and risk. This included weekly executive activity summaries and internal monthly dashboards about financial, human resources and operational performance, and monthly team meetings. Meeting minutes showed relevant discussions considering risk and quality issues, including the provision of training.
- There was a clear and involved clinical and internal audit programme in the medical directorate. This drove the vision, strategy and quality measures.
- The service referred to quality measurement outcomes to identify areas for future improvements and 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 infections.

Leadership of service

- The medical directorate 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.
- All staff we spoke with told us that their leaders were visible and approachable. Staff explained they frequently saw matrons and senior staff on the wards and were comfortable interacting with them.
- Junior medical staff informed us that senior medical colleagues and consultants were supportive.
- Staff we spoke with knew the whistleblowing policy and said 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.
- The majority of staff told us that they found that they worked with supportive and professional colleagues. Staff explained that they had strong peer groups and aimed to support each other wherever possible. The National Staff Survey 2014 where 79% agreed or strongly agreed colleagues were supportive reflected these findings.
- Senior staff told us they felt their duties, input and comments were well received however; some junior grades and newly qualified staff members stated that they did not always feel valued by the management.
- Staff agreed there was a culture of openness and honesty throughout the service.
- Some assistant practitioners told us that although they found that some staff on their base wards understood their roles, they often encountered some confusion from staff about the level of care they could provide. This meant that they felt undervalued by some staff on occasions.
- Despite concerns highlighted by staff regarding staffing levels and pressure of work generally, morale on the wards we visited was good.
- Staff were aware of the 'Speak up, we're listening' policy 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.

Public engagement

- The service contributed to the trust 'Take 2 minutes' real-time patient feedback survey which obtained comments from patients on their experience within the trust.
- 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. Patients and carers confirmed to us that they felt engaged and well supported by the service.
- Ward 19 Infectious Diseases Unit completed its own Patient Satisfaction Survey in October 2015 with recommendations highlighted following patient feedback.
- Staff provided us with examples of changes to services for patients requiring infusion therapy to treat multiple sclerosis (MS) related symptoms. In response to patient feedback, this service had now moved permanently to private cubicles in the neurosciences short stay unit.
- The service contributed to the trust published 'open and honest' care report shared its website each month. This included details such as patient complaints, safety thermometer data, and infection control statistics. This was accessible to the public to help inform them about the service.

Staff Engagement

- The medicine service quarterly e-bulletin provided staff with information on senior staff, risks, complaints and staff awards.
- Staff engagement had brought about service development within the trust. For example, the immunology service had seen nurses lead patient education programmes and in dementia care, 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 of the trust had been influential in supporting and moulding these groups, for example, the service incorporated gender identity awareness into nurse preceptorship training.

Innovation, improvement and sustainability

Medical care (including older people's care)

- 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 at the RVI had long established relationships with Newcastle University Medical School and Northumbria University.
- The stroke service was nationally recognised 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 resulted in an increase in Interstitial Lung Disease (ILD) patient referral numbers. A number of academic papers have followed.
- 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 three-day course combining core knowledge and practical sessions to develop trainee knowledge and raise awareness of these issues.
- The neurology department had developed numerous pioneering services such as videoconferencing complex clinic allowing case discussions with clinicians across the UK and the establishment of care standards for patients with mitochondrial disease that have been adopted throughout the UK and internationally.
- Rheumatology innovations had seen the service develop the first specialist spodyarthritis nurse in the UK and the early arthritis clinic, which was shortlisted for a 'Best Practice Award' by the British Society for Rheumatology and had excellent results in National Clinical Audit for Early Arthritis (HQiP).

Surgery

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

Information about the service

The Royal Victoria Infirmary (RVI) has been providing healthcare to communitiesin Newcastle and the North East for over 250 years.Services provided by the RVI include upper gastro-intestinal, breast surgery, endocrine and thyroid surgery, colorectal surgery, cardiology, general surgery, trauma and orthopaedic surgery, gynaecology, neurosurgery, ophthalmology and plastic surgery.

The RVI had 16 theatres in total; four general surgery, two gynaecology, two plastic surgery and one emergency theatre based in the Leazes wing. The New Victoria wing had seven theatres, three of which were for trauma and orthopaedics three for neurosurgery, one mixed and two neuroradiology theatres.

Compared to all trusts in England, the Newcastle upon Tyne Hospitals surgical spells were the highest at 76,629 with 37.9 % of those spells dealt with by Royal Victoria Infirmary (RVI) surgical service. The spells by type were 59% day case, 20% elective, 21% emergency. Spells by speciality were 39% other, 13% upper gastrointestinal (GI), 18% plastic surgery, 30% ophthalmology.

We spoke with 29 patients, 12 relatives and 50 members of staff. We observed care and treatment and looked at care records for 23 patients.

Summary of findings

The overall rating for surgery is 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. There were effective twice-daily consultant led handovers at shift changes, to ensure staff could manage any risks.
- 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 30 serious incidents in surgery between August 2014 and July 2015. Eleven related to pressure ulcers, nine falls, three of the serious incidents, which related to the unexpected death of inpatients, two infection control incidents, two surgical incidents and three others. Incidents were investigated through Root Cause Analysis, which were comprehensive, and actioned.
- Duty of Candour requirements were stated within the Being Open/Duty of Candour Policy and the trust Incident Policies. We found that the requirement to be open with patients was included in monthly incident investigator training. All matrons and directorate managers received e-mail notification if an incident grade was moderate or above. Serious incident reported

templates were revised for falls, pressure ulcers and general incidents to include a section to record that an apology and explanation were given to the patient and their relatives.

- The Duty of Candour requirements were embedded in surgical services. Local clinical governance meetings featured Duty of Candour as an item for discussion. Ward managers gave an example of duty of candour in practice. We were told about an error when monitoring the healing of a skin flap. Information relating to the error and a full root cause analysis was given to the patient. The outcome showed staff required training in relation to a new piece of equipment used and improvement in communication between departments was required. A full apology was given to the patient and training commenced. Further discussion was held with staff at the daily team safety briefing, six weekly ward meeting and by email.
- Staff understood their responsibilities to raise concerns, to record safety incidents and near misses. All nursing staff spoken to were able to clearly explain reporting processes and felt confident that follow-up action would be taken with appropriate feedback provided. Nursing staff felt that the level of reporting on the ward was good and consistent. However, some staff felt that there were occasions when staff shortages were not reported.
- Mortality and morbidity reviews fed into service improvement plans and were undertaken monthly. These were well established and multi-disciplinary. Lessons learnt were established and fed back through the trust by safety huddles, ward meetings, newsletters and on a one to one basis as necessary.

Safety thermometer

- There were 86 pressure ulcers, 16 falls and 24 catheterised urinary tract infections (CUTIs) between September 2014 and September 2015. No clear trends in prevalence were apparent from the data. Investigations were undertaken for each incident and because of the findings; staff began working with the Falls and Syncope Service (FASS), 'Time 2 Turn' and pressure ulcers prevention (PUP) groups to reduce pressure ulcers and falls. Staff were aiming for falls and pressure ulcers to reduce by 50% following the implementation of action plans.
- One hundred percent of patients, on admission, received an assessment of venous thromboembolism (VTE) using the clinical risk assessment criteria described in the national tool. Patients were re-assessed within 24 hours of admission. Patient records provided this evidence.
- Staff advised that safety was monitored through the completion of moving and handling assessments; falls risk assessments, completion of Braden Scale for Predicting Pressure Sore Risk, NEWS and Malnutrition Universal Screening Tool (MUST) assessments and by following infection, prevention and control measures.

Mandatory training

- The education department monitored attendance at mandatory training programmes for all staff.
- The trust early warning system steering group agreed an education strategy. It included the introduction of the NEWS training session. The NEWS training programme was delivered through online access or lectures.
- Trust data showed mandatory training completion was variable for each surgical ward. The standard compliance rate expected was 95% for each training programme. Overall, training results 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. Sixty-eight percent of staff had received adult basic life support, 87% had received infection, prevention and control training. Overall training rates were 82%. However when records were broken down by wards it was apparent that the accuracy of the electronic recording was problematic. Staff stated their training rates were higher but not logged electronically.
- Most staff we spoke with confirmed they were up to date with mandatory training. All had paper copies of their training records, which were more accurate.
- Clinical educators were in post and supported staff with all training, their continued professional development and through revalidation.

Safeguarding

- Surgical safeguarding concerns and alerts fed into the trust safeguarding committee, which aimed to meet quarterly from January 2016. The committee agreed safeguarding dashboards would become a standing agenda item for this group. Feedback from significant case reviews occurring in surgery was discussed.
- The surgical training dashboard showed attendance/ compliance of staff at safeguarding training but it did

not show the length of time trained. This was not a problem with training levels 1 and 2 however level three required a specific number of training hours. The safeguarding teams worked jointly with the training department to improve compliance and the safeguarding trainers group had produced an action plan. Ninety percent of staff had received safeguarding adults' level one and 50% level two

- Front line staff from surgical services received key points of intervention around Female Genital Mutilation (FGM) and sexual exploitation. There was a newsletter update for staff with a summary paper for medical staff.
- Staff understood their responsibilities and discussed safeguarding policies and procedures confidently. They felt that 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.

Cleanliness, infection control and hygiene

- Wards and patient areas were clean. We observed staff wash their hands, use hand gel between patients and observed staff comply with 'bare below the elbows' policies.
- All elective patients undergoing surgery underwent screening for Methicillin Resistant Staphylococcus Aureus (MRSA) and procedures were in place to isolate patients in accordance with infection control policies.
- There were seven cases of MRSA between August 2014 and August 2015. There were 95 cases of Clostridium Difficile (C.Diff) in the same period. The number of cases per 10,000 bed days was consistent over time and similar to the England rate. Nurses were aware of MRSA and C.Diff policies and procedures on the intranet.
- Transfer to theatre did not occur for patients in isolated areas until they were clear from infection. C.Diff infected patients were isolated and treated in a single room with ensuite toilet.
- We found each department 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 and actions fed back to ward and departmental managers.
- Overall figures recorded in the infection prevention and Control Clinical Assurance Toolkit (CAT) showed environmental cleanliness on target at 98.6%, assurance measures below target at 96%, clinical assurance above target at 98.5% and staff knowledge below target at 86.9% against a target of 98%.
- Environmental cleanliness figures from matron monthly checks showed an overall achievement of 98.6% against a target of 97.8%., (hand hygiene opportunity 99.4%, hand hygiene technique 99.1%, IPC practice 99.6% and waiting room seating / couch integrity 99.7%).
- Data relating to staff knowledge showed about infection control was 89.7% against a target of 98%.

Environment and equipment

- The wards were bright, fresh, and in a good state of repair.
- Cardiac arrest and suction equipment checks took place daily and weekly. Details were recorded within the ward areas.
- All equipment maintenance was up-to-date and safety tested.
- Utility rooms were clean, tidy and well organised. All syringes and cannulas were stored in labelled drawers.
- The arrangements for managing domestic and clinical waste kept people safe. All staff spoken to were aware of the clinical and domestic waste disposal procedures, the use of specific bags and special ties to seal clinical waste. Separate bins for clinical and domestic waste were evident throughout all wards visited.
- Equipment used for bariatric services was held by the moving and handling team. This was to ensure safety for both staff and patients. Requests were made to the moving and handling team when equipment was required. The team delivered the equipment and trained staff in its proper use.

Medicines

- We found allergies clearly documented on prescribing sheets. We checked six records at random and found all six of them to be correctly completed.
- Ward managers were aware of the local microbiology protocols for the administration of antibiotics and liaised with pharmacy prior to prescribing for MRSA and C.Diff.
- All medication was prescribed and administered in line with the trust policy and procedures. Pharmacists liaised with the ward teams regularly.
- Staff working on the wards attended a mandatory yearly update on storage and recording of controlled drugs

(CD). 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.
- Fridge temperatures were within the required limits.

Records

- We looked at 23 patient medical records including the corresponding nursing notes and end of bed files. All files were completed appropriately and showed evidence of admission assessment; NEWS recorded regularly, 'Time 2 Turn' charts, food and fluid balance sheets, consent forms with mental capacity assessments where necessary.
- All the records examined included a pain score and allergies documented in the notes. We observed patients wearing red wristbands to raise staff awareness of allergies.
- All documentation was signed and dated, clearly stating named nurse and clinician. Loose paperwork identified in one file was reported and corrected at the time of inspection.
- All patient records checked were legible, clearly documented with clinical notes stored in a cabinet and nursing notes held at the nurses' station. The medical records and nursing notes remained in line of sight of the ward clerk.

Assessing and responding to patient risk

- Surgery used NEWS risk assessment and sepsis-screening tool. This allowed staff on the ward to record observations, with trigger levels to generate alerts, which helped with the identification of acutely unwell patients. Records we looked at showed NEWS scores were completed correctly. Staff we spoke with were aware of the escalation process when a patient deteriorated.
- We found evidence of comprehensive risk assessments in surgical records. Information included the completion of cognitive assessment tools, falls risk, pressure ulcer risk, and bed rails.
- The Falls and Syncope Service (FASS) based at the RVI was the largest unit of its kind in Europe. FASS undertook research for patients presenting with a range of problems such as balance disorders; dizziness; low blood pressure; gait; or unspecified lack of co-ordination and falls. New patients underwent a series of investigations to establish the cause of their condition and clinicians assessed, identified and treated risk factors for falls, blackouts, dizziness and osteoporosis. Surgical wards referred to FASS as necessary.
- The trust ensured compliance with the Five Steps to Safer Surgery through application of the World Health Organisation (WHO) surgical checklist. The WHO checklist audit showed note completion at 98%, sign in at 95.6%, time out at 94.1%, and sign out at 90.7%. Audits showed that 98% of the entire team attended the surgical briefings. We observed that theatre staff followed the 'Five Steps to Safer Surgery', and completed the World Health Organisation (WHO) checklist appropriately.
- We chose records at random. All had fully completed WHO documentation prior to surgery. We also observed correct surgical site marking on a patient immediately prior to their surgery. We observed the WHO surgical checklist being used for radiological interventions.
- There was an occasional need to care for critical care patients in recovery whilst waiting for critical care beds to become available. Seven patients have been admitted over a 12-month period with an average stay of 04:50. The service accepted this was less than ideal but most admissions were a result of emergencies on the wards resulting in critical care admission. The beds on the two adult critical care units were used flexibly but on occasion demand outstripped supply. The recovery staff supported by the anaesthetic and intensive care medical staff had the relevant experience in caring for patients who required extended recovery.
- There was 24 hours per day, seven days per week access to interventional radiology and therapeutic endoscopy.

Nursing staffing

- A formal regular nurse staffing review process had been in place since October 2012. The surgical department had a funded establishment agreement based upon their methodology and professional judgment triangulated by benchmarking relevant national guidance and acuity/dependency information. Establishments were agreed with the relevant clinical teams, and were then agreed by the Nursing and Patient Services Director, who recommended these to the Trust Board.

- Senior nursing roles, ward sister/charge nurse, matron, deputy directors of nursing, had the responsibility for safe and effective nurse staffing levels.
- Staffing guidelines with clear escalation processes were in place. Site cover was provided out of hours 24 hours per day, seven days a week by a team of senior nurses (patient services co-ordinators) with access to an on-call manager/director.
- Monitoring of actual against planned staffing levels took place on a shift-by-shift basis. Monthly assessments of patient acuity/dependency were undertaken on adult in-patient areas using the Safer Nursing Care Tool, and reported on the trust's Clinical Assurance Toolkit. We observed that actual and planned staffing levels were appropriate.
- The trust had an established staff bank, which provided cover for short notice requests. The staff on the bank were trained and managed "in house".
- Nursing staff sickness between April 2014 and May 2015 showed: Bands 2 - 4 with 8.99% sickness, Bands 5 - 6 with 5.53% sickness and Band 7 - 8A to C with 0.42% sickness.
- Bank usage between April 2014 and May 2015 was 6.5%. The national average is 4.63%.

Surgical staffing

- Medical staffing skill mix was similar to the England average. Across surgical services, consultant 42% (national average 41%), middle career 4% (national average 11%), registrar group 45% (national average 37%) and junior doctors 9% (national average 12%). Overall, the staffing mix was similar to the national average.
- Medical staffing vacancies, sickness and turnover for surgery were below the national average consistently between April 2014 and May 2015.
- Arrangements were in place for the use of locum, bank and agency staff to ensure patient safety. Locum usage at the RVI between April 2014 and May 2015 for orthopaedic surgery was 46.9%. However, this was due to a clinician reducing hours from full to part time and a locum filling those hours. We found continuity as one locum was used consistently. Neurosurgery locum usage rates were 21.0%, upper gastrointestinal surgery was 9.3%, plastic surgery general was 8.6%, Oral & Maxillofacial surgery 4.0%, breast surgery was 0.6% and plastic surgery locum usage rates were 0.5%
- The RVI had on call arrangements which were: eight senior house officers (SHO) on call 8am to 8:30 pm seven days a week, four Foundation year one (F1) doctors weekdays 12 noon to 8pm and weekends from 8am till 8pm. On weekends, there was one SHO and one F1 on from 8am until 8pm. There was one consultant on call at all times, covering both sites and one on call consultant in hospital 8am to 8pm seven days a week.
- In all other specialties, surgical cover arrangements were safe with appropriate senior surgical input.
- Surgical handovers took place twice daily and were primarily consultant led. Handover took place in private areas to maintain confidentiality. An electronic handover tool was used.
- The anaesthetic department was the largest department within the Newcastle Hospitals Trust, comprising over 100 consultant anaesthetists and 60 core and specialist trainees. Members of the department provided the bulk of the senior medical critical care workforce in the four adult and two paediatric critical care areas and supported with pain services. Consultant anaesthetists led the service.

Major incident awareness and training

- Major incident plans were in place and last reviewed and updated in August 2015. Maintenance of the plan was the responsibility of the major incident steering committee and reviewed annually.
- The theatre coordination team consisting of a theatre manager and an anaesthetic coordinator controlled all 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 and 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) until a review was undertaken to assess nature, size and type of incident and immediate staff available to manage the admissions. Processes were in place for monitoring compliance with the policy.
- Staff in surgery understood the lockdown procedure, which involved the lockdown of buildings and sites owned by the trust in response to an anticipated or presenting threat or hazard.

- 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.
- The impact on safety when carrying out changes to the service and staff, was assessed and monitored through robust, embedded assessments, staff engagement and ongoing service monitoring.

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

- Patient treatment was in line with national guidance from the National Institute of Health and Care Excellence (NICE), the Association of Anaesthetics, and The Royal College of Surgeons.
- Standardised relative risk readmission rates for elective surgery showed that the RVI was similar to the England national average for readmissions. For non-elective surgery the RVI performance showed a ratio of 86 for all surgery in comparison to the national average (100). Non-elective admissions in RVI had a lower (better) risk of readmission than the England average.
- New evidence-based techniques and technologies were used to support the delivery of high quality care. All staff were actively engaged in activities to monitor and improve patient outcomes and had opportunities to participate in benchmarking, peer review, accreditation and research.
- The trust used care bundles, care pathways and performance dashboards to ensure patient outcomes were positive, improved, monitored and reviewed. The care bundles and pathways were in line with best practice procedures.
- The trust reviewed and audited the patient outcomes across vascular, breast, colorectal, gastroenterology and general surgery including endoscopy and transplantation services. There were 30 active audits and 10 reviews underway in surgical services at the time of inspection. The trust participated in the bowel cancer, lung cancer, national emergency laparotomy, and hip fracture audits nationally.
- The trust evaluated their own performance against similar organisations using data provided by a range of sources.

Nutrition and hydration

- Staff reported that dieticians were very accessible. Dieticians visited GI wards daily and there was a dedicated upper GI dietician as part of the enhanced recovery initiative.
- Dieticians met with bariatric patient's pre-op, post-op and followed up at home.
- Mealtime audits to monitor progress formally took place biannually with monthly self-assessment by ward sisters. Information and lessons learnt was shared at the clinical leaders, clinical managers and nutrition link nurses forums, nutrition steering group, and with catering managers.
- Nursing staff ensured patients were provided with nutrition and fluid if their operation was cancelled and when appropriate post operation, including out of hours.
- Meal charts were completed comprehensively and reviewed.
- Dieticians left feeding plans on each ward for patients requiring nasal gastric feeds required out of hours, which allowed nurses to commence feeding regimes.
- Malnutrition Universal Screening Tool screening and nutritional care plan completion had increased annually to 99% and 94% respectively. Fluid Balance and food charts had both achieved 100% completion rates. Assisted/fed as required scored 90% this year down

from 100% in 2014, which was an improvement on the 2012 score of 45%. Hand wash offered was 88%. 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. However, these were recently introduced.

- The quality of food was reported to be very high by patients. Patients said food was always hot; there was a good choice and good quality.

Pain relief

- The efficacy of pain management audit showed pain scores were assessed and documented 81% of the time. Isolated events of pain above or equal to four occurred in 33% of patient days. Two or more consecutive events of pain above or equal to four occurred in 34% of patient days. The audit confirmed that pain scores were poorly documented; however, of the patients whose pain scores were erroneously recorded 83% reported that they were satisfied with their pain management.
- There was a pain management audit in the recovery room. Forty patients were asked questions following general anaesthetic with the final pain score being recorded as discharge was taking place. This was conducted over a six-week period, throughout three recovery rooms in the RVI. 90% of patients reported pain scores of less than four out of 10 against a target of 95%. Recommendations implemented following the audit were to provide more information to patients regarding patient controlled analgesia (PCA), in order to optimise pain relief. Staff were to ensure they were asking 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 to assess the grade of doctors highlighting pain as a significant risk factor when obtaining consent from patients. Outcomes showed that of the 114 doctors, 49 doctors discussed pain as a complication. Sixty-five 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. Research was ongoing but positive.
- The trust invited patients to participate in a trust-approved audit based on a prospective data collection questionnaire at RVI pain management clinics. The data was collected between June 2014 and August 2014. The main aim of the survey was to assess views from patients about using technology as a tool for chronic pain management. The questionnaire was completed by 126 of the 140 patients asked to participate, with a response rate of 90%. The trust found high rates (80%) of availability and accessibility for internet use among patients. Those who used the internet for health related information found it as a useful tool, but they also expressed their concerns about the quality of information.
- 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.
- When asked, patients reported that pain relief was always provided in a timely manner.

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 85.5%, which was lower than the national average of 91%.
- The trust had a mixed performance in the 2014 and 2015 national emergency laparotomy audits (NELA). Actions plans showed recommendation points of which five points were completed, six were in progress and one recommendation was 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 (worse) 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 average.
- The trust was flagged as an elevated risk in the May 2015 Intelligent Monitoring reported for the mortality of Trauma and Orthopaedic conditions and procedures. Mortality indicators for elective hip and knee patients were in line with the national average.
- The national Hip Fracture Database highlighted that the RVI performed well on the majority of key indicators but could do better in certain areas. Key areas showed 97.4% of patients had a MMSE (Mini Mental State Examination) on ward admission; 92.8% a peri-operative medical assessment; 76.7% had surgery on the following day's trauma list. Bone health assessment protocols were in place with 100% patient compliance after fracture; over 80% of extracapsular hip fractures were managed with either a sliding hip screw or intramedullary device as per NICE guidelines; the acute length of hospital stay was reduced at only 11.5 days with the length of stay being around 26 days.

Competent staff

- 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.
- Nursing staff had opportunities to undertake specialist training and were encouraged to develop. It was acknowledged that this could be dependent on staffing rotas and other external pressures. Overall, staff felt supported with their training and in maintaining competence. Some staff advised they were supported to finish their degree but found it difficult to take study leave on occasions.
- 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, objectives 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. Staff were happy with this; felt supported and said they benefited from the more formal peer group discussions.
- Staff felt they understood the revalidation process. Matrons were going through revalidation first as a way of building up knowledge and experience to support nursing staff and provide guidance and mentoring.
- New members of staff were mentored and supported until they gained skills, knowledge and experience to do their job when they started their employment. Experienced members of staff were gradually encouraged to take on additional roles and responsibilities once it was deemed appropriate.

Multidisciplinary working

- We observed all necessary 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 (MDT) meetings for most pathways. These MDTs included nurse specialists, surgeons, anaesthetists, and radiologists.
- The trauma and orthopaedic department worked closely with a range of disciplines to maximise outcomes for patients. MDT ward rounds took place including physiotherapy, and occupational therapy input alongside the surgeon.
- 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 Burns Service was run by a highly skilled multi-disciplinary team made up of specialist surgeons and nurses, together with psychologists who provided emotional support during a very difficult time for patients and their families.

Seven-day services

- All surgical patients were seen daily and at weekends. F2 or SHO grade staff undertook ward rounds at the weekend. A consultant was on-call 24 hours daily, seven days a week.
- There was routine physiotherapy input at weekends with occupational therapy services supporting Monday to Friday.
- There was availability of pharmacy input out of hours with an on-call facility at the weekend. The pharmacy was available for discharge medications and hospital orders until 1 pm on a Saturday. After 1 pm on Saturday and on Sunday, there was an on-call pharmacy.

- The trust delivered most services 24 hours a day, seven days per week. 'Everyone Counts: Planning for Patients', committed the trust to the introduction of seven day routine services to reduce variation in care experienced in NHS organisations at weekends.
- There were key diagnostic services (CT, MRI and X-ray) available 24 hours a day, seven days a week to support clinical decision-making.
- SpRs and consultants saw plastic surgery patient's seven days per week. General surgery patients were seen Monday to Friday with the ability to see a consultant at the weekend should their health deteriorate.

Access to information

- Risk assessments, care plans, and test results were completed at appropriate times during the patient's care and treatment. We saw these records were available to staff enabling effective care and treatment. Information was logged on the trust electronic system, which meant patients could be tracked through various pathways.
- Ward clerks, doctors, and nursing staff felt the electronic system was adequate at providing and sharing patient information.
- There were appropriate and effective systems to ensure patient information was co-ordinated and accessible to staff.
- 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. Portable laptops were used during ward rounds.
- Electronic notes went direct to GPs in the Newcastle and Gateshead area following the patients discharge. GPs could ring medical staff direct for advice if required.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- We looked at clinical records and observed that patients had consented to surgery in line with the trust policy and Department of Health guidelines.
- Mental capacity assessments were undertaken by the consultant responsible for the patient's care and Deprivation of Liberty Safeguards (DoLS) were referred to the trust's safeguarding team. A person's mental capacity to consent to care or treatment was assessed when there were concerns around mental impairment prior to any procedure taking place. Mental Capacity assessment forms were clearly recorded and held in the patient medical file. Each form stated why the patient did or did not have capacity to consent to treatment, was signed and dated by the clinician. There was evidence that discussion was held with patients, family members and other professionals prior to a best interest decision being made.
- Staff spoken to understood the difference between lawful and unlawful restraint practices, including how to seek authorisation for a deprivation of liberty. There were no patients restrained at the time of inspection. However, we were advised that documentation would be held in the patients' medical file.
- Patients advised that staff ensured informed consent was given by speaking to them several times before and after surgery about their procedures.
- We found policy and procedures in place, which ensured that capacity assessments and consent was obtained by middle grade level staff or above. Elective patients were informed about consent as part of their pre-assessment process and were given information regarding risks and potential complications.
- All staff received consent training as part of their induction and this was supplemented by additional dementia training.
- Audit had identified occasions when no application for Deprivation of Liberty were submitted.

Are surgery services caring?

Outstanding ☆

We rated caring as outstanding because:

- Patients were supported, treated with dignity and respect, and were involved as partners in their care. 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. We heard of examples where staff went the extra mile to celebrate patient birthdays and by organising a wedding for a terminally ill patient.
- Patients were involved and encouraged to be involved in their care planning and decision making, with

additional support if 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.

- 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 patient 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

- Recent audits (December 2015) showed 98% of patients would recommend the hospital to friends and relatives.
- Each patient felt their privacy and dignity had been respected and they were happy with the quality of care they had received.
- We observed staff treating patients with kindness and respect. Staff took time to introduce themselves to patients and explain the treatment and care provided.
- We spoke to 41 patients and relatives and they told us that staff were kind and caring, with patients stating that, "Words don't do justice to the level of professionalism and care the staff offer", "professional, dedicated and caring individuals. Thanks for treating me with dignity and respect", "devotion to patients was overwhelming", "standard of care received over seven days was exemplary", "two nurses cared for me the first night after my operation and made me feel safe and secure".
- Patients felt that their personal information was maintained confidentially.
- We saw staff promote independence and encourage those in bed to take part in personal care, to mobilise within their limits and positively encourage those patients who were having difficulty. Physiotherapists worked with patients and encouraged them to walk between six and eight times a day.
- Staff said they had not had to raise concerns about discriminatory behaviour but felt confident that should an incident occur, they and their colleagues would address the concern immediately.
- Patients told us staff responded promptly to the call bell system and that they asked about pain control.
- During inspection, we saw examples where staff went the extra mile to celebrate patient birthdays and by organising a wedding on the ward for a terminally ill patient. A great deal of time and effort was taken to ensure the wedding took place smoothly, legally and to the patient's wishes.
- Wards visited and the day treatment units 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 50 staff and it was clear that the demonstration of a caring approach was a high priority. Staff spoke to patients as individuals and demonstrated 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.
- 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.
- 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.
- MSU patient feedback showed that 12% out of an 18% response rate of patients saw an orthotist within one to two weeks. Eighteen percent stated they had enough time to speak with the orthotist at the first appointment and stated that area was clean and tidy, staff were approachable and friendly.
- 32 patients (80%) completed the Colorectal Cancer Patient Information Satisfaction Survey. Of the 32 patients that responded 81% stated that they met with the stoma nurse in outpatients clinic prior to surgery. Seventy-three percent stated the information provided about their condition was excellent, and 85% rated the service as excellent.

- Patient Experience Survey from the Male Lower Urinary Tract (LUTS) Clinic showed a 60 patient response rate. Fifty-eight of those patients stated they were happy with the information provided; the opportunity to ask questions and stated that their privacy and dignity was maintained during tests.
- 242 patients (51% completion rate) completed the RVI Endoscopy Patient Satisfaction Survey. Two hundred were happy with the timing of the appointment, all stated staff greeted them in a friendly and polite manner, and over 220 patients said they would recommend the service to friends and family.
- Neuroradiology Interventional Service Patient Experience 2014 showed that 87% of 141 patients returned their questionnaire. All 141 patients stated that they had consistently received a high quality service.

Understanding and involvement of patients and those close to them

- Patients said that staff took time to explain procedures, risks and possible outcomes of surgery and after care. Patients advised that complex information was repeated more than once by different levels of staff so that they understood their care, treatment and condition. Patients and their families received information in a way they could understand and were knowledgeable about treatment, progress and their discharge plan.
- Staff explained that they 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.
- 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.
- 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.

Emotional support

- A multi-faith 24-hour chaplaincy service was available. The trust chaplaincy team was responsible for raising awareness about spiritual, religious and pastoral needs. There were sacred spaces/chapels and quiet prayer rooms with access to prayer resources including prayer mats and sacred texts. The chaplaincy team consisted of clergy, lay and volunteers from a range of Christian traditions, together with four Honorary Jewish Chaplains and local contacts from other faith communities who supported the needs of the communities as and when requested.
- Work was underway to appoint Honorary Muslim Chaplains and to develop a Faith Forum to support the work in a more formal way.
- Chaplains visited patients on wards on a regular basis. The trust care after death policy highlighted the importance of ritual in death and provided guidance on releasing bodies out of hours where there were specific spiritual, religious or cultural reasons.
- Clinical psychology support services commissioned by the trust supported patients for example support was routinely provided for burns, amputees and stoma patients.
- 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. Two patients said they had used the psychology service before and after surgery and found it very beneficial.
- Patients were helped to maintain contact with family and friends. A patient who resided in the south of England did not have visitors due to location. A staff member brought in a phone charger from home so the patient could charge their mobile and maintain contact with those close to them. The patient advised that the act of kindness made their situation bearable.

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

innovative approaches to providing integrated person-centred pathways of care that involved other service providers, particularly for patients with multiple and complex needs. Where reasonably practicable, patients could access services in a way, and at a time that suited them. Ward managers were clear about zero tolerance for discrimination.
- The service 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.

Service planning and delivery to meet the needs of local people

- Commissioners, third party providers and stakeholders were heavily involved in planning services. Consultation was undertaken with commissioners regarding each of the departments within the directorates five year plan. Commissioners were actively involved in annual reviews of the service and dialogue was maintained with national commissioning groups. Surgical services 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, individual and cultural needs and engagement with the local population took place when planning new services. Flexibility, choice and continuity of care were evident during inspection; for example, patients drove the telehealth initiative.
- The Burns Service was based at the RVI, but with patients coming from across the North East, the service worked in close partnership with smaller, local hospitals to hold outreach clinics to reduce the distances patients had to travel to be seen.
- The Colorectal Enhanced Recovery Programme clinic operated weekly for patients requiring major bowel surgery, with multidisciplinary input from pre-assessment nurses, colorectal nurse specialists, physiotherapists, dieticians and consultant anaesthetists.

Meeting people's individual needs

- Services were fully accessible to disabled people who could access and use the service on an equal basis to others.
- There were appropriate arrangements to take account of individual needs of people being discharged with complex health and social care needs. Discharge planning was undertaken through multi-disciplinary planning with the patient, family, physiotherapy, OT, local authority and when necessary, the CCG for Continuing Health Care Funding.
- Interpreting services were available for patients whose first language was not English.
- 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. The burns team helped establish several patient support groups whose aim was to help make therecovery process from burns injuriesas quick and smooth as possible.
- 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.
- Staff were aware of additional support from learning disability liaison services. Areas of good practice showed 60% of people with a learning disability received a hospital passport.
- Plans to improve dementia environments showed actions to replace white crockery with coloured, purchase 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, explore options for an outdoor space for patients, review patient and carer experience. Areas refurbished were to receive appropriate lighting, colour contrast walls, privacy curtains, removable mirrors and appropriate signage.

- Leaflets were available for patients regarding their surgical procedure, pain relief and anaesthetic. Alternative languages and formats were available on request.
- There was a dementia strategy which staff in the service were familiar with. The service aimed to improve the use of 'Forget Me Not' and complete an audit of use in line with "John's Campaign".
- There was Medi Cinema at the New Victoria Wing, which was available for patients to watch during recovery.

Access and flow

- Bed occupancy between quarter one and two 2014/ 2015 and Q2 2015/2016 fluctuated. The highest being 89.1% and the lowest being 83.4%.
- 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.
- Since October 2014, 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). We found that RTTs were met for urology (92.2%), general surgery (94.4%), plastic surgery (91.9%) and ENT (93.4%) but not for trauma and orthopaedics (85.9%), during the same period.
- There was no risk identified for 62-day wait for first treatment from urgent GP referral, 62-day wait for first treatment from NHS cancer screening referral or 31-day wait from diagnosis for all cancers.
- The average length of stay in the RVI was generally longer than the England average. The average length of stay following spinal surgery was 3.3 days compared with the England average of 4.2 days. Plastic surgery length of stay was 3.1 days (2.5 national averages) and neurosurgery was 5 days stay on average compared to 4.4 national averages. Non-elective lengths of stay were predominantly above the national average at 6.1 days compared to 5.2 days.
- The trust followed a transfer policy regarding the movement of patients onto orthopaedic elective wards. This policy was in place to minimise the risk to elective patients post-surgery, to identify appropriate patients to reside from medical wards, and to separate elective and trauma patients.
- Discharge planning began at the pre-assessment stage. The trust set a planned date of discharge as soon as possible after admission. Surgical wards worked with the discharge liaison team to reduce delays in handing over care to social services or nursing home providers for those patients with complex needs. Intelligence data showed that delayed transfers of care which were due to community equipment and adaptions 3.7%, awaiting care package in the patient's own home 12.7%, awaiting residential or nursing home placement 0.5%, patient choice 34.5%, completion of assessment 8.1% and patients waiting for further NHS non-acute care 36.1%.
- There were a number of medical and surgical outliers across all wards. This was thought to be partially due to winter pressures. During the inspection, one ward visited held 60% surgical patients and 40% medical patients. A second ward was similar but this was intentional as part of the ward was specifically created for winter pressures.
- Patients said they were kept informed when procedures ran over time of if there were other delays such as x-ray, transport, or results.
- Theatre utilisation was on average 96% at RVI.

Learning from complaints and concerns

- The service received nine complaints in May 2015, which was 14% of the trust-wide complaints for that month.
- All surgical complaints were discussed at board level and complaints panel monthly. An electronic dashboard highlighted trends, themes and service level information.
- 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.
- The trust website offered information on how patients and relatives could raise concerns and this was available as a British Sign Language video. Throughout the trust, there were posters informing patients and relatives of the Patient Advice Liaison Service (PALS) with contact details.
- Patients and relatives could raise 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.

- Concerns could be recorded anonymously on NHS Choices and responses were given to avoid formal complaints wherever possible. Frontline staff, PALS and patient relations staff tried to resolve issues at the time they were raised before they become formal complaints.
- There were no risks identified in terms of complaint response times for the service.
- Action plans were created and implemented to improve the quality of care following complaints. There were a number of mechanisms used in surgery for sharing learning from complaints; for example, monthly patient safety briefings and bulletins, 'You said we did' information was visible, procedural change reports, open and honest care reports as well as lessons learnt discussions in clinical governance meetings within the service and surgical professional forums.
- A questionnaire was sent out following every final response to the complainant. This questionnaire requested feedback on patient satisfaction, response timeliness, level of detail provided, completeness and how understandable it was. These responses were collated and reported to the complaints panel. Each final response letter also signposted the complainant to the Parliamentary and Health Service Ombudsmen should they remain dissatisfied. The patient relations department monitored and reported on complaints.

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.

Vision and strategy for the service

- Work on new models of care for surgery was underway. The trust were engaged in development of Accountable Care arrangements in Northumberland and North Tyneside; the Success Regime in North Cumbria and considering suitable models in Newcastle (and Gateshead).
- The Financial Recovery Programme (North Tyneside) had introduced a referral management system for many surgical elective specialties but the trust stated it had not slowed treatment for patients, as the trust prioritised clinical needs.
- There was a 'Transformation Programme' in place to challenge existing models and improve quality, safety and efficiency. Initial priorities included admission and discharge; demand and capacity; outpatient services and theatre utilisation.
- The surgical directorate acknowledged that there were a number of organisational weaknesses and challenges. These included some aspects of information technology and informatics, which required improvement. Delivery and sustainability were key targets in a small number of sub speciality areas. Risks and challenges identified included the increase in demand for emergency and non-elective services. The trust acknowledged workforce shortages in line with national trends including nurses, radiographers, sonographers, junior doctors and senior specialist medical staff.
- We observed staff demonstrate the values of the trust during the inspection. 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.

Governance, risk management and quality measurement

- There was alignment between the recorded risks on the risk register and what different staffing grades said was 'on their worry list'. All staff were confident that their concerns were being addressed and understood that priority would be taken for some concern over others.
- Surgical governance committees were involved with audits and sanctioning innovation such as new implants, consultations with stakeholders took place regarding research and surveys.
- There was an effective governance framework to support delivery of the strategy. There was a holistic understanding of performance, which integrated the views of patients with safety, quality, activity and finance. The Clinical Directors and directorate managers explained they continually sought ways of improving quality of practice while advancing skills and procedures for patients. Patient's representatives, along with local and national patient surveys were considered when seeking improvement.
- 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 risk register for surgery was updated frequently, with high risks reviewed with input from medical staff, ward staff, and senior management. The associate director met monthly with matrons, service line managers, and the risk manager to review incidents, which had occurred, and any wider risks identified.
- All senior staff in the service including the associate director, clinical leads, service line managers, matrons, and band 7's monitored performance and quality information. Measures included finance, complaints, mortality, and morbidity, cancelled operations, the quality dashboard metrics, capacity and demand information and waiting time performance.
- There was a regular performance meeting with the Deputy Chief Executive and Business and Development Director to ensure quality standards were achieved.

Leadership of service

- During several interviews, it became clear that 'leaders' in surgery understood the challenges associated with good quality care and could identify the actions needed to address these. 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 told us that senior members of staff were very visible, always approachable and helped on the ward where necessary. Staff felt the support senior staff provided broke down barriers to prevent a 'them and us' culture. Managers encouraged supportive relationships among staff and felt peer support, such as group discussions were beneficial when sharing information, lessons learnt, new practice or policy information. Staff could identify the surgery medical and nursing leads.
- The clinical directors (CDs) and directorate managers (DMs) led surgical services. The unit comprised of two CDs and two DMs. Two modern matrons led, managed and supported the ward managers. Staff spoke extremely highly of senior leaders and there was a clear respect for those in managerial positions.
- The matrons attended a regular matron forum with all of the trust matrons and the deputy director of nursing. Information gained at these meetings was openly shared with other staff grades appropriately.

Culture within the service

- We found staff morale to be 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.
- At ward and theatre levels, we saw staff worked well together and there was respect between specialities and across disciplines. We saw examples of very good team working on the wards between staff of different disciplines and grades.

- Staff were well engaged with the rest of the hospital, reported an open and transparent culture on their individual wards, and felt they were able to raise concerns.
- Staff spoke positively about the service they provided for patients. High quality compassionate patient care was seen as a priority and the culture centred on the needs and experience of people who used services.
- Action was taken to address behaviour and performance that would be deemed inconsistent with the vision and values of trust, regardless of seniority. This was demonstrated recently following a serious incident within the directorate.
- There was a strong emphasis on promoting the safety and wellbeing of staff. Health advocates were in post to support staff as necessary.

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.
- 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, 'You said, we did' feedback was available on all ward and reception areas. 'Tell us what you think' boxes were in public areas 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

- Each ward area held monthly staff meetings, which discussed key issues for continuous service development. Staff said 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 happened following concerns or ideas to improve an area of practice. Staff felt encouraged to be involved in service improvement.
- When staff raised equality and opportunity concerns in 2014 the trust introduced staff networks including LGBT, BAME, Disability, Active participation in Newcastle Pride and a Stonewall champion.
- We saw that 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.

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. A young doctor based at the RVI won two prestigious national awards for gastrointestinal surgery. An Upper Gastro-Intestinal Cancer Nurse Specialist at RVI won the'innovations in your specialty' award category. The nurse created and developed the oesophageal and gastric cancer awareness campaign called'Oesophagoose'.This campaign involved developing a goose logo and mascot, and included an awareness-raising campaign using newspaper adverts, posters on local public transport, radio broadcasts and case histories on local TV to raise awareness of the disease.
- Other innovations included reorganisation of the monthly regional craniofacial ophthalmic input to coordinate patient's appointments to allow same day clinic assessment; the trust was the first in the UK to use da Vinci Robot for small lung cancers. The service used the latest robotic and laparoscopic equipment to treat many urological and lung conditions, which allowed minimal damage to healthy tissue.

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 Royal Victoria Infirmary (RVI) and the Freeman hospital. The RVI is home to the city's Accident and Emergency Department and is a major trauma and neurosurgical centre, which influences patient admission to critical care.

Critical care is a vital hospital service and is the area where the sickest patients in the hospital are treated. Newcastle has one of the largest critical care units in the United Kingdom with a total of 89 adult beds and approximately 7,000 admissions a year (at its highest for 5 years) 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 Royal Victoria Infirmary:

- Ward 38, in the older Leazes wing of the RVI, has 20 beds and provides intensive and high dependency care for patients who have had complex gastric, plastic and gynaecology surgery. It also provides care for medical emergencies and to patients who have suffered extensive burn injuries.
- Ward 18, in the new Victoria wing of the RVI, has 22 beds and provides intensive and high dependency care for patients who have complex neurosurgery and traumatic injury. Patients with serious trauma, head, orthopaedic and spinal injuries are also admitted to ward 18.
- The home ventilation team has a base office in ward 18 and they provide a service for patients who need on-going support and a breathing machine (ventilator) at home.
- There is a nurse-led, 24/7 critical care outreach service based in ward 18. 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 RVI. During inspection, our team spoke with 22 members of staff. We spoke with one patient and eight relatives. We observed care, reviewed policy and documentation and checked equipment in all units. We observed a morning medical handover and team safety brief. We also attended the critical care monthly audit 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.

Critical care

Summary of findings

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

- 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.
- Standards for infection prevention and control were good and rates of infections were better than national averages.
- The teams in critical care 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.
- 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.
- 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 average, care, and treatment was planned and delivered in line with current evidence based guidance and standards. The unit contributed to the national evidence base in their comprehensive approach to research and audit.
- The team were able to identify and mitigate risks, which were 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 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

- Ward 38 identified a number of environmental and facilities issues. This was highlighted in the critical care risk register and in a trust gap analysis report to the Trust Board in 2015. Despite this, the service was managing risks consistently well to ensure safe care.
- Although 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 in both, ward 18 and 38. 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.

Critical care

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 accomplishment in safety. In the one serious incident, we saw there was a clear investigation and lessons shared. There was Duty of Candour to inform the patient and family of the incident with an honest account and apology. Staff understood how to raise concerns.
- Patient care was safe. We saw a low incidence of patient incidents, avoidable harm and hospital acquired infection. There was a monthly critical care quality dashboard to share performance, activity and patient safety indicators.
- Nurse staffing met the Guidelines for Provision of Intensive Care Services (2015).
- Pressure ulcer incidence had reduced by 60% in the last 4 years. The work of the pressure ulcer prevention group in critical care had made a significant impact on practice and incidence.
- 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. Arrangements for managing medicines were good, and there was evidence of antimicrobial stewardship.
- Documentation in care records and daily reviews were consistent and records were securely stored. Risk assessments in care pathways and on critical care observation, charts were complete.
- Compliance across the wards with calculating the National Early Warning Score (NEWS) was supported through a rolling programme of audit and training provided by the critical care outreach team. Staff we spoke with told us that they had a good reputation and were visible, supporting staff in the hospital wards in the early detection of the deteriorating patient. The team covered a 24-hour rota, 7 days a week.
- Staff demonstrated a consistent and organised approach to safety briefings across both units. These were consultant led, involved the multidisciplinary team and performed daily or as required.
- The critical care service was a vital part of emergency preparedness and we observed evidence of critical care team's capable involvement in a major test of the hospitals major incident policy, using The Emergo Train System (ETS) in March 2015. A Public Health England report was produced as part of the feedback.

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Incidents

- Critical care at the RVI reported no never events and one serious incident in June 2015.This incident was reported to the Strategic Executive Information System (STEIS).
- The learning from this incident was shared across critical care. We saw evidence of thorough investigation and action plans. Senior nursing and consultant staff described how the Duty of Candour was followed to fully inform the patient and family following the serious incident in June 2015. Junior staff we spoke with were aware of the investigation and actions that had been put in place to prevent future patient harm.
- Staff at the RVI reported 262 incidents between June and September 2015. All staff we spoke with knew how to report incidents and how to escalate any concerns. There was a good reporting culture.
- Ward 18 staff reported 124 incidents with one moderate harm grading. Ward 38 staff recorded 138 incidents with one moderate harm grading. The main theme was pressure ulcer and moisture lesion incident reporting across both units. We saw evidence of improvement work, led by the nurse consultant that had significantly reduced the number of pressure related incidents by 60% over the past four years.

- The system for incident reporting had a prompt email mechanism to senior managers for any incident graded as moderate or above, with additional questions which encouraged an open approach and Duty of Candour with patients.
- Staff completed the 'apology' section in the reporting template for all incidents that were serious and caused the patient harm.
- Staff attended a monthly review of incidents. Senior staff gave feedback in a variety of ways including newsletters, meetings and teaching sessions. Incidents were discussed in the safety brief we observed.
- Monthly mortality and morbidity meetings were well attended and we noted good involvement of the multidisciplinary team. During our visit, we noted a positive example of mortality review processes in action. A joint review of a complex haematology case had been arranged with the multi-disciplinary team to share practice and education.
- 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

- The NHS Safety Thermometer is a national improvement tool for measuring, monitoring and analysing preventable patient harm-free care. It focuses on four avoidable harms: pressure ulcers, falls, catheter-associated urinary tract infections (CAUTI), and assessment and treatment for preventing venous thromboembolism (VTE).
- Safety Thermometer data was available to staff and during the inspection but it was not consistently displayed in the RVI critical care units. It was not clear how visitors to the unit were assured of the good performance in critical care from the information displayed. Staff we spoke with told us that the trust planned to implement a new system for display of safety thermometer.
- 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; 27 pressure ulcers were reported in 2014/15, which represented an 83% reduction in less than four years.
- There had been three patient falls in ward 18 and none in ward 38 between June and September 2015. The incidents were graded appropriately with two as insignificant and one causing minor harm. More than 95% of all staff had attended moving, handling, and falls prevention training.
- There were no catheter-associated urinary tract infections.(CAUTI)
- Additional audit and monitoring from September 2015 to the time of inspection had been put in place to improve previous inconsistent compliance with VTE assessment across critical care in 2015. At the time of inspection, the units had achieved a 95% target for risk assessment. Medical staff carried out audits on Sunday and Tuesday evenings at midnight and we saw evidence of this in the safety brief and minutes of meetings. Of the 12 notes we inspected 12 had a completed assessment. Patients assessed at risk received prophylaxis. The critical care team had identified VTE and prophylaxis treatment for patients at risk as a priority requiring further action and improvement. There were no incidences of VTE in 2014/15 in critical care.

Cleanliness, infection control and hygiene

- There had been no incidence for the past 5 years in the critical care unit of acquired Methicillin-resistant Staphylococcus aureus (MRSA) bacteraemia.
- On admission, a screening programme was in place in the critical care unit. The incidence of Methicillin-sensitive Staphylococcus aureus (MSSA) bacteraemia was recorded, with six incidences in ward 18 and 38 during 2014/15. In addition, three cases of Escherichia coli (E.coli) were reported in the RVI critical care units. There was evidence of consistent reporting and incidence was better than or comparable to national figures in similar sized units, contributing to the overall trust position of continuing to reduce incidences of hospital acquired infections.
- There had been seven incidence of unit acquired Clostridium Difficile (C.Difficile) in 2014/15. Staff said 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 team meetings as part of a structured review process.

- 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. The team 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 2014/15 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.
- 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 reduction in infection. Improvement work and audit was on going in critical care.
- Ward 18 and 38 were visibly clean. Ward 18 had good access to hand washing sinks, whereas ward 38 did not. We did observe all staff taking good opportunities to wash their hands, use appropriate personal protective equipment (PPE) and use hand gel dispensers.
- The matron scorecard for July- September 2015, consistently reported 100% of staff took opportunities for hand hygiene, but noted inconsistent compliance with staff demonstrating the correct hand washing technique. Ward 18 recorded a low of 80% against technique in September 2015 but a 100% compliance with infection prevention and control practice. Ward 38 reported a consistent 100% in 2015 in all aspects of the audit for infection prevention and control.
- We noted in the matron's scorecard, in minutes of meetings and on display in the unit, that Ward 18 environmental audit from August 2015 to the time of inspection had achieved 96% to 98%. (96% had been graded as amber and 98% as green) Ward 38 results were 96% to 100%.
- 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 18 or 38.
- We observed critical care assistant staff, domestics and nurses routinely cleaning bed areas and equipment. Staff we spoke with were aware of their responsibilities and we observed systems in place for cleaning duties and sign off.
- Domestic staff in both units told us about the correct storage and use of cleaning chemicals. We observed domestic staff changing bedside curtains and their cleaning schedules were available for review. There was evidence of water flushing schedules and domestic staff had a good understanding of the risks associated with a build-up of waterborne bacteria.
- Staff followed the uniform policy and we observed good adherence to the 'bare below the elbows' policy by all staff. We observed a nurse challenge a doctor in ward 38, over the correct use of PPE, and we observed that opportunity was taken to teach the correct process to encourage future good practice.
- Availability of isolation single rooms was good in Ward 18, but more restricted in Ward 38. Ward 18 had six single isolation rooms with good facilities for prevention and control of infection. Ward 38 had three single rooms in the ITU area; however, these had limited airflow requirements for infection prevention and control standards.
- Ward 38 HDU area had no access to single isolation rooms. One single room in ward 38 ITU was heated independently to provide specific care and treatment for patients with burn injuries.
- A consultant Microbiologist led daily ward rounds and was involved in multidisciplinary safety briefs.
- Staff attended training for infection control as part of mandatory training. Ward 38 met compliance targets for training with 96%. Ward 18 had 80% attendance at the time of inspection, but had action plans to achieve the target before March 2016.

Environment and equipment

- The environment was noted to be of a significantly different standard in ward 38 and ward 18 critical care units. Ward 18 was newly refurbished in 2011, spacious and of modern standard.
- Ward 38 had been in the older part of the RVI's Leazes wing since 1992 and expanded in 2001. A number of

environmental and facilities issues had been observed during inspection and these were highlighted in the critical care risk register and in a trust gap analysis report to the board in 2015. The priorities were observed as;

- Patient bed spaces and were noted to be half the recommended 25.5 m2 (Department of Health HBN 04-02, 2013). The 11.5 m2 bed space size we observed, did not give sufficient clear floor space to allow room for visitors, staff and equipment brought to the bedside.
- The hand washing facilities were inadequate in ward 38, particularly in the HDU area, where five sinks serviced 10 beds.
- There was no isolation facility in HDU, and limited privacy within each bed space, only curtains and bed space dividers offered this.
- The three isolation rooms had inadequate airflow positive/negative pressure, airlock and ventilation systems.
- Storage was inadequate. We observed the department to be tidy but cluttered with stock and equipment.

- Ward 18 and 38 had consistently good environmental audit scores ranging from 95-100% in 2015.
- We checked 27 items of equipment in ward 18 and 13 in ward 38. We found all equipment was well maintained and safety tested. We observed a thorough record of medical device training for staff.
- We noted that staff checked resuscitation equipment, trolleys, and they were stocked and clean. We observed the standardised airway rescue carts, which were well stocked and checked. Staff we spoke with told us that carts were in all areas where patients were likely to need urgent respiratory management and intubation.
- Storage facilities were excellent and well organised in ward 18.
- Staff we spoke with explained a good system for requesting medical equipment through the equipment loan library at the hospital. This system provided additional medical devices and mattresses as required.
- Visitor's areas were good in critical care. Both units had dedicated quiet rooms and visitors rooms. Both units needed to accommodate a large number of visitors who may also be distressed and anxious. We noted a number of people in corridors, rather than using the dedicated facilities.
- Visitor's rooms in ward 38 had been recently reviewed, in response to surveys and new furniture items had been purchased to enhance the environment.

Medicines

- Four critical care pharmacists (one with a part time role) provided medicines management support across four units, with daily review of prescribing Monday to Friday and an on-call system at weekends. Pharmacists accompanied the consultant-led ward round.
- We spoke with pharmacists who reported a shortfall in dedicated staffing with little mitigation or support for 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 units risk register.
- In respect of the size of critical care (87 beds) across both hospital sites, the pharmacy provision was not adequate against 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 produced for the peri-operative 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.
- We observed 11 paper and electronic prescription charts in ward 38 and ward 18 and no errors were noted.
- There were 114 drug incidents reported and followed up across critical care units 2014/15. Ward 38 reported 45 incidents, with 14 of those being a prescribing error. Ward 18 reported 19 errors with 10 related to administration and calculation of drugs. Measures were in place to improve medication safety and reduce incidents.

Records

- All units had a paper system for recording and documenting healthcare practice and treatment. Staff we spoke with told us 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 17 care records, which included critical care observation charts at the bedside and 11 prescription charts (paper and electronic). They were all accurate, complete and in line with Core Standards for Intensive Care (2013), and professional GMC and NMC standards. We found some variation in legibility of handwriting entries. We also saw a good example of a signatory list, signed and printed by all staff writing in the care record.
- Notes were stored at the bedside but not locked securely, although there would be minimum risk of breach of confidentiality with this arrangement in critical care due to the level of supervision at the bedside.
- 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 staff we spoke with said they could easily access and locate the patient information they needed. This was observed in practice.
- Information governance training was provided as part of the mandatory programme. Ward 38 had achieved the 95% compliance target for attendance; ward 18 had 78% 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 and staff we spoke with were aware of how to contact the trust safeguarding lead.
- Staff we spoke with said 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 observed a member of the trust safeguarding team attend ward 38 to support patient assessment and complete the Deprivation of Liberty Safeguards (DoLS) process with the patient and team.
- At the time of inspection, 86% of all staff in ward 38 had attended level 1 safeguarding for adults and 61% at level 2 against the 95% compliance target for safeguarding adults. 86% of all staff in ward 38 had attended level 1 safeguarding for children and 67% at level 2 against a 95% compliance target.
- At the time of inspection, 93% of all staff in ward 18 had attended level 1 safeguarding for adults and 74% at level 2 against the compliance target of 95%. 93% of staff in ward 18 had attended level 1 safeguarding for children and 79% at level 2 against the 95% compliance target.
- We saw evidence of action plans to achieve targets in both ward 18 and 38, staff could access an e-learning module for training.

Mandatory training

- The trust had a mandatory training policy and compliance targets of around 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 18 had achieved the 95% compliance target in 8 out of 21 modules. 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.
- Ward 38 had achieved the 95% compliance target in 12 out of 20 modules. The eight modules that were under target included safeguarding adults, mental capacity act, learning disabilities, anti-bribery, and corruption training. An action plan was in place to achieve the target before April 2016.
- Staff we spoke with across critical care were positive about the training they received, and told us it was easily accessed on the intranet.
- The critical care units also 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; these were carried out on each shift and attended by doctors and the multidisciplinary team. Clinical risks were discussed for all patient admissions.
- There was an 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.
- We spoke with the lead for outreach at the RVI, who 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 attended.
- The outreach team were involved in developing safer care of patients with tracheostomy. A number of approaches were being introduced as part of the National Confidential Enquiry into Patient Outcome and Death (NCEPOD, 2014) 'on the right trach' recommendations. Designated wards in respiratory medicine had been identified for all patients discharged from critical care as part of a trust approach.
- Audit of NEWS was bi-monthly to ensure compliance and accuracy of observations and promote early assessment and escalation of patients at risk of deteriorating in wards. Audit results were good with a stable compliance of 90% of staff recording accurately.

Nursing staffing

- The nursing establishment in critical care at the RVI 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 18 and 38. Staff we spoke with told us that critical care had a good reputation and was an attractive place to work in the trust and across the region.
- Staff we spoke with told us recruitment was not a problem and any vacancies were quickly filled from a waiting list. We spoke with a number of staff who had chosen to travel to Newcastle for nursing posts in critical care. Nurse managers had been able to over recruit to avoid any predicted gaps in staffing. Vacancy rates in critical care were low across all nursing grades and units.
- On the day of our inspection, actual levels of staff were good against planned levels and ward 18 and 38 adhered to the staffing guidelines for the provision of intensive care services (2015). Nurses reported to us that safety and critical care nurse/patient ratios were a priority. Staff rotas observed in both units had consistent staffing levels recorded for the previous 3 months.
- Ward 18 had used 2-6% bank staff to cover short notice sickness and staff shortage and demand from increase in patient acuity or close observation needs. Ward 38 had similar, zero or minimal cover with bank staff in 2014/15.
- Sickness and absence rates across the critical care unit were 4.3% against a trust average of 4.3%. Ward 38 had a consistent 4% rate and ward 18 had 4.7% sickness absence. This had been stable since 2013.
- 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 told us of the benefits of the role. ACCP's rotated across all four units.

- We spoke with a nursing assistant who was training to be a critical care assistant. This was an extension of health care assistant duties and nurses worked closely with a mentor and were able to take arterial blood gases and care for patients in HDU when required.
- We observed a good approach to nursing handovers and the safety briefs with all staff. Staff demonstrated a consistent and organised approach to safety briefings across both units. These were consultant led, involved the multidisciplinary team and performed daily or as required. 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.
- There were supernumerary clinical education nurses in post as recommended in intensive care standards 2013.

Medical staffing

- Ward 38 and 18 at the RVI met all 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.
- Due to the size of the units and current consultant establishment it was noted that weekday, daytime consultant to patient ratio was 1:10 in ward 38 and 18. Out of hours, consultant cover however was 1:20 or 22.
- Resident medical cover rotas included experienced critical care doctors and anaesthetic trainees, ACCP's, and trust grade doctors. They covered a daytime ratio of 1:8 or less, however they could cover up to 10 or 11 patients out of hours.
- Ward 18 had 8.75 and ward 38 had eight experienced consultant Intensivists who each took an expert lead on a range of areas of critical care practice. They delivered 60% of their job plans to critical care.
- Two consultants were on the unit 0800-1800 Monday to Friday and one on call from 1800 – 0800. One consultant per 24 hours covered weekend days.
- The 'orange role' or out of unit cover, was the single point of referral for the whole hospital to a single 'dect' phone held by the allocated consultant or junior doctor. These calls included referrals to critical care from the emergency department, major trauma, assessment suite and any NEWS triggers from critical care outreach and wards.
- Consultants covered 'orange role' Monday to Friday 08.00 – 13.00hrs and a junior doctor fulfilled the role during the afternoon, with support of the on-call consultant. This level of cover was closely monitored and featured in the risk register. 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 RVI.
- It was recognised that demand in critical care does not reduce at weekends. There were staged proposals to expand consultant critical care sessions to ensure weekends are consistent with weekdays. Staff we spoke with felt that the unit was safe at weekends even with half of the cover afforded Monday to Friday.
- A junior doctor we spoke with on ward 38 told us that he felt very well supported and that the unit was well staffed during the day, in comparison to other units he had experienced. He described good support out of hours and excellent teaching opportunities from senior staff.
- There was minimal use of locum or agency critical care medical staff or anaesthetists at the RVI site in 2014/ 2015. Anaesthetic locum use for February and March spiked to 9.8% from an average of 2% previously.
- We recognised that investment and strategy for long term planning for consultant critical care medical and anaesthetic staff was in place. This was clear in executive meeting minutes and in discussion with the consultant team.
- Sickness and absence of medical staff was reported to be 1.6% in 2014/15, although still slightly higher than the trust average of 1.4%.
- Safety briefs and handovers were consultant led. These 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. Staff demonstrated a consistent and organised checklist approach to daily safety briefings across both units, there was prompt for staff introductions, discussion of safety issues, quality and reporting of incidents 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. RVI was prepared for the role of second receiving UK hospital.

Are critical care services effective?

Outstanding ☆

. We rated effective as outstanding because:

- Patient care was planned and delivered by staff that 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.
- The unit's mortality rate was comparable or better than units of similar size in the United Kingdom. Ward 38 and 18 at the RVI performed within normal expectation against general units within the Intensive Care National Audit and Research Centre (ICNARC). Both units had a lower than expected standard mortality rate (SMR).
- The critical care outreach team provided a 24 hour, seven days a week service. They performed follow up of patients after discharge to wards as part of a thorough rehabilitation approach in critical care. The team led education for staff across the trust for the 'patient at risk course' and contributed to developing guidelines and training for staff in designated wards managing patients with a tracheostomy.
- 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 (MCA) and Deprivation of Liberty Safeguards (DoLS). Training was in place and units had planned to achieve compliance targets for staff in critical care in 2016. Consultant staff had taken a professional lead on developing 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 acutely ill patients in hospital was good at the RVI. The critical care outreach team were 24/7 and had led on work including, bi-monthly audit, improvements in general, neurological and spinal charts, and a clear NEWS policy. We saw the critical care discharge letters in practice and excellent training provided across the trust, including the 'patient at risk course' delivered by the critical care outreach team.
- 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.

- 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 the designated wards in the hospital and followed up by the critical care outreach team. The critical care outreach team provided a structured training course to all staff caring for patients with tracheostomy and laryngectomy.
- Patients at risk of VTE were risk assessed and prescribed prophylaxis in accordance with NICE QS3 Statement 5. Audit and monitoring was carried out to ensure compliance targets were maintained. Additional audit had been put into place to improve on a reported reduction in compliance with assessment in 2015. At the time of inspection, we noted 100% compliance with assessment in 12 care records and the critical care audit had achieved the 95% target with no incidence of VTE in 2014/15.
- The home ventilation team based in ward 38 at the RVI managed patients who required respiratory support at home. This included total outpatient investigations, set up of equipment, patient and family support and provided the UK's first overnight blood gas monitoring service. All of these measures prevented unnecessary admission to hospital. The team had set standards of care and produced national guidance on carer training for specialist respiratory equipment.
- Consultant led follow up clinics had been in place for some time at the RVI for critical care patients who had experienced a stay in critical care of longer than 4 days. 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.
- The nationally recognised care bundle to reduce the risk of ventilator-acquired pneumonia was in use and an audit had been carried out in ward 18 that tested compliance with the elements of the bundle. Clinical guidelines and audit of care of central venous catheter lines was also in place and referred to national guidance.

Pain relief

- We reviewed five care records and charts in ward 38 and pain assessment was recorded.
- A validated tool for pain assessment in intubated patients, the critical care pain observation tool (CPOT) had been recently introduced on the unit and required evaluation. Staff we spoke with were aware of the tool and reported that it was simple to use. We observed staff discussing and assessing the need for analgesia with their patients.
- Pain scores were discussed in handovers and charted appropriately at the bedside.
- We spoke with patients and their relatives who told us that staff managed their pain well and asked them if they were comfortable.
- We did not see any evidence of pain audit in critical care during our inspection.

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.
- A dietician was dedicated to the unit 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.
- We saw excellent fluid management and hourly documentation of fluid balance.
- Patient information to help patients and relatives understand nutrition in critical care was available. This included advice around nasogastric and intravenous feeding and helpful contact details.

Patient outcomes

Critical care

- The 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 reporting.
- 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 – 31st March 2015.
- Mortality was consistently 7-9% across all units during the past 5 years. Mortality was reported as a percentage of all discharges, deaths and transfers out of the unit. In 2014/15 ward 38 had a 10.7% (141 deaths) and ward 18 had 8.6% (136 deaths). It was reported that ward 38 and 18 at the RVI perform within normal expectation against general units within the ICNARC CMP.
- Both units had a lower (better) than expected standard mortality rate (SMR). Ward 38 had a SMP of 92% and ward 18 had 93%. SMP is recorded as a percentage with figures greater than 100% indicating excess mortality and figures less than 100% indicating greater than expected survivors.
- Discharges out of hours, between 22.00hrs and 07.00hrs have also been proven to have a negative effect on patient outcome and recovery. RVI critical care discharges out of hours were 2.6%, which was consistently lower than the national average of 8.4% for 2014/15.
- We noted that early readmission to critical care after discharge (within 48 hours) had improved in 2014/2015. It was reported ward 18 had 1.3% and ward 38 had 1.5%, however this was slightly higher than the national average of 1% but within acceptable range. All early readmissions were discussed in the monthly MDT meetings.
- Overall readmission to critical care after discharge was 7.8% for all units across both sites, which exceeded the national average of 4.2%. Ward 18 and 38 reported 6% readmission of patients. Performance was comparable with the network and national average for 2014/15.
- There was no evidence to suggest that ward 18 and 38 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.
- Patients receiving home ventilation service increased to over 500 active patients in 2014/15, which represented an increase of over 50% in the past 5 years.
- 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 0.72/1000 patient CVC days was well below the published national and international averages of 1.4/1000 CVC days.
- Patients identified as needing intensive care were admitted within 4 hours of the decision to admit by medical staff.

Competent staff

- Staff we spoke with said 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. Critical care had developed a local induction programme that was attended by all new starters.
- 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.
- 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. Staff were expected to achieve 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.
- There was supernumerary clinical education nurses in post as recommended in intensive care standards 2013 and nursing staff we spoke with told us that they felt supported in achieving the national critical care competencies and the provision of training and support was good in both units.
- 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 50% of nursing staff on ward 38 (53 of 106 staff) and 62% (71 of 114 staff) on ward 18 had achieved this target.
- Ward 18 hosted a critical care conference bi-annually with workshops for staff. Newcastle is also the host for the NoECCN conference in 2016.
- Nursing staff were able to rotate across any of the four critical care units as part of their professional development.
- Junior medical staff we spoke with told us that overall, they were impressed by the educational opportunities, both informal teaching on ward rounds, supervision and formal education.
- Nurses we spoke with told us clinical supervision was available and the trust had a supportive strategy in place for revalidation. We saw nursing staff sharing the processes for revalidation with one another in ward 38.
- 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.
- 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.

Multidisciplinary working

- We observed the multidisciplinary team working and communicating well with each other during the inspection of ward 18 and 38. This included physiotherapist, dietetics, speech and language, occupational therapists and pharmacy staff.
- Physiotherapy staff reported good compliance with core standards for intensive care units for Monday to Friday services. Patients admitted Monday to Friday had rehabilitation assessment complete but we observed significantly less compliance at weekends. Minimum rehabilitation standards of 45 minute sessions were also achieved during weekdays but not at weekends were staffing operated an on-call system. These issues were documented on the unit risk register.
- 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. Additional experience and support was gained within the critical care home ventilation service.
- We observed dieticians making patient assessment and discussing care and risk assessment at the bedside. The dietetic service was dedicated to critical care and worked well as part of a Monday to Friday service.
- The home ventilation team consisted of three consultants, 2 nurse specialists and a specialist physiotherapist. It currently supported over 500 patients.
- Organ donation retrieval team and specialist nurses supported 30 organ donations from the RVI site in 2014/15.

Seven-day services

- The RVI was the emergency or 'hot' site, with a large accident and emergency department. Subsequently admission to critical care of emergency and unplanned patients was at any time of day or night.
- 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.
- An embedded process of daily consultant patient ward rounds and review was clear in wards 18 and 38.
- There was access to diagnostic services across 24/7 at the RVI site.
- Critical care outreach achieved considerable activity across 24/7 services. In 2014/15, they had 10607 contact visits with patients across wards and took 1900 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 system. The trust had a plan to roll out a pilot for electronic patient records across wards and staff reported that this would be a positive step.
- There was the capability to produce detailed discharge letters for complex critical care patients using the electronic systems.
- Joint work with the NoECCN was on going to improve information given to GP's about patients critical care interventions and problems.

Consent and Mental Capacity Act

- Critical care was taking a proactive approach to the management of patient's assessment of capacity and 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.
- 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.
- 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 care records and consent had been obtained when it was possible in two examples. 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 (MCA, 2015) and possible Deprivation of Liberty applications. There had been MCA training of 92% nurses in ward 38, and 79% in ward 18.

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 RVI as having a strong, visible person centred culture. Staff were highly motivated and delivered care that was kind and promoted peoples dignity.
- We observed excellent examples of relationships with patients and their visitors that prompted one relative to call the team "family". This positive response was echoed in comments from across both units.
- 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.
- People's spiritual needs and the drive to improve a good quality of life were fully embedded into practice.

Compassionate care

- Without exception our team observed staff being caring and compassionate with patients and relatives during the inspection. We observed episodes of care that were kind and 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 41 responses at the RVI and a 50% response rate from the 40 surveys distributed in both units.
- 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. Results were more detailed and relevant to the critical care patient and environment than the family and friends and trust approach.

Critical care

- Most themes and comments were very positive, there was feedback to suggest that patient information could be easier to access and that ward 18 and 38 had small and noisy waiting areas that were not always private. The feedback for problems with ward 18's intercom system at the entrance of the unit had prompted arrangements for a staffed reception.
- Critical care had a proactive approach to seeking patients and their family's experiences. A pilot ICNARC national research study had been carried out in ward 37 at the Freeman hospital with plans to roll out across all units. The Family Related Experiences Evaluation (FREE) study in 2014 had included the views and opinions of 873 family members of 475 patients
- The consultants introduced wearing a named uniform as people had responded that they were not always sure who was in charge.
- There were many examples of compassionate and exemplary care. We spoke with staff who told us that patients were able to have trips outside as part of rehabilitation. We learnt from patients and families that arrangements for ventilated patients to go outside of the unit to the park or local shopping centre were encouraged to improve patient mood and motivation. Person centred care was a priority and patients and families were included in planning.
- We noted the commitment to continuity of patient care in the team. An example of this was the continuity given to a critical patient who had required a cross-site transfer from Ward 18 to have cardiac investigations at the Freeman hospital. Flexible working and collaboration of the anaesthetic consultants was evident in this case as they worked together, beyond the end of their shift to arrange a smooth transfer to and from the other hospital site.
- We spoke with relatives of patients and they told us emotional stories of their experiences with caring staff. Relatives used powerful statements to describe staff, such as "they're like family" "I wouldn't change them for anything."
- A mother wrote "The professional care, support and kindness to our son and us, as a family has been outstanding. Having been in ITU/HDU for 6 weeks we/ our son has had a high ratio of input from the team who are so hard working and dedicated to their craft/ vocation. In short we feel all the team have given 110% in every aspect of the care". This comment was not out of place with many others received by the units.
- Ward 18 and 38 had received the trust wide "personal touch" award and nominations. These were given to departments or individuals following a patient or family nominating outstanding compassionate care.
- During our inspection we received positive feedback about staff for example; "I can't let the amazing treatment from the day staff in ICU go unrecognised apart from never being more than a few steps away from bedside the way they were with me and other visitors was nothing short of amazing. The care they showed is something I've never seen before and they constantly checked on you and keep you informed."

Understanding and involvement of patients and those close to them

- 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. Staff from the nurse bank had been requested to support patients in the past.
- During observation of handovers we listened to staff, discuss individual needs of patients. This included good examples of assessment of capacity and dementia.
- The home ventilation support team had established a teaching programme specifically for carers. The survey information provided to us by the team showed excellent feedback and they felt very proud of the positive comments and responses.
- 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 are sensitive and key skills delivered by knowledgeable and experienced staff.
- As a response to suggestions from people that the unit could be a noisy place all units have introduced patient eye masks and ear plugs to promote sleep by reducing noise and distraction for the patient.

Emotional support

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

Critical care

- There were annual memorial services in critical care. Over 400 relatives of patients who had died within the critical care units attended the service in November 2015.
- As part of critical care follow up clinics psychologist services were available for counselling specific to patients who had experienced long stay in critical care. Staff we spoke with told us that they could access this service for inpatients if they were assessed as low in mood or required additional professional support or advice.
- 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.
- During our observation in ward 18, we noted the attention given to a patient's spiritual needs. The team had located and contacted a Buddhist priest from the local community at the request of family members. Consideration of Buddhist rituals during the priests attendance were well thought out and offered the family and patient the privacy they needed.

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 we spoke with. Lessons were shared with staff at all levels.
- 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.
- Patients received timely access to critical care treatment, a low number of critical care elective admissions were cancelled and this exceeded national targets. Patients were not transferred out of the unit for the wrong reasons and out of hour, discharges were kept to a minimum.

However

- Approximately half of all discharges to ward areas were delayed beyond 4 hours due to the pressures on hospital beds although this did not prevent the patient from receiving the care and treatment they needed.
- Bed occupancy in critical care was 85% overall and had steadily increased over the past 5 years. The team were planning for future services and took into account the current lack of capacity. Aspirations for expansion of critical care services at the RVI 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. The critical care unit were exploring achievement of CQUIN targets and NICE guidance CG83 for early rehabilitation. The physiotherapy team were establishing early rehabilitation models for critical care patients. 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. This was a consultant led service based in ward 38.
- The home ventilation service was comprehensive and well led. It delivered care to over 500 patients in their own home in 2014/15. This was a very busy regional and supra-regional service as it was becoming increasingly common for patients with a tracheostomy and ventilation needs to be cared for outside of the acute hospital environment. The team in critical care provided the 24-hour support and advice telephone service.

Meeting people's individual needs

Critical care

- The trust had interpreter services. Services also included British Sign Language. There was evidence of approximately 1000 episodes of use of interpreters with a balance of face to face and telephone interviews.
- The critical care team were skilled in managing patients with complex needs and we saw evidence of individual care planning.
- The organ donation service was included in provision for critical care and an experienced retrieval team was based on ward 18, accessible 24/7.
- We saw evidence of shared learning associated to caring for patients with a learning disability. 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.
- External legal provider advice service was 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.
- Patient satisfaction survey results led to adoption of more flexible and open visiting times in ward 18 and 38. The introduction of named uniform for consultants had been a direct response to comments expressed by families of patients who had been unable to identify staff in the unit.
- A range of specific information guides to support patients and relatives were available and information files had been developed for visitors to both units.

Access and flow

- The overall number of admissions at RVI had steadily increased in 2014/15 to 3330, with ward 18 having 27% of overall admission to critical care. Admissions have almost doubled in 5 years.
- Ward 38 had 20 beds (ten level 2 and ten level 3) and ward 18 had 22 beds (twelve level two and ten level 3 beds). Access to level two and 3 care was planned flexibly within the bed capacity to meet demands on service.
- A critical care consultant reviewed 100% admissions to the unit within 12 hours of admission in both units in line with GPICS standards through the system of twice-daily ward rounds.
- The Intensive Care society identifies 80% as an average occupancy for critical care to accommodate the frequently changing needs of emergency and elective services. The RVI 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%.
- Discharges should occur within 4 hours of the decision made by a consultant. This was frequently not achieved due to bed pressures at the RVI site. Ward 38, at 62.8% and ward 18 at 66.9%. Approximately 3000 of the 6400 discharges were delayed more than 4 hours from decision to discharge in 2013 to 2015 across all units. Three of four units exceeded the national average of 57%.
- Bed occupancy at midnight overall was 85%. Ward 18 had 91% in 2014/15 and ward 38 had 89% and had around a 10% increase during the past 5 years.
- No elective surgery was cancelled due to lack of critical care bed availability on ward 38. There had been 38 cancelled bookings on ward 18. This represented 4% against the national average of 9%.
- 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 the ICNARC data, patients were not transferred out of the unit for non-clinical reasons.
- Patients had access to a fully established, consultant led follow up clinic.
- Seven patients in 2014/15 that had been intubated and ventilated in emergencies were cared for safely in theatre recovery area whilst awaiting an emergency critical care bed. Critical care staff reported that the plan for a post-anaesthetic care unit (PACU) model had been proposed at the RVI site, as this model was working well at the Freeman hospital. The team were very aware of the limited critical care capacity and the issues were identified on the risk register.

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. We saw Patient Advice and Liaison Service (PALS) leaflets in waiting areas.

- There were six formal complaints investigated in 2014/15 and shared across all critical care units. Key concerns included communication issues, staff attitudes, noise levels and privacy issues.
- 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:

- The governance framework in critical care was clear and an experienced and motivated team managed the service. They 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. Staff felt valued and it was evident from conversations with staff that patient centred, quality of 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.
- 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 RVI and Freeman hospital. There was a vision for expansion of services at the RVI site to meet the needs of future developments and address risk in ward 38. There was an aspiration towards a single site 60 bed critical care unit at the RVI site. This strategy was clearly documented in minutes of meetings at all levels and staff we spoke with were aware of strategic plans.
- The role of the Advance Critical Care Practitioner (ACCP) was valued by all levels of staff and the programme continued to be supported. The team welcomed visitors to the unit to share experiences of introducing the ACCP programme.
- There was a plan in development for an electronic healthcare record and charting system.
- 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, 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 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.
- 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.
- Ward 38's failure to comply with standards for environment, (it opened in 1992 and expanded in 2001) was clearly a priority. Activity had tripled since 2001 from 500 admissions a year to 1500. The unit had significant space, design and storage issues and did not comply with the Guidelines for the Provision of Intensive Care Services (GPICS), infection control or HBN 04-02 standards.
- 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. The inadequate pharmacy cover across all units was not included in the risk register. In addition to the risks associated with environmental issues on Ward 38, those relevant to the RVI units included;

- Nurse staffing issues and in wards 38 and 18. (reported in July 2015 and resolved at the time of inspection)
- Anaesthetic 'out of unit' cover for wards and major trauma for afternoons and weekends.
- Critical care rehabilitation could not be provided to GPICS standard with current physiotherapy establishment,
- Lower submission of cardiac arrest audits than 95% target.

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.
- 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 RVI 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 22 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 (NoCCN).
- 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. Critical care involved patients, their families and the public when developing services or seeking feedback about current provision.
- The visitor satisfaction audit in 2015 led to improved visiting facilities at RVI and the development of a 7 day staffed reception.
- Public engagement had been arranged with local people for development of a face transplantation service. 100 people attended the public meetings and response was being used to inform service development.
- The 'ICU steps' UK support group was available locally for relatives to network with others who had been affected by critical illness.
- Critical care staff supported community fund raising events and we saw evidence of this in the newsletters.
- 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 high priority.

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.
- 22 members of staff we spoke with were proud of working in critical care services across both sites. RVI staff were very positive about their roles and had chosen to work in the unit over other regional units.
- 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

- 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 have dropped by 67% over 3 years. This was shared at regional level and a peer review journal published.

- Six nurses volunteered a study group pilot, which explored symptoms of professional burnout and compassion fatigue, known as secondary traumatic stress. Staff we spoke with told us that this had been a very positive and personal experience. A group met monthly on six occasions, to discuss the emotional reactions to events in the critical care environment. There were plans to expand this approach and resource.
- Critical care patient follow up, rehabilitation clinics were a priority for staff, and clinics had been established for some time. Patient satisfaction with the service was rated highly.
- Newcastle critical care were 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 working within the four adult units. Many centres around the UK had visited Newcastle to learn about the programme and implement the role within their critical care units.
- We observed guidelines and practice that would support that Newcastle critical care were best practice leads in the application of Mental Capacity Act 2005 and DoLS legislation. The Law Society as a means of improving current legislation was currently using the template that the unit had produced.
- Training and education provided at Newcastle critical care was excellent. It included a trauma simulation centre, tracheostomy training and the patient at risk course.
- A weekly independent legal service for families in ward 18 critical care unit was introduced where families could book an appointment with a lawyer to ask advice on a range of issues. The uptake had been two appointments a week.
- A simple but responsive improvement had been the change to named consultant uniform in response to feedback from patients.
- The critical care outreach service sustained 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.
- The home ventilation service was innovative, comprehensive and well led. It delivered care to around 500 patients in their own home in 2014/15. The service led the way for patients needing total management of their respiratory failure at home with carers. The team offered diagnostics, extensive training and patient support. The team had written the national curriculum for specialist consultant training. The domiciliary visits covered the whole of the North of England, up to the Scottish border, west coast and Teesside.

Maternity and gynaecology

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

Information about the service

The trust offered an extensive range of maternity services for women and families based in this hospital and the community. The service was the specialist referral centre for maternity services in the North East of England and Cumbria. Services were based in the hospital and community settings, ranging from the Newcastle Birthing Centre for women assessed as low risk and specialist care for women whose pregnancies required close monitoring for example fetal medicine and antenatal clinics. Four teams of community midwives provided antenatal and postnatal care in women's homes, clinics, children's centre and GP surgeries across Newcastle. There was also a team of research midwives. The trust undertook gynaecological surgeries such as a women's health unit and the Northern Centre for gynaecological surgery (NCGS). There was an early pregnancy service which was open seven days a week for women who were suffering symptoms of miscarriage in the early weeks of pregnancy

The service at Newcastle Hospitals NHS Foundation Trust delivered 5282 babies between April 2015 and December 2015, with 1123 babies born in the Newcastle Birthing Centre (midwifery led service) and 4159 babies born in the Newcastle Delivery Suite (consultant led unit).

The service offered both medical and surgical termination of pregnancy and carried out 682 medical and 282 surgical terminations between April 2015 and December 2015. There were processes in place to ensure the sensitive disposal of pregnancy remains.

We visited the fetal medicine, antenatal clinic, Newcastle birthing centre, delivery suite, Termination of pregnancy service, early pregnancy assessment unit, maternity assessment unit, antenatal and postnatal ward, and community midwifery services and gynaecological services. We spoke with 32 women and 66 staff, including midwives, midwifery support workers, doctors, consultants and senior managers. We observed care and treatment and looked at 17 care records. We also reviewed the trust's performance data.

Maternity and gynaecology

Summary of findings

We rated maternity and gynaecology services as outstanding overall with the safe and responsive domains rated as good because:

- We observed and were given examples by staff and patients of areas of good practice in the care and treatment of women.
- The service provided safe and effective care in accordance with National Institute of Health and Care Excellence (NICE) recommended practices. Staff monitored outcomes for women using the service continually and took action where improvements were necessary.
- Resources, including equipment and staffing, were sufficient to meet women's needs. Staff had the correct skills, knowledge and experience to do their job.
- Staff took women's individual needs in planning the level of support they needed throughout their pregnancy. Staff treated women with kindness, dignity and respect. The service took account of complaints and concerns and took action to improve the quality of care.
- A highly committed, enthusiastic team, each sharing a passion and responsibility for delivering a high-quality service, led the women's health directorate, which included maternity and gynaecology services. Governance arrangements at all levels, enabled managers to identify and monitor risks effectively, and review progress on action plans.
- Engagement with patients and staff was strong. There was evidence of innovation and a proactive approach to managing performance improvement.

Are maternity and gynaecology services safe?

Good

We rated the safe domain as good because:

- There were effective systems for reporting, investigating and acting on adverse events. The service routinely collected and reviewed standards and safety and shared it with staff.
- Staffing levels were set and reviewed at ward and board level using nationally recognised tools and guidance.
- Medical, nursing and midwifery staffing was worse than the national recommendations for the number of babies delivered on the unit each year, however, we were assured actions were being undertaken to address this.
- Staff planned and provided care and treatment in a way that ensured women's safety and welfare. Staff followed safety guidance for infection prevention and control.
- The service managed medicines safely. Records relating to women's care were detailed enough to identify individual needs and to inform staff of any risk and how they were to be managed.
- There were clear safeguarding processes in place: staff knew their responsibilities in reporting and monitoring safeguarding concerns.
- The service had won funding from the NHS Litigation Authority (NHSLA) in the sign up to safety campaign. The funding was awarded to reduce the incidence of avoidable neonatal injury sustained during childbirth by 50%.
- We had no concerns with the safety of gynaecology services.

Incidents

- Trust policies for reporting incidents, near misses and adverse events were effective in maternity services. All staff we spoke with said they were encouraged to report incidents and were aware of the process to do so. Staff reported incidents on the trust's electronic incident-reporting system. Staff told us they received feedback about incidents they had reported (if they had checked the appropriate box on the online form), with details of the outcomes of any investigations.

Maternity and gynaecology

- There were 499 incidents reported for the service for June and September 2015. One incident was reported as 'catastrophic', 10 were classified as 'major', 41 were classified as 'moderate'. The service completed Root Cause Analysis (RCA) reports. We found evidence of discussion and learning shared with staff.
- There were 34 incidents reported in the gynaecology service for June and September 2015, one was identified as 'major, three were reported as moderate. Themes focused around complications during treatment and patient accidents. We were assured that the service was working with the corporate teams to reduce these trends.
- The service used internal communication methods to inform staff of learning and changes to practice (for example, the bimonthly obstetric newsletter "Risky Business"). We observed discussion of the service developments at team handovers.
- There were no Never Events reported for maternity in 2014/15. Never Events are serious, wholly preventable patient safety incidents that should not occur if proper preventive measures are used.
- Monthly audit and perinatal meetings monitored perinatal mortality and morbidity (attended by gynaecology, obstetric and neonatal staff). Although these meetings were not routinely minuted, important issues were recorded and shared. Outcomes from serious case reviews were also discussed at operational and governance meetings throughout the directorate, including being discussed at weekday morning risk meetings, which were attended by junior and senior staff.
- Staff we spoke with were able to discuss the principles of duty if candour, however senior managers within the service informed us it was not fully understood when it was implemented. However, we were assured the service were implementing Duty of Candour appropriately, and reviewed evidence of when it had been used.

Safety thermometer

- At the time of inspection, the service did not use the national Safety thermometer indicator. However, we were assured that the directorate quality and safety group had fully considered this choice.
- We reviewed data from the Clinical Assessment Toolkit (CAT), a tool used to collect data in relation to the safety thermometer. We reviewed the assessments for September 2015, for the women's health directorate. Results were between 80% to 100%, for hand hygiene, matron's monthly check, infection prevention and control, waiting area/couch integrity and environmental cleanliness.

Cleanliness, infection control and hygiene

- There were no cases of hospital-acquired Methicillin-Resistant Staphylococcus Aureus (MRSA) or Clostridium difficile (C. difficile) in 2014/15, within the women's health directorate. However, there was one case of methicillin-susceptible Staphylococcus aureus (MSSA). We reviewed evidence, which showed outcomes of the root cause analysis, learning and actions, which were being taken to prevent a recurrence.
- Appropriate signage was on display regarding hand washing for staff and visitors, and there was adequate numbers of hand gel dispensers around the departments.
- Observations during the inspection confirmed that all staff wore appropriate personal protective equipment when necessary, and followed 'bare below the elbow' guidance, in line with national good hygiene practice.
- We reviewed data which showed 86% of staff had completed infection prevention and control training. We were assured that processes were in place to encourage staff to complete the online training course for example, we observed leads in handover encourage staff to access the training.
- The CQC Survey of Women's Experience of Maternity Services (2015) showed the service scored 'about the same' as other trusts for cleanliness, infection control and hygiene.
- Data reviewed on ward boards showed, for the most recent hand hygiene audit, nursing, midwifery and medical staff on delivery suite and wards were between 98% and 100% compliant. We asked staff what the dates were for this audit however, they were unsure as the infection control team undertook the audit and there were no dates provided on the feedback cards.
- Failsafe systems were in place to identify women for Hepatitis B and HIV at booking to ensure care provided followed the correct care pathways. Data between January and March 2015 showed 100% of women were screened for HIV and Hepatitis B.

Environment and equipment

Maternity and gynaecology

- There was adequate equipment on the wards to ensure safe care specifically, cardiotocography (CTG) and resuscitation equipment. Staff confirmed they had enough equipment to meet patients' needs.
- The service used a CTG training tool to assess staff competence and awareness of the functionality of the equipment. For example, daily checks to ensure the date and time on the CTG was accurately set, and all necessary equipment was available to monitor the fetal heart rate.
- The trust's medical engineering department regularly checked maintenance of equipment and records showed staff carried out equipment checks each day.
- The Newcastle Birthing Centre had 11 single en-suite rooms, which were used for labour and postnatal stay. Five of the rooms had birthing pools. We were assured staff tested evacuation from the pool regularly and trust data showed there was a 30% water-birth rate between April and December 2015. Staff informed us almost all women chose to labour in water however, many chose to give birth outside of the pool.
- There was one birth pool on the Newcastle delivery suite.
- All delivery rooms had piped ENTONOX® (Nitrous Oxide and Oxygen) and other gases. The delivery suite had a fetal blood analyser.
- The design of the maternity unit helped to ensure women and babies were safe. The NBC was separate from the delivery suite as it was based on the ground floor with lift access to the Maternity unit based on the first floor. This allowed for a clear separation of uncomplicated midwifery led care and consultant led care, however, staff informed us that should a labouring lady require transfer to the delivery suite on the first floor there was a priority key for lift access and this was practiced on a regular basis. However, we did note that access to the lift was outside the unit and was open to the public; we were informed by staff that they restricted public access during transfer.
- The delivery suite had 14 delivery rooms, including the Halcyon Suite, which was used for women giving birth following pregnancy loss. The delivery suite also had an induction suite, which had six beds, a three-bedded post-operative recovery room, and an enhanced recovery suite, which had four beds. There were two operating theatres, and should a third theatre be required staff were able to use gynaecology theatres on the second floor.
- The service had made appropriate adjustments to ensure women with a disability had access to suitable facilities. This included adapted bathroom and toilet areas. Specialist equipment for women with a high body mass index (BMI) was available when required.
- The service had bariatric equipment; both theatres had tables, which could take a maximum weight of 450kg and specialist bariatric lithotomy polls. There were four delivery beds, which could be used for bariatric patients. The service planned antenatal care for women who would require bariatric equipment postnatally and this was documented in their individual care plan and provided in time for admission.
- The antenatal ward had 14 inpatient beds which consisted of two single rooms, however these were not en-suite and three four bedded bays. Each bay had toilet facilities; however, there were two showers. This ward also had three single rooms, which were used by parents with babies on the neonatal unit, to enable parents to spend the night with their baby prior to discharge from the unit. These beds were accessible to antenatal women if required.
- There were two postnatal wards however, these were integrated, which equated to 42 postnatal beds. We found there were limited shower facilities as there were three showers and one bath for the majority of these women. There were two cubicles with en-suite facilities.
- The maternity assessment unit (MAU) had two single consulting rooms, and the rest of the assessment space had chairs and two were behind curtains. We found that there was also a waiting room; however, this was a small and cramped space. Women were advised to inform staff in the MAU of their arrival and then they would be called, but there was no integrated reception area. We found that this unit was quite cramped and there was a lack of private space for confidential discussions.
- Staff we spoke with informed us they had enough equipment to meet the need of patients. These included cardiotocograph machines (CTG) which monitor a fetal heart rate over a period of time.
- All quality control checks on equipment such as cardiac arrest trolley's, blood glucose monitors and CTGs were present with no gaps noticed.
- We reviewed stock and store cupboards and found no issues of concern. On the antenatal ward however, due to the lack of storage space there was no dedicated clean utility. We found that items usually stored in the

clean utility such as medication cupboards, sterile stores and fluids were stored behind the midwives station, however, all medications and fluids were in locked cupboards.
- The neonatal unit was situated close to the delivery suite. Staff we spoke with informed us that paediatric staff could attend emergencies quickly.
- The gynaecology ward (ward 40) had 22 inpatient beds and 7-day surgery beds, and bariatric equipment was available from the moving and handling team, who trained staff in how to use it.
- The gynaecology theatre was situated on the second floor and there were no concerns with access from the gynaecology ward.

Medicines

- Medicines were stored in locked cupboards and trolleys in all clinical areas in the women's health directorate.
- Medicines that required storage at a low temperature were stored in a specific medicines fridge. All fridge temperatures were checked and recorded daily. There were no gaps in recording. Nurses and midwives told us they received support from the on-site pharmacist, when necessary.
- Records showed the administration of controlled drugs were subject to a second, independent check. After administration, the stock balance of an individual preparation was confirmed to be correct and the balance recorded.
- Records showed controlled drugs were checked in line with hospital policy.
- There were processes in place to record all medications dispensed by nurses and midwives under the patient group directives (PGDs) during the discharge process.
- We found on the antenatal ward that drugs were stored on an emergency trolley (these drugs would be used to control a woman's blood pressure if it was dangerously high), and were stored behind the midwives station and were not locked away. We discussed this concern with senior staff. When we returned to the ward on our last day on site we found the emergency trolley and drugs were now stored behind a locked door in the linen cupboard, and notices had been placed to ensure staff all knew where the trolley was being kept. Staff informed us they were looking into options of tamper proof boxes and trolleys.

Records

- Staff kept clinical records to a high standard. We reviewed 16 records from the maternity and gynaecology service. All contained a clear pathway of care that described what women should expect at each stage of their labour.
- The service kept medical records securely in line with the data protection policy. The trust used a barcode scanning system to track their patient records.
- Risk assessments were completed at booking and repeated at every antenatal visit.
- Women carried their own records throughout their pregnancy and postnatal period of care. The unit used the North East Personal Child Health (NEPCHR) 'red book' this was given to women before the new-born examination and was completed correctly.
- The service used approved documentation for the process of ensuring that all appropriate maternal screening tests were offered, undertaken and reported on during the antenatal period.
- We reviewed the results of a documentation audit dated September 2015. The service reviewed a random sample of 80 records. The audit identified improvements were required in four areas, these were:
  - Antenatal risk assessment
  - Intrapartum risk assessment
  - Cardiotocograph tracings (Fetal heart rate monitoring)
  - Bladder care
  - Basic standards for documentation.

We found that the results of the audit were discussed within the Risky Business newsletter and within the quality and safety committee minutes. During our inspection, we reviewed a random sample of 10 care records and found them to be completed to a high standard.

Safeguarding

- There were effective processes for safeguarding mothers and babies. The service had a dedicated midwife responsible for safeguarding children, and had recently been given protected hours to undertake this role. The safeguarding midwife worked alongside the named nurse for safeguarding children. Should the lead midwife be off site or on leave band six midwives were encouraged to "act up" and provide cover. These

midwives shadowed the safeguarding midwife prior to providing cover and additional support during this time. Staff we spoke with informed us they received feedback and felt well supported in this role.
- Risk assessments and clear care pathways were in line with the safeguarding policy.
- Staff demonstrated a good understanding of the need to safeguard vulnerable people. Staff understood their responsibilities in identifying and reporting any concerns.
- The safeguarding lead told us all midwives received annual safeguarding training and community midwives had face-to-face supervision every 6 months. All staff we spoke with said they were happy to call the lead nurse if they had concerns.
- Records for the women's services showed 100% of eligible staff had completed level one children's safeguarding training; however, 99% of staff had completed children protection level three training. All midwives we spoke with told us they had completed levels two and three safeguarding children and level three enhanced training.
- Records showed 98% of staff had completed safeguarding adults level three training against a trust target of 95%.
- We found robust systems in place to ensure the safety of mothers and their babies. We reviewed a report following a test of the child abduction policy in March 2015. It was found that all staff managed the situation appropriately. During our inspection, we observed all visitors accessed the wards from a central reception desk and were required to call for access again to the individual ward.
- We asked staff how they assessed and reported concerns around female genital mutilation (FGM). The World Health Organisation (WHO) defines FGM as procedures that include the partial or total removal of the external female genital organs for cultural or other non-therapeutic reasons. Senior clinical staff told us there had been training about FGM the previous year, which raised awareness. A guideline was in place to support staff in the identification of those at risk of FGM and management. Since September 2014, it has been mandatory for all acute trusts to provide a monthly report to the Department of Health on the number of patients who have had FGM or who have a family history of FGM. In addition, where FGM was identified in NHS patients, it is now mandatory to record this in the patient's health record; there was a clear process in place to facilitate this reporting requirement.
- Private rooms were available on the pregnancy advisory unit to counsel young women. Staff were trained to ask girls aged 13 to16 about their sexual activity and refer to appropriate agencies where necessary. Girls under 13 years were referred automatically to the safeguarding team.

Mandatory training

- Midwifery, health care assistants (HCA) and medical staff attended obstetric mandatory training programme, which included emergency drills, adult and neonatal resuscitation, infant feeding, record keeping and risk management awareness. Midwives were required to attend 3 days of training and medical staff and HCAs attended two days of this training.
- All attendance at training provided by the service (including CTG training) was monitored by the administration team who fed in to the trust wide electronic staff training database. Managers were informed when staff were due for training to ensure staff were allocated to training within a timely manner.
- We reviewed data which showed 94% had completed their mandatory training requirements, additionally we found that basic life support training had been completed by 98% of staff.
- We reviewed mandatory training data for ward 40, which showed 83% of staff had completed their mandatory training requirements against the Trust target of 95%, and adult basic life support training had been completed by 72% of staff.

Assessing and responding to patient risk

- Midwifery staff identified women as high risk by using an early warning assessment tool known as the Maternal Early Warning System (MEWS) to assess their health and wellbeing. This assessment tool enabled staff to identify and respond with additional medical support if necessary. We reviewed eight records and saw all contained appropriately completed MEWS tools. We also reviewed internal audit data dated November 2015, which showed good compliance with the MEWS tool.
- Arrangements were in place to ensure checks before, during and after surgical procedures in line with best practice principles. This included completion in

obstetric theatres an adaptation of the World Health Organisation (WHO) surgical safety checklist. During our inspection, we observed staff undertake a WHO checklist and it was fully completed, however, staff did not re-introduce themselves to the patient.

- An obstetric audit of the WHO checklist for the period October 2015 (sample size of 23) showed good compliance with completion, however, it was highlighted that only 7% of women had their temperatures taken on arrival in theatre. Actions plans included a re-audit of the checklist in January 2016 and plans to spot check records were in place.
- There was access to clinical specialists based at both the Royal Victoria and Freeman sites. We were given examples of arrangements where the obstetric and neonatal teams would perform caesarean sections at the Freeman site if the health of the mother or fetus required. For example a fetus requiring cardiac surgery immediately following birth where transferring the baby from the RVI to the Freeman Hospital would cause a delay.
- There were clear processes in the event of maternal transfer by ambulance, transfer from homebirth to hospital and transfers postnatally to another unit.
- The unit used the 'fresh eyes' approach, a system which required two members of staff to review fetal heart tracings. We observed staff were allocated a fresh eyes reviewer at the beginning of each shift, which indicated a proactive approach in the management of obstetric risks.
- Nursing staff used the nursing early warning score (NEWS) risk assessment and sepsis screening tool. This allowed staff on the ward to record observations, with trigger levels to generate alerts, which helped with the identification of acutely unwell patients. Records we looked at showed NEWS scores were completed correctly. Staff we spoke with were aware of the escalation process when a patient deteriorated.

Nursing and Midwifery staffing

- The service did not meet the national benchmark for midwifery staffing set out in the Royal College of Obstetricians and Gynaecologists guidance (Safer Childbirth: Minimum Standards for the Organisation and Delivery of Care in Labour) with a ratio of 1:30 across both community and hospital staff against the recommended 1:28.
- A team of practice support midwives were based on the Newcastle Delivery Suite 24 hours a day. The NHSLA sign up to safety bid funded this resource. The focus of the team is to provide direct support and guidance for newly qualified and new to post midwives, and they provide ongoing support and development to the midwifery team.
- The service used an acuity tool to assess workload, which is based on the Birthrate Plus® tool. The head of midwifery and matrons reviewed staffing levels and benchmarked against other Shelford Trusts in order to identify the appropriate staffing levels. The results of this work identified that the service required: an additional 20 whole time equivalent (WTE) qualified midwives: and an increase to the skill mix to include additional nursery nurses on the postnatal wards and maternity support workers. Senior staff provided us with assurance that a recruitment process was underway which included an internal development programme for health care assistants.
- There was a safe staffing and escalation protocol to follow should staffing levels by shift fall below the agreed roster.
- We found staffing levels were displayed on the entrance to all wards and there was a correlation between planned and actual staffing numbers.
- Women told us they had received continuity of care and one-to-one support from a midwife during labour. However, the service did not collect 1:1 care in labour electronically at the time of inspection. We reviewed paper documentation on site, which identified on the NBC this was 100% and as far as possible 1:1, care in labour was provided on delivery suite.
- We were advised that community midwife caseload numbers were between 1:100 and 1:150. This was worse than the nationally recommended 1:98. We discussed this with senior staff and we were assured that the service was recruiting a further eight midwifery staff and three community midwifery support workers. This would improve the caseload numbers.
- We observed handovers on the delivery suite and the community midwives, which were comprehensive. On the delivery suite, there was a further bedside handover. We observed handover between midwives and again this was concise.

- The service used bank midwives from their own staffing establishment should shifts require cover. The total hours worked was monitored by management to ensure staff were not working too many hours, which could affect patient safety.
- The early pregnancy assessment unit was staff by three WTE. This allowed a 7-day service to be provided. Staff reported this suited the needs of the service.
- There was a team of 13 research midwives and nurses, who led on the data collection and support for medical staff in research projects. Staff we spoke with informed us they obtained consent and worked collaboratively with the medical staff, and it was not a hierarchical system.

Medical staffing

- The medical staffing mix for the maternity and gynaecology service across the trust was mixed compared with the England average, with 35% consultant grade staff, which was equal to the England average. Middle grade staff, that is doctors with at least three years as a senior house officer or at a higher grade, was 1% at the trust and the England average was 8%. The trust had higher than the England average for registrar level staff, which formed 61% of the staff, against an England average of 50%. Junior doctors, those in foundation years one or two, made up 3% of staff, with the England average at 7%.
- The delivery suite had consultant cover 98 hours per week. This was based on an onsite consultant presence for 14 hours a day seven days a week.
- The consultant obstetricians provided acute daytime obstetric care on the labour ward and participated in out-of-hours work when they were on call for the obstetrics and gynaecology units.
- Multidisciplinary ward/board rounds took place at 08.00hrs and 20.00hrs for all women and review of critical care women as their condition dictated; the labour ward coordinator also took part in the medical handovers.
- Consultants worked on a team basis, and provided cover within the team for sickness and leave. This meant that all antenatal clinics had a consultant present, and women would receive consistent care.

Major incident awareness and training

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

Are maternity and gynaecology services effective?

Outstanding ☆

We rated the effective domain as outstanding because:

- There was an excellent induction programme for newly qualified midwives. This included a 6 month period of supernumery and preceptored practice.
- We found excellent multidisciplinary working between hospital and community services and support from allied healthcare professionals and specialist expertise was available to women using services.
- The service used national evidence-based guidelines to determine the care and treatment they provided and participated in national and local clinical audits. Patient outcomes were routinely monitored and action taken to make improvements.
- Staff had the correct skills, knowledge and experience to do their job. Training ensured medical and midwifery staff could carry out their roles effectively. Competencies and professional development were maintained through supervision.
- Women reported having their pain effectively managed and there were choices for managing pain. An anaesthetist was on duty to administer epidurals. Women were offered support to feed their baby's, and food and drinks were always available for mothers.
- We had no concerns on the effectiveness of the care provided within gynaecology services.

However

- Patient outcomes were monitored using an interim maternity dashboard and not all patient outcomes were documented on the dashboard; we were assured all patient outcomes were scrutinised.

Evidence-based care and treatment

- Medical and clinical staff reported having access to guidance, policies and procedures on the hospital intranet.
- We could see from our observations and through discussion with staff that care was in line with the National Institute for Health and Care Excellence (NICE) Quality Standard 22. This quality standard covered the antenatal care of all pregnant women up to 42 weeks of pregnancy, in all settings that provided routine antenatal care, including primary, community and hospital-based care.
- The care of women who planned for or needed a caesarean section was seen to be managed in line with NICE Quality Standard 32. For example we saw evidence of a discussion with a consultant before an elective caesarean and a debrief after birth.
- There was evidence to indicate NICE Quality Standard 37 guidance being met. This included the care and support that every woman, their baby and as appropriate, their partner and family should expect to receive during the postnatal period. There were arrangements in place that recognised women and babies with additional care needs and referred them to specialist services. For example, there was provision for babies requiring an on-site special care baby unit (SCBU).
- Staff were consulted on guidelines and procedures, which were regularly reviewed and amended to reflect changes in practice. Policies and procedures were available on the trust's intranet and were approved by the obstetric group. We reviewed 16 policies; however, 12 were just out of date but were currently under review. Although these guidelines were identified on the intranet as out of date, there were no clinical implications.
- We found staff in the fertility control service followed The Abortion Act 1967 and Abortion Regulations 1991. This included the completion of the necessary forms (HSA1 and HSA4).
- We found the care of women using the services were in line with Royal College of Obstetrics and Gynaecology (RCOG) guidelines (including 'Safer childbirth: minimum standards for the organisation and delivery of care in labour'). These standards set out guidance about the organisation, safe staffing levels, staff roles, and education, training and professional development.
- At the time of inspection the service monitored patient safety using a quality assurance framework, which laid out a number of key areas, which would be monitored on a regular basis.
- The unit was implementing the perinatal institute gestation related optimal weight (GROW), which involved increased antenatal surveillance and recognition of fetal growth restriction. Antenatal care pathways reflected the enhanced monitoring the project needed, resulting in increased antenatal monitoring for all pregnant women.

Pain relief

- Women received detailed information of the pain relief options available to them, this included Entonox piped directly into all delivery rooms, and pharmacological methods such as Diamorphine and Pethidine.
- Anaesthetic cover was based on the delivery suite 24 hours a day and included an epidural service.
- Between January and December 2105 24% of women used epidural as a method of pain relief.
- The service promoted normal birth as much as possible; all delivery rooms in the NBC had active birthing equipment to encourage women to be upright and mobile during labour.
- The NBC reported a water birth rate of 30%, however, senior staff we spoke with informed us that a greater number of women laboured in water but chose not to delivery in the birth pool.
- The service did not actively promote alternative therapies such as aromatherapy and hypnobirthing, although staff we spoke with informed us that they had supported women using hypnobirthing techniques.
- There were effective processes in place to ensure postoperative gynaecology patients had their pain appropriately managed.

Nutrition and hydration

- There was specialist infant feeding coordinator who led on the implementation and training associated with the implementing United Nations Children's Fund (UNICEF) Baby Friendly Initiative standards. The infant feeding

coordinator was training the division of tongue tie and worked Trust-wide to support staff returning to work, and support women admitted to hospital who required breastfeeding support but not specific to maternity.
- The trust had implemented United Nations Children's Fund (UNICEF) Baby Friendly Initiative standards. The maternity unit was awarded full UNICEF baby friendly accreditation in October 2014, and were due for reassessment in October 2016.
- Breastfeeding initiation rates for deliveries that took place in the hospital for April 2014 to June 2015 were reported between 68% and 70%.
- Women who chose to formula feed their baby were asked to bring their own powdered formula and bottles into the unit. This milk was stored in locked cupboards in a milk kitchen and women were supported to make their formula correctly throughout their stay on the ward.
- Each ward we visited had a day room where women had open access to breakfast cereals, and hot drinks. Women who delivered on the NBC had access to a kitchen, where they were able to heat pre-packaged hot meals.
- Women told us they had a choice of meals and these took account of their individual preferences, including religious and cultural requirements. Women we spoke with said the quality of food could be improved.

Patient outcomes

- There were no risks identified in maternal readmissions, emergency caesarean section rates, elective caesarean sections, neonatal readmissions or puerperal sepsis and other puerperal infections (Source: HES 2014/15; Intelligence Monitoring Report May 2015).
- Emergency caesarean section rates between April and December 2015 were 15%, which was comparable with the England average of 15%. For elective sections, the service achieved 14%, which is comparable with other regional trusts taking high-risk patients although it is higher than the England average of 11%.
- We reviewed data, which showed between April and December 2015 the service had an induction of labour rate of 36%.
- The service achieved a normal vaginal delivery rate of 59%, which was comparable with the national average of 60% between April and December 2015.
- The National Neonatal Audit Programme (NNAP) includes two questions that would apply to the maternity area. The report for 2014 indicated the location achieved 98% compliance with temperature taking of babies born at less than 28 weeks and 6 days. The unit scored 88% for the percentage of mothers being given a dose of antenatal steroid when they delivered a baby between 24 plus 0 and 34 plus 6 weeks gestation. This was better than the NNAP standard of 85%.
- Between April and December 2015, the trust reported 20 stillbirths. This was comparable with other teaching hospitals and teaching units, due to the complex needs of the women referred to this regional unit.
- Between April and December 2015, the unit reported that 2% of births at the unit experienced third and 4th degree tears. At the time of inspection, the trust had not set a target on the number of tears as they were awaiting the results of national and regional work before setting these metrics.
- Between April and December 2015 the unit reported a postpartum haemorrhage (PPH) (a blood loss following delivery of over 1500mls) rate of 3%. At the time of inspection, the trust had not set a target on the number of PPHs as they were awaiting the results of national and regional work before setting these metrics.
- There were six unplanned maternal admissions to the intensive care unit (ITU) and two planned admissions between April and December 2015.
- We reviewed data, which showed 3% of babies born at term (between 37-42 weeks gestation) were admitted to the special care baby unit.
- The service reported an average HIV coverage for April and September 2015 of 91%, and during the same time fame there was a 93% referral rate for women identified to have Hepatitis B.
- Between April and June 2015 the services reported an average of 6% of avoidable repeated new-born blood spot tests, however, between July and September 2015 this reduced by half to 3%. The increased number of repeatable tests was attributed to insufficient samples following the commencement of new laboratory standards.
- Staff we spoke with informed us of positive outcomes following review at the consultant led FGM clinic, especially where women consented to de-infibulation (reversal of the 'cutting'). We reviewed data from the trust that showed that overall 12% of deliveries were achieved with FGM; 36% of all women who had FGM achieved a vaginal delivery.

- Between October 2014 and September 2015 summary hospital-level mortality Indicator (SHMI) data showed the outcomes for deaths following cancer of the cervix were better than expected at one death against a target of 2.

Competent staff

- The head of midwifery and matrons monitored staff training. The appraisal rate at the time of inspection was 90%. This was below the trust target of 95%, however, we were assured processes were in place to address this.
- We reviewed the training programme for obstetrics covering 2015. Subjects covered included: antenatal and new-born screening, and public health initiatives. The training programme also included skills drills in subjects such as cord prolapse (including at home) and breech delivery, shoulder dystocia, eclampsia and obstetric haemorrhage.
- Newly qualified band 5 midwifery staff had a period of 'preceptorship', where they received additional support and went through a programme of competencies. There was an initial six-month induction to the maternity unit where new staff rotated to the community, antenatal ward, postnatal ward, delivery suite and the NBC. Depending on the placement there was an initial period where the staff member was supernumerary (not included in staffing numbers) and then shadowed their allocated preceptor. Staff reported the level of support and training was "excellent". This included competencies, which were signed off by preceptors; staff reported they were fully supported in their transition to band 6 staff.
- Healthcare support workers were required to attend training to support the delivery of services and examples of subjects covered was the care of deteriorating patients and MEOWS, maternal observations, skills drills, breech births, eclampsia and neonatal life support.
- Staff working in both maternity and gynaecology confirmed they had an annual performance review or were expecting to have one in the immediate future. Staff we spoke with informed us the review offered a chance to discuss their performance and development needs, and that this was a valuable and positive opportunity.
- Revalidation was part of appraisal process for medical staff and was coordinated within the directorate. Staff we spoke with reported no difficulty in getting an appraisal done.
- All midwives had a named supervisor of midwives. Staff said they had access to and support from a midwifery supervisor. They reported the process was very similar to the annual performance review. All Supervisors of midwives (SOM) were rostered on to SOM Wednesday. This was an initiative where a dedicated SOM would undertake supervisory activities, support staff, undertake a walkabout of the wards, and discuss women's experience of their care. The 2015 local supervisory authority (LSA) report identified that SOM's needed to review the SOM audit plan and how it could be used to audit midwifery practice and the effectiveness of SOM Wednesday. In addition, the service had to ensure that all records were secured in a safe and secure way. Staff we spoke with assured us that these concerns were being addressed; throughout our inspection, we found that all records were stored securely. At the time of the LSA audit the ratio of midwives to SOM was 1:16 which was greater than the recommended level of 1:15, however, the service were due to appoint three additional SOMs which would reduce this ratio to within recommended levels.
- The results of the General Medical Council National Training Scheme Survey 2015 showed educational and clinical supervision, induction and adequate experience for junior doctors was within expectations for this trust. We reviewed evidence, which highlighted an undermining of trainees. All staff we spoke with were aware of this and reported steps were put in place to prevent this from happening in the future. All medical staff we spoke with reported good working relationships with midwives and mentioned there was a lot of 'healthy debate', which was positive and constructive.
- Junior doctors attended protected weekly teaching sessions and participated in clinical audits. They said they had good ward-based teaching, were supported by the ward team and could approach their seniors if they had concerns.
- The service used an electronic training package (K2) as formal certified training for fetal monitoring during labour. This was complimented by in-house training. This work was part of the NHSLA Sign up to Safety bid, which funded backfill (additional midwives), to enable staff to undertake the training.

Maternity and gynaecology

Multidisciplinary working

- There was excellent multidisciplinary working in the women's health directorate. All staff, including those in different teams and services for example consultant and nursing and midwifery worked collaboratively to ensure the best possible care was provided to their patients.
- Staff were involved in assessing, planning and delivering women's care and treatment. The service led regional and local multidisciplinary team networks in areas such as fetal medicine.
- There was excellent access to medical care for women who had other conditions, for example, specialist medical antenatal clinics for women with comorbidities for example cardiology, urology and FGM.
- Women had access to interventional radiology for cases of placenta praevia (where the placenta presents before the fetus). This was performed prior to elective caesarean section and performed in partnership with the radiology team.
- We observed communications with GPs summarising antenatal, intrapartum and postnatal care in medical records. We also observed communications between Fetal Medicine and the patients' local trust to inform of treatment plans.
- Staff confirmed there were systems in place to request support from other specialties such as physicians, consultant microbiologists and pharmacy.
- Midwives at the hospital and in the community worked closely with GPs and social care services while dealing with safeguarding concerns or child protection risks.
- The health visitors and the community midwife team worked together to identify and report potential risks to hospital staff. Risks were notified to health visitors, and community midwives had access to pathways about vulnerable women.
- Staff confirmed they could access advice and guidance from specialist nurses/midwives, as well as other allied health professionals, for example infant feeding, twins, fetal medicine and diabetes.
- Patients and staff we spoke with provided examples of multidisciplinary working in practice, for example working with multiple allied health professionals, medical and surgical specialities to support women during pregnancy and childbirth.
- The service worked closely with Special Care Baby Unit (SCBU) and provided transitional care on the postnatal ward. The team providing support included neonatologists and nursery nurses in addition to the ward establishment of midwives.

Seven-day services

- An obstetric theatre team was staffed and always available. Anaesthetic cover was based on delivery suite 24 hours a day. There was a shortage in the number of operation department practitioners (ODP); however, the service managed this by using staff rotation onto the delivery suite.
- There was medical staff presence on the labour ward 24 hours a day, with consultant presence 14 hours a day. This equated to a 98 hour each week consultant cover.
- The pregnancy assessment unit was open 24 hours, seven days a week and undertook routine day assessments of pregnant women including blood pressure profiles and they triaged all emergency admissions, and pre operation checks.
- Urgent ultrasound facilities were available 24 hours a day seven days a week through the on-call medical team and midwife sonographers.
- Community midwives provide 7-day cover with antenatal clinics, all postnatal visits took place in the homes, and they were available at weekends.
- The early pregnancy unit was open seven days a week. This meant women who may experience the early signs of pregnancy loss could be seen in a timely manner.
- Women could be referred to the gynaecology emergency admission unit 24 hours a day.

Access to information

- All local and national policies were filed on the trust intranet for staff to access. We also saw displays of pathways, which related to full pathways on display in clinical areas. This meant medical and nursing staff would be able to see at a glance the next step to take in a pathway. Senior staff informed us they were responsible for updating the pathways when new policies were approved.
- Staff used an electronic system to order pharmacy supplies and request repairs to equipment. All staff we spoke with informed us how this was done, and had no concerns.

- Copies of the delivery summary were sent to the GP and health visitor to inform them of the outcome of the birth episode. We spoke with community midwifery staff who informed us they had regular contact with health visiting services.
- Processes were in place to ensure that vital material was obvious in the maternal health record using different coloured plastic pockets to store different types of information that might be needed in an emergency.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- Women confirmed they had enough information to help in making decisions and choices about their care and the delivery of their babies.
- Consent forms for women who had undergone caesarean sections detailed the risk and benefits of the procedure and were in line with Department of Health consent to treatment guidelines.
- There was a system to ensure consent for the termination of pregnancy was carried out within the legal requirements of the Abortion Act 1967. We reviewed seven records during our inspection and found these records were in line with legal requirements.
- The service had robust systems in place to monitor the consent forms and followed processes to ensure that all staff obtaining consent were qualified to do so.
- Staff had a good understanding of mental capacity and described the process of caring for women who may lack capacity. We reviewed evidence, which showed how this worked in practice and multiagency approaches to support women who were having their capacity assessed. However, no specific training data was available.
- We were told of instances where best interest assessments, MCA 1, and 2 forms were completed in order to develop a multiagency plan to protect the best interests of unborn babies. Independent mental capacity advocates (IMCA) were also available to support the parents if required.

Are maternity and gynaecology services caring?

Outstanding ☆

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

- Overwhelmingly we received feedback that care was excellent and compassionate. Women reported being treated with respect and dignity and having their privacy respected at all times. Women told us that nothing was too much trouble for staff.
- The friends and family test was continually positive and scored very high consistently.
- We observed staff demonstrating a strong, visible person centred culture throughout the service. Staff were highly motivated and passionate about giving exceptionally high standards of care.
- Information was provided in ways that could be understood and women felt involved in making informed decisions about their care. Partners were involved and were made to feel comfortable and able to ask questions.
- Staff took into account the individual needs of women and their partners and ensured appropriate support was provided to them.

Compassionate care

- Results from the CQC Maternity Service Survey 2015, showed the service scored better than other hospitals in two of the 19 questions about antenatal care, labour, birth and postnatal care, with the other areas scoring about the same as other hospitals.
- All women we spoke with were positive about their treatment by clinical staff and the standard of care they had received. Women told us they had a named midwife. They felt well supported and cared for by staff, and their care was delivered in a professional way. Comments included, “brilliant birth experience”, ‘“staff sensitive, happy with every stage of the procedure”, and, “had every confidence in the staff”.
- Results of the NHS Maternity Friends and Family Test showed between September and December 2015 an average 25% of women would recommend the antenatal care, (no responses were received between September and November 2015), however, 100% of

women would recommend antenatal care, which was better than the England average of 96%. 99% of women would recommend their birth experience. This was better the England of 97%. 98% of women would recommend the postnatal ward compared to the England average of 94%.

- The response rate for the antenatal and postnatal community FFT in this service was low; however, there was only one instance of negative feedback noted. We saw staff proactively promoting patient experience projects, including the NHS Friends and Family Test, which included a feedback card and envelope system to improve the response rate.
- We observed positive interactions from all staff from ward domestic to consultant with women and their partners. Staff were seen to be calm and compassionate, altering their communication style depending on the situation. We heard staff providing advice and encouragement, as well as dealing with urgent situations with calmness and efficiency.
- Partners and families we spoke with overwhelmingly told us that staff were caring and go the extra mile to care for their loved ones.
- We spoke to a domestic who told us that she loved her job and although it was busy at times, she wanted to make a difference for all of the families.

Understanding and involvement of patients and those close to them

- Women were involved in their choice of birth, at booking and throughout the antenatal period. This was especially the case for women who had complicated pregnancy for example those who required the support of the Fetal Medicine unit. Women we spoke with said they had felt involved in their care; they understood the choices open to them and were given options of where and when to have their baby safely.
- We noted the rate of home births was low (below 1%); Records showed staff discussed birth options at booking and during the antenatal period. Supervisors of midwives and the consultant team were involved in agreeing plans of care for women making choices outside of trust guidance for example requesting homebirth with either a current or previous high risk pregnancy. The team focused on supporting women's choices of birth while ensuring they were making fully informed decisions.
- Staff recognised and respected women's needs, always considering their personal, cultural, and social needs.
- Staff showed determination and creativity to overcome obstacles in delivering care and achieving a positive and safe pregnancy and birth experience for women.
- Results from the CQC Maternity Service Survey 2015 showed the trust scored better than other trusts for patients being involved enough in decisions about their care during labour and birth and having confidence in the staff caring for them during labour and birth.

Emotional support

- Bereavement policies and procedures were in place to support parents in cases of stillbirth or neonatal death; a specialist midwife and a labour ward lead supported this. People's emotional and social needs were highly valued by staff, for example, the service was developing the butterfly project in partnership with the neonatal unit. The aim of this project was to develop visual aids to alert staff that the woman had had a multiple pregnancy where one baby had died. The butterfly symbol would also be used on the surviving baby's medical records and may be placed in the cot with the baby with its siblings name on as a memory of the lost baby and to alert staff.
- Staff discussed with us how they cared for women following bereavement. It was clear that women of all stages in their pregnancy loss and their families were dealt with compassionately. Staff provided care and support to parents, relatives and each other. Staff offered the chaplaincy service to women to provide extra support. Bereavement services included the provision of a private room and the use of cold cots in order to keep the baby with the parents for as long as the parents required.
- There were effective and confidential processes for women attending the pregnancy advisory service. Staff supported women to make informed choices about their termination of pregnancy options.
- Staff supported women experiencing pregnancy loss regarding their choice of disposal of fetal/placental tissue.
- Staff were fully committed to working in partnership with their patients. Women we spoke with informed us they were aware that their treatment plan would depend on the progress of their pregnancy. This meant that women were aware of all treatment options for all eventualities.

Maternity and gynaecology

- Women we spoke with following labour told us that the midwives were friendly and supported them, which made them feel calm, and cared for throughout the birth.

Are maternity and gynaecology services responsive?

Good

We rated the responsive domain as good because:

- We found excellent partnership working to support vulnerable women in order to improve care pathways and clinical outcomes.
- There was access to the early pregnancy assessment unit 7 days a week.
- The service was aware of its risks and the need to ensure services responded to meet increasing demands.
- Patient flow through the maternity unit enabled women to access the service at each stage of their pregnancy.
- Facilities in maternity were set up in a way that enabled staff to be responsive to the needs of women and their families. There was access to investigation, assessment, treatment and care at all stages of their pregnancy. Where women had additional healthcare-related needs, there was access to specialist support and expertise.
- The termination of pregnancy pathway provided an efficient and effective service to women and girls in response to their respective needs.
- Women using the service could raise a concern and be confident that concerns and complaints would be investigated and responded to.

Service planning and delivery to meet the needs of local people

- The service worked in a multiagency partnership with other agencies to support vulnerable mothers for example Plummer Court (Drug treatment services) and Family Nurse Partnership (FNP) and Northumbria Police initiative Operation sanctuary (supporting vulnerable women at risk of child sexual exploitation). All partners worked together to improve education, care pathways and clinical outcomes for vulnerable women.
- The service was aware of its risks and the need to ensure that services were planned and delivered to meet the increasing demands of the local and wider community. For example, women from the local population could elect for delivery at either home, or the midwifery led Newcastle Birthing Centre or if required the consultant led Newcastle Delivery suite.
- There was a maternity partnerships pathway for women requesting unconventional care, for example requesting homebirth with either a current or previous high-risk pregnancy. This guideline was used to support discussions and planning for women who requested maternity care outside the trust guidelines. Women were offered an appointment with the Maternity Partnership Team (MaP) which consisted of senior medical staff and midwives including supervisors. Following these appointments, plans were developed in partnership with the woman, who was given ownership of the plan. Copies were placed in the handheld maternity record and main hospital notes so that all staff were aware of the plan and what had been agreed.
- The services were developing relationships with local and regional commissioners of services, the local authorities, other providers, GPs and patients to coordinate and integrate pathways of care that met the needs of the total population. We observed a collaborative approach to planning and delivering care and treatment with examples of well-developed sub-specialty clinics in maternal and fetal medicine, nurse-led colposcopy and hysteroscopy clinics and gynaecology.
- Services were planned and delivered to enable women to have the flexibility, choice and continuity of care wherever possible. A birth reflection service was available to all women. A card was provided on discharge and women were invited to call at any time with no restriction on the number of days or years following delivery. Staff we spoke with said some women had called decades following their delivery and were given dedicated time to do this.
- Due to the nature of the service and the distance women travelled to deliver, there was no formal maternity service liaison committee (MSLC). The service obtained the views of women through the weekly 'SOM Wednesday'. SOM Wednesday involved the duty SOM speaking to women on the antenatal and postnatal wards, and part of this discussion included the service provision and their experience of the service and if

improvements could be made. Examples of improvements made following feedback included welcome information for women on the different uniforms of staff they would meet on the unit.
- There was a clinic specifically for women who experienced heavy menstrual bleeding which included scanning and provided a number of treatment options including fibroid resection.

Access and flow

- Between March and December 2015, the service achieved 84% of bookings appointments before 12 completed weeks' gestation and 94% of booking before 20 weeks gestation. It was reported that 1% booking had an unknown gestation. At the time of inspection, there were no targets set for this indicator. It was suggested that the percentage of number of bookings, which took place following 20 weeks, was due to fetal anomaly scans, which were undertaken outside the unit and resulted in care being transferred/booked at the RVI for care through the fetal medicine unit.
- Women received an assessment of their needs at their first appointment with the midwife. The midwifery package included all antenatal appointments with midwives, ultrasound scans and all routine blood tests as necessary. The midwives were available, on call, 24 hours a day for home births as needed. Community midwives were on call for home births and delivery suite cover if it was busy. The numbers on call would flex depending if there were an imminent home birth.
- Bed occupancy between April and December 2015 ranged between 49% and 60%, on the antenatal and postnatal wards. Also during this timeframe, bed occupancy was 44% on the Newcastle birthing centre and 50% on the Newcastle Delivery Suite.
- The pregnancy assessment unit (PAU) was open 24 hours a day, seven days a week and incorporated day assessment and triage. Women were referred by the community midwife, GP, A&E or by self-referral. We reviewed data, which showed the average number of women seen each day was 49, with an average time spent on the unit of three hours 31 minutes.
- The CQC's survey of women's experiences of maternity services for 2015 received information related to access and flow. With respect to the question 'if they needed attention during labour and birth, a member of staff helped them within a reasonable amount of time' the trust scored 9.1, which was the same as other trusts. With respect to the question 'if they needed attention after the birth, a member of staff helped them within a reasonable amount of time' the trust scored 7.9 which was the same as other trusts. During our inspection, we found that staff answered call bells promptly.
- Information provided by the trust showed that the unit had not closed to admissions between January 2014 and December 2015.
- The termination of pregnancy care pathway outlined the route for medical or surgical termination of pregnancies. Access to the service was available subject to best practice guidance. The number of abortions between April and December 2015 was 682 medical and 282 surgical terminations across gynaecology and obstetrics services.
- The gynaecology emergency admission unit was based on Ward 40 and was open 24 hours a day. Women could be referred to the unit from accident and emergency, or their general practitioner or the minor injuries unit.
- The early pregnancy assessment unit was open 7 days a week. This allowed women who may be experiencing recurrent miscarriage or pregnancy loss to receive care.
- The service did not collect data about the percentage of women seen by a midwife within 30 minutes and a consultant within 60 minutes during labour. However, staff told us all women were seen immediately on transfer to the Newcastle delivery suite. However, they were seen by a consultant in accordance to need, for example, a low risk woman would not need to be reviewed by an obstetric consultant.
- Staff we spoke with informed us scan and consultant appointments were at the same time as much as possible. All women we spoke with found this helpful and reduced the time they spent in the antenatal clinic.
- All complex patients referred to the obstetrics and gynaecology services had an MDT discussion and access to other specialities. This meant that all patients had a clear plan of care and staff ensured that patients and their families were involved in the development of the plan and would have ownership of it.

Meeting people's individual needs

- There were arrangements to support individuals with complex needs (including social and health concerns), with access to clinical specialists based at both the Royal Victoria and Freeman sites. We were given

examples of arrangements where the obstetric and neonatal teams would perform caesarean sections at the Freeman site if the health of the mother demanded it.

- There was a network of midwives and consultants with special interests; this included five practice support midwives based on the delivery suite and 12 midwife sonographers. Additionally there were midwives who specialised in multiple pregnancy, specialist haemoglobinopathies (genetic defects of the blood), bereavement, antenatal and newborn screening, teenage pregnancy, drug and alcohol, parent education, safeguarding, risk management, domestic violence and infant feeding. However, there was not a perinatal mental health or smoking cessation specialist.
- There was a consultant led FGM clinic to support women through pregnancy and birth. Women were informed of their birth options and provided education, which they could share with their local community.
- Midwifery staff described their role in supporting individuals who had learning disabilities. The emphasis was around ensuring the individuals concerned understood the provision of maternity care. Next of kin and carers were involved and, where necessary, social services, to ensure the best outcomes for parents and child.
- Staff could explain how the translation service was accessed and used.
- Midwives said they encouraged 'normalisation' about women's experiences, providing a good environment, as relaxed as possible, "with lots of information and informed choice".
- Women were triaged by the Newcastle Birthing Centre to identify if they were in labour. Women who were in early labour either were sent home or could mobilise on the ward. Evidence-based guidance showed that women who were reviewed in a designated area away from the delivery suite experienced shorter labour and less medical interventions (Evidence Based Guidelines for Midwifery-Led Care in Labour Latent Phase, Royal College of Midwives, 2010).
- There was no provision on the postnatal ward for partners to stay, as there was limited space. However, we were told of instances where young parents were offered to have their mum stay with them to give them support during the night.
- There were processes to ensure disposal of pregnancy remains were handled sensitively. Women were provided with a choice of how they would like to dispose of pregnancy remains, following pregnancy loss or termination of pregnancy.
- Specialist nurses undertook holistic needs assessments, which ensure the emotional needs prior to surgery.
- Patients who used the women's health services had access to informative literature. We saw examples on display, such as whooping cough in pregnancy, smoking cessation, pathway through labour and optimal infant nutrition. We also saw that women were provided with a pregnancy book, which was developed and provided by the service. This gave women evidence-based information to enable them to make an informed choice about their care.
- The service also had its own dedicated areas on the trust website. Pregnant women and their families could access this site to help orientate them to the service and the options available to them.
- Information to support the termination of pregnancy pathway included leaflets about medical and surgical pregnancy termination, to support women in making an informed choice.

Learning from complaints and concerns

- The patient relations officers identified the lead in the service, who would carry out the investigation for complaints. Staff we spoke with told us they were supported through this process and were actively encouraged to reflect as soon as possible on situations, which may lead to a complaint in the future.
- Both formal and informal complaints were treated with the same seriousness by the service. Staff offered to meet the complainant when complaints were received. Meetings were followed up in writing, detailing the outcome. Between October 2014 and September 2015, the service received 56 formal complaints, 17 of these were about gynaecology services and 37 of these were about obstetric services. We reviewed these cases. The outcomes were appropriate, with duty of candour appropriately applied in all cases. Themes of these complaints included communication, staff attitude and medical treatment.
- The board discussed outcomes from complaints monthly and learning from these was communicated to

staff through the bi-monthly risky business newsletter, and the 'You said, we did' information. We saw this information clearly displayed in all ward areas we visited during our inspection.

Are maternity and gynaecology services well-led?

Outstanding ☆

We rated the well-led domain as outstanding because:

- We found a strong, cohesive senior leadership team who understood the challenges of providing good quality care and of managing the service and had identified effective strategies and actions needed to address these. This was particularly evident with the configuration of services, which were well developed and understood throughout the maternity and gynaecology departments. We also found strong departmental leadership who were supported in developing further leadership skills and to take ownership of their own departments.
- Staff of all levels and experience were encouraged to submit ideas and were empowered to develop and implement solutions to provide a high-quality service.
- Governance arrangements were embedded at all levels of the service and enabled the effective identification and monitoring of risks and the review of progress on improvement action plans. Regular robust detailed reporting at departmental and board level enabled senior managers to be aware of performance.
- A positive culture of openness and candour with a collective responsibility for quality, safety and service improvement was evident. Public and stakeholder engagement was seen as a priority. The views of the public and stakeholders were actively sought through engagement, recognising the value and contributions they brought to the service.
- Staff were encouraged to drive service improvement and used creative and innovative ways to ensure they met the needs of women who used the service.

Vision and strategy for this service

- Services for maternity and gynaecology were based with the Women's Health Directorate.
- The service had a clear vision for maternity and neonatal services. The vision included the current limitations of the service in relation to capacity within the unit and options for improvement, which would ensure services and patient activities were physically organised in a way to optimise operational efficiency and a better patient experience. Senior staff we spoke with informed us the views of service users and frontline staff were sought to develop the strategy.
- The service also had strategic objectives, which were aligned to the Trust Annual Plan. Strands included growth in targeted areas, building capacity and improving efficiency, comprehensive community outreach, and care closer to home and promoting research and innovation. We found progress had been achieved or made in 19 of the 21 objectives. Concerns, risks, and remedial actions were clearly identified and were appropriate to the objective.

Governance, risk management and quality measurement

- There was a well-defined governance and risk management structure. The maternity risk management strategy set out clear guidance for the reporting and monitoring of risk. It detailed the roles and responsibilities of staff at all levels to ensure that poor-quality care was reported and improved.
- The quality and safety committee met monthly to monitor safety and risk throughout the service; we reviewed meeting minutes and found focused and detailed discussion with clear outcomes and actions.
- The service demonstrated a dedicated focus on understanding and addressing the risks to patient care. The risk management midwife worked proactively with wards, audit leads and supervisors of midwives and fed into the governance processes to recognise and raise concerns and ensure safe practice. For example, there were daily risk meetings on delivery suite in which all staff were invited, also all staff we spoke with informed us they were supported following adverse events and supported in an objective manner.
- Performance and outcome data was reported monthly, however, at the time of inspection the service were in the process of developing their dashboard. We were assured that current internal processes at monitoring patient outcomes and risks were effective using manual records and audit. The senior management team informed us they hoped to have a red, amber, green

(RAG) rated dashboard, however, it was hoped that the update of the electronic maternity information management system would support the data collection. However, this was not the case. A business case had been approved to develop a dashboard, which was fit for purpose. At the time of inspection, the dashboard was in the final stages of testing and was working through gaps in data collection. The service was also working regionally to develop thresholds and agreement from all maternity and gynaecology services in the North East. This meant that all services would be measured against the same parameters, which would support comparison of services.

- Local risk registers assisted the obstetric group and the quality and safety group to identify and understand the risks. There were 15 risks identified for maternity and gynaecology: all had risk levels attached to them and were ordered in the level of the risk (highest to lowest) existing controls and gaps, and action necessary. For example, the risk of insufficient consultant obstetrician time to comply with the national Royal College of Obstetrics and Gynaecology (RCOG) and Royal College of Midwives (RCM) which was 168 hours a week. The service was maintaining a 98-hour consultant cover. We found there was clear alignment of what staff had on their 'worry list' with what was on the risk register.
- There was a regular performance meeting with the Business and DevelopmentDirector.This was facilitated to challenge the quality of the service.
- Governance documents clearly identified the roles of the supervisor of midwives and the Local Supervising Authority. Supervisors of midwives told us they attended in this capacity and not in a dual role. This was in line with recommendations by the Nursing and Midwifery Council.
- All staff we spoke with had an awareness of the new Duty of Candour regulations that came into effect on 27 November 2014. Policies on being open were in use and an open culture was observed.
- The service had completed a gap analysis following the publication of the Kirkup report (2015). All identified gaps had clear actions documented against them; we reviewed evidence that the directorate had reviewed this analysis since the initial analysis.

Leadership of service

- Maternity and gynaecology formed part of the Women's Services Directorate. There was a clear managerial structure, which included strong clinical engagement. We found the consultant body to be cohesive and proactive in decision-making, with innovative approaches to areas such as sub-specialisms and job planning.
- Leadership was encouraged at all levels within the service. Team leads were supported to complete the trust leadership programme and through 1:1 meetings with managers.
- We observed a strong, cohesive leadership team who understood the challenges for providing good quality care and identified strategies and actions to address these. This was evident in discussions around the development of the unit and improvement of the environment.
- The Head of Midwifery (HOM) and matrons were seen in clinical areas and had a good awareness of activity within the service during the inspection. Staff we spoke with said the HOM and matrons were seen in uniform and worked clinically if needed. Staff were clear about who their manager was and who members of the senior team were.
- Staff we spoke with informed us the consultant body would take into account the views of all staff in the care of women, we also observed midwives being asked for their opinions by medical staff during our inspection.

Culture within the service

- An open, transparent culture was evident where the emphasis was on the quality of care delivered to women. The service encouraged a 'no blame' culture where staff could report when errors or omissions of care had occurred and use these to learn and improve practice. For example, staff we spoke with informed us they were encouraged to reflect on adverse incidents as soon as possible. This included staff that may even have been in to inform a patient of a phone call or provide a drink.
- We observed strong team working, with medical staff and midwives working cooperatively and with respect for each other's roles. All staff spoke positively and were proud of the quality of care they delivered. Some junior doctors commented that although it was a big unit with complex patients, it was a "fantastic unit" to work in.

- Staff told us about the 'open door' policy at department and board level. This meant they could raise a concern or make comments directly with senior management, which demonstrated an open culture within the organisation.
- We spoke with newly qualified band five nurses who felt fully supported through the induction programme and senior staff were eager to support them through the process. Throughout our inspection, we observed positive interactions and support from preceptors to band five midwives.
- Staff we spoke with informed us they had been student midwives at the trust and elected to stay in the organisation, as they felt valued.

Public engagement

- The service actively sought the views of women and their families. A pilot study was undertaken where 40-45 volunteers from the service from all staff groups talked to parents and discussed their care and if any improvement could be made. For example, women and their partners who were attending the unit had protected parking spaces. The butterfly initiative was developed following feedback from patients during one of these discussions. The senior management team has identified this pilot was successful and had decided to continue with this form of engagement.
- As part of the SOM Wednesday initiative (this was an initiative where a dedicated SOM would undertake supervisory activities, support staff, undertake a walkabout of the wards, and discuss women's experience of their care), women's views were collected on a weekly basis and escalated to the management team as required.
- The HOM and matrons undertook walkabouts to obtain the views of patients.
- The service has undertaken a local health needs assessment to identify the hard to reach communities and working with local partners such as commissioners to support them effectively.

Staff engagement

- There were no service specific results in the 2015 NHS staff survey results for staff engagement. The national survey showed on a scale of 1-5, with five being highly engaged and one being poorly engaged, the trust scored just short of four. This score was better than other trusts.
- We spoke with staff and in all areas staff were very engaged and felt involved in service development. There was a staff council in which staff could raise concerns and be involved in the future development of the service, for example, referral pathways to the early pregnancy assessment clinic were streamlined.
- The trust wide staff Family and Friends test showed that 96% would recommend the trust as a place for their friends and family to be cared in and 76% of staff would recommend the trust as a place to work.
- All staff had a skills passport to encourage development in their current roles. This meant that staff were able to progress their careers should they wish.

Innovation, improvement and sustainability

- The northern centre for gynaecological surgery used a 'Da Vinci Robot' to carry out some surgical procedures. This meant surgery was minimally invasive and reduced recovery time for patients.
- The service had begun using Botox in urogynaecology.
- The fetal medicine unit had begun to offer support to outlying hospitals in Cumbria using telemedicine. There is a live video link to the fetal medicine unit. During the scan, the fetal medicine doctor is able to review the scan in real time and provide direction and support to the person scanning the patient in the local hospital. This means the patient will not need to travel a significant distance to Newcastle, but also will support the clinical skill of the staff performing the scan.

Services for children and young people

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

Information about the service

Services for children and young people at the Royal Victoria Infirmary (RVI) are located within the Great North Children's Hospital (GNCH), one of the largest children's hospitals in the UK. The GNCH provides the most extensive range of children's services anywhere outside of London.

Local services include general and community paediatric medicine and paediatric emergency medicine. The majority of services are regional, covering the North East and Cumbria. These include burns and plastic surgery, diabetes and endocrinology, high dependency and intensive care, immunology and infectious diseases, oncology, neurology, orthopaedics, paediatric surgery, respiratory and rheumatology. The GNCH also treats patients from the rest of the UK, Europe and, in some cases, worldwide who require a bone marrow transplant, one of only two centres in the country to provide this service.

There are 14 paediatric wards, including inpatient, day cases and intensive care, with over 240 beds, 75% of which are single rooms with ensuite facilities.

A neonatal unit is located within the Maternity unit at the RVI. The unit, which covers the whole region, provides 12 intensive care cots, 4 high dependency cots and 18 special care low dependency cots.

During our inspection, we spoke with 21 medical staff, 36 nursing and allied healthcare professionals and 10 non-clinical personnel. We also spoke with 25 families and reviewed 30 sets of healthcare records.

Summary of findings

Overall, we rated services for children, young people and families at the Great North Children's 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 focused 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.

However

- Although managers planned, implemented and reviewed staffing levels regularly, some wards and units reported staff shortages. Senior nurses and medical staff were taking appropriate steps to mitigate the risk and keep children and young people safe.

Are services for children and young people safe?

Requires improvement

We rated safe as requires improvement because:

- Some wards and units reported staff shortages. The neonatal unit, for example, did not meet the British Association of Perinatal Medicine (BAPM) guidelines and the current occupancy rate was 106%. Senior nurses and medical staff from the unit were taking appropriate steps to mitigate the risk and keep babies safe. For example, staff closed cots and transferred babies who required only low-level care to other special care baby units in the region. Overall, managers responded to staff shortages quickly and adequately although we visited one ward where staff shortages had negatively affected staff morale. Recruitment for nursing staff was ongoing and managers acknowledged the national shortage of junior medical staff was a potential risk to services.
- The directorate did not meet the 95% target for paediatric (PBLS) and adult (ABLS) basic life support training across all services. There was a plan to introduce more trainers and, although the level of compliance varied across wards and units for nursing staff, the majority had achieved over 80%.

However

- 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.
- 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.

- 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.

Incidents

- The trust had an incident reporting policy and staff reported incidents of harm or risk of harm using the risk 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 289 incidents reported between June 2015 and November 2015 relating to children's services and 49 incidents specific to neonatal services. The majority of incidents in both services were categorised as insignificant or minor and we saw staff had taken action where appropriate. For example, following an incident relating to a bowel preparation prescription, the matron took action to review the procedure for issuing prescriptions for this specialist group of children. We also saw documented evidence of root cause analysis and actions plans.
- The trust's 'Being Open' policy complied with the Duty of Candour requirements. Medical and nursing staff knew the principles and we observed this in practice. Junior doctors from the neonatal unit told us they always spoke with parents and apologised if they did not successfully insert a cannula on the first attempt.
- We saw evidence that staff discussed incidents at monthly quality and safety meetings attended by medical and nursing staff plus senior managers from the service. Staff we spoke with told us they also talked about current incidents, any actions, learning from previous incidents or changes to practice at daily handover briefings and team meetings.
- Medical and nursing staff discussed mortality and morbidity at monthly governance meetings. Clinicians discussed recent cases, outcomes and actions, and the information shared across the staff groups. Clinical teams also discussed mortality and morbidity in arenas beyond the GNCH borders. For example, staff from the children's bone marrow transplant unit attended the National Annual Audit for Primary Immunodeficiency Haematopoietic Stem Cell Transplant (HSCT) and National Paediatric HSCT group audit meetings as part of a wider review process.
- We reviewed data from the Clinical Assessment Toolkit (CAT), an audit tool used to collect data in relation to the safety thermometer. Data recorded in December 2015 showed children's services achieved 96% overall in the clinical assurance assessment. Measures included invasive device insertion and care, immunisations and asepsis.
- There were no never events recorded between August 2014 and July 2015. 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.
- There was one serious incident, reported in 2014, when an oncology patient received the incorrect treatment regime. Managers conducted a full investigation and we saw evidence a root cause analysis was completed. We spoke with the senior nurse from the unit who told us senior clinicians were open and transparent with the child's family and met with them to reassure them about the low level of risk.

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. We spoke with a parent in the paediatric intensive care unit who described the unit as 'spotless' and told us staff were constantly cleaning and washing their hands.
- 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.
- All staff were clear on their responsibilities for cleaning and cleaning schedules were displayed on the wards and units. Immediately after clinicians had discharged a child, we observed a healthcare assistant and a nursery nurse clean a cot. They worked as a team and

continuously checked each other were completing their tasks. They informed the domestic staff once the task had been completed who then cleaned the environment in the room.

- One of the band 7 nurses from the neonatal unit was also the infection control lead for the team. She provided evidence of service improvement in relation to incidents of Pseudomonas infections on the ward. Looking at the previous 24 months data, the nurse identified an increase in the number of infections. The team considered options to improve practice and subsequently made changes to the use of Sterile Water for skin cleansing. Further monitoring over the following 15 months showed only one occurrence of Pseudomonas infection in a baby.
- 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.
- Matrons also completed monthly checks to monitor cleanliness. This included patient bed space, treatment rooms, the uniform 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.
- There was a toy cleaning policy and staff explained they cleaned toys regularly in line with the documented procedure.

Environment and equipment

- The GNCH had a warm, family-friendly atmosphere despite its clinical setting. Wards and units were brightly decorated and there were dedicated areas for younger and older children. Most wards and units had separate areas for families.
- We saw evidence of processes to ensure equipment was safe. We also saw documentation for checking and cleaning equipment, including moving and handling risk assessments. Resuscitation trolleys held appropriate equipment and staff regularly checked them. In the paediatric intensive care unit, we observed the two resuscitation trolleys were located in a position that enabled easy access from all areas in the unit.
- 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.
- There were notice boards on the wards, visible to patients and families. They included information about staff teams, staff uniforms, '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 to the question that asked if the ward where their child stayed had appropriate equipment and adaptations for them.

Medicines

- Medicines were securely stored and handled safely. Storage cupboards and fridges were tidy and locked. Nursing staff or healthcare assistants recorded and monitored the minimum and maximum fridge temperature appropriately and there was dedicated pharmacy support across all services.
- There were robust systems across wards and units to manage medicines safely, which included dedicated members of staff fulfilling specific tasks. For example, in the paediatric intensive care unit, a designated sister checked the cleanliness of the units, stock rotation and expiry dates.
- We reviewed 23 prescription charts. Overall, staff completed the charts accurately and the writing was legible. Staff recorded the date and their signature, allergies were documented, medication that was omitted or not administered had a documented reason, and antibiotics were prescribed as per guidelines. Staff also recorded the weight of the child.
- Staff completed medicines management training online and managers reviewed competencies to ensure staff were certified to administer medicines safely. We spoke

with a nurse in the paediatric intensive care unit who explained new staff were also required to undertake written and practical assessments, in addition to mandatory training requirements.

- Staff were encouraged to report incidents about medication errors and we saw documented evidence to support this. One junior doctor told us a drug error they reported was shared with other staff as a learning experience. There was an escalation policy and staff were aware of what to do should a situation arise.
- The matron from the neonatal unit told us staff reported 23 drug errors in 2015, the majority of which related to gentamicin. A band 7 nurse led a focus group to discuss the incidents, learn from them and improve the process. One of the outcomes from the review concluded that nurses should take only one baby from the postnatal ward at a time to receive medication, rather than three or four, which had been the previous practice.

Records

- Medical and nursing staff managed and stored records safely. We did not see any unattended notes during our inspection.
- We reviewed 30 sets of care records. Overall, we saw notes were legible and staff completed them accurately and included appropriate information, for example, consent, risk assessments and nutritional status. However, nursing, medical and other allied health professional notes, such as physiotherapy, were not all integrated which meant they were not all together in one file. Specialist units, such as the bone marrow transplant unit, ensured files for each patient were easily distinguishable and were colour-coded according to the child's condition.
- There did not appear to be a formal system for reviewing or auditing care records, however we did review a safeguarding children audit, which looked at how effectively staff recorded safeguarding concerns. Overall, the outcomes were positive and the audit identified three key recommendations: to complete all demographic information, revisit the process for checking formalised meeting minutes received from Children's Services and, to repeat the audit annually.
- We spoke with senior nursing staff who told us they informally reviewed notes and, if they noticed any errors or omissions, fed back directly to the member of staff involved.
- The notes for babies in the neonatal unit were available for parents and carers to read and were located at the end of each cot. Staff encouraged families and carers to read them and made them easily accessible.

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. There were also dedicated safeguarding leads on each ward or unit who staff could contact in the first instance if they had any concerns.
- 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.
- 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. The trust target for safeguarding children level one and level three training was 95% however; the majority of staff had not achieved this. Evidence showed most medical teams had achieved over 70% compliance in level one while only four specialities achieved over 75% in level three. Nursing staff from all services had achieved over 75% in both level one and level three.
- 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. Medical and nursing staff filed the form in a red folder at the front of the patient's care record. According to the trust 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 presented the outcomes to the trust safeguarding committee.
- Medical and nursing staff routinely discussed safeguarding concerns or children who were subject to a child protection plan at daily handover meetings on the ward or unit. We observed this in practice during a multi-disciplinary meeting on the burns and plastics unit and during a morning handover meeting in the paediatric intensive care unit.

- Access to wards and departments in the GNCH, and to the neonatal unit, 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. There were specific training days arranged each year and managers rostered staff to attend. 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.
- One of the risks on the risk register highlighted the service was not compliant with the required levels of paediatric (PBLS) and adult (ABLS) basic life support training. An update to the risk register showed there were currently 17 PBLS and 3 ABLS trainers and there was a robust plan to deliver training. Data provided to us by the trust showed medical staff from the bone marrow transplant unit, general paediatrics, the children, and young people's unit had met the 95% target for both PBLS and ABLS. Although the level of compliance varied across wards and units for nursing staff, the majority had achieved over 80%.

Assessing and responding to patient risk

- Daily handovers took place and included discussions about patient safety as well as detailed information sharing about each child. Staff completed risk assessments for every child upon admission to the ward. We attended a morning handover in the paediatric intensive care unit. Clinicians initially discussed patients informally with nurses before the in-depth medical briefing, which enabled the team to highlight any issues that might have an impact on the child's condition or welfare. For example, nurses had identified a safeguarding concern in relation to a family member of a young child. The team agreed to monitor the situation closely and liaise with the ward, where the child had been previously, for a full case history.
- Children's services used the paediatric early warning scores (PEWS), an early warning assessment and clinical observation tool. This included a clinical observation chart, coma scale and additional information such as 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 medical staff and nurses who demonstrated a clear awareness of how to assess patient risk and what action they would take in response. Senior nurses audited PEWS data through the Clinical Assessment Toolkit (CAT).
- Senior nurses told us they had recently introduced 'safety huddles' on the wards to increase awareness of deteriorating children. Huddles included medical and nursing staff and focused on assessing and responding to individual patient risk.
- Some services were developing ways of identifying whether a child was at risk of specific conditions. For example, the team from the children's bone marrow transplant unit were in the process of agreeing funding to introduce the testing of severe combined immunodeficiency (SCID) as part of the new-born screening process.
- The neonatal unit did not use a new-born early warning trigger and track (NEWTT) tool however, senior clinicians and nursing staff were in the process of introducing the tool on the postnatal ward. Staff monitored babies regularly and never left them unattended.

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.
- Many services were specialist and, as such, senior nurses told us they did not use a specific acuity tool to calculate safe staffing levels. However, the trust was in the process of introducing the Safer Nursing Care Tool developed by the Shelford Group, an organisation comprising the Chief Executives of ten of the leading

NHS multi-specialty academic healthcare organisations in England, including Newcastle Hospitals. One senior nurse told us she had established a working group to support the introduction of the tool on her unit.

- We looked at rotas produced by senior nurses who monitored and reviewed the actual, against planned, staffing levels every day on their wards, on a shift-by-shift basis. We spoke with one senior nurse who explained she was in the process of introducing some new shift patterns to manage the peaks and troughs of her unit more effectively.
- Data provided to us by the trust showed the number of staff in post across the majority of wards was below the actual whole time equivalent establishment. Data published in January 2016 also showed the total monthly planned staff hours versus the total monthly actual staff hours did not always match and varied from ward to ward. For example, the average fill rate on ward 1a (paediatric medicine) was 66% during the day and 72% at night while the average fill rate on ward 10 (paediatric surgery) was 115% and 137% respectively. The average fill rates, day and night, for other wards overall was 92% during the day and the same at night.
- A senior nurse from the children's community nursing team had recently joined the team on ward 1a and told us staffing was a significant issue on the ward. The senior nurse explained recruitment was ongoing and there were plans to increase the number of nurses on the ward. She told us it was her priority to 'make it right'.
- The matron from the neonatal unit told us they did not meet the staffing levels recommended by the British Association of Perinatal Medicine (BAPM). This was a risk on the directorate risk register. BAPM recommends the nurse to baby ratio for intensive care should be 1:1 (one nurse to one baby). For high dependency care, the ratio should be 1:2 and low dependency care should be 1:3. The matron explained the team only met those standards 54% of the time. However, the matron reviewed staffing levels daily and met with the band 7 nurses and consultant team to review the number of staff on duty and each baby on the unit.
- Demand for neonatal care was high and bed occupancy rates for intensive care cots regularly exceeded the recommended occupancy rate of 80%. The unit was currently operating at an occupancy rate of 106%. To ensure the safety of the infants on the neonatal unit, the matron and clinical lead made the decision to close some cots and transfer infants requiring low-level care to other special care baby units in the region. This meant babies who were most at risk continued to receive intensive or high dependency care at the RVI. The most recent Neonatal Service Annual Report (2014) reported 438 transfers undertaken during the year. Of those, 115 infants were transferred out of the unit due to over-capacity and 85 postnatal referrals were refused. The matron had just completed a staffing review, which highlighted the need for more staff to meet the rising demand of babies requiring intensive care. Once new staff joined the team, the matron told us she was confident the unit would comply with BAPM.
- In the event of staff shortfalls in other wards and units, managers took appropriate action to mitigate any risk to patient safety. For example, there were six nurses on maternity leave from one unit and managers made the decision to close beds to keep staffing levels safe. Nurses from the surgical ward also told us that, although they had capacity for 25 beds, managers decided to close seven of those to maintain appropriate cover.
- The matron for oncology services explained the staffing ratio should be 1:2 (one nurse to two patients). Although she acknowledged this could drop to 1:3, levels had never fallen below that ratio. Nurses from the oncology inpatient ward and day unit worked together to ensure staffing levels were safe.
- A senior nurse from the paediatric intensive care unit told us recruiting and retaining staff was not a problem. Although nurses worked long hours, both day and night, the unit provided flexible working hours to meet the demands of the service.
- Nursing staff displayed Safer Staffing levels on notice boards in the wards and units we visited. We observed 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.
- On specialist units such as the children's bone marrow transplant unit, staffing levels were the same for both day and night cover. Managers offered overtime to the existing nursing team when appropriate. This meant children were safe, as nurses from other wards and units were not as familiar with the complex medication the children received. Other specialist wards such as the

regional burns and plastic surgery unit also covered any vacancies and shortfalls using bank and overtime from their own nursing team. Staff did not report any problems.

- There were staffing guidelines and a clear escalation plan in place. Everyone we spoke with felt confident raising concerns about nurse staffing with a senior nurse or manager. One nurse told us, 'I go straight to the nurse in charge if we are short-staffed and finding it difficult to get a break. Action is always taken immediately'.
- We spoke with a nurse who told us she felt staffing levels on her unit were safe when compared with previous trusts she had worked in. Other nurses reiterated the same observations and felt managers worked hard to ensure levels were safe. Recruitment was ongoing and over 30 new candidates had recently been shortlisted for paediatric nursing posts across the GNCH.
- Although all wards and units utilised bank staff, the average usage was lower than the trust average. Staff explained some services were too specialist. Specific knowledge and experience was required therefore this minimised the opportunity to utilise bank nurses.
- The monthly sickness rate average for children's services varied across wards and nursing bands in the last financial year. The majority of wards were below the trust average.

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 Great North Children's Hospital.
- Most of the medical staff we spoke with reported no problems in relation to staffing levels and told us rotas were manageable. Consultants covered the junior doctor out-of-hours rota when there were shortfalls. Junior doctors could easily access consultants out-of-hours and told us senior doctors actively encouraged them to call if they had even the slightest concern about a patient.
- Some junior doctors in the paediatric intensive care unit reported challenges with their rota. For example, doctors explained there should be two doctors on duty at all times. At night, this often fell to just one. However, if required, consultants stayed late or expected doctors to call them if there were any problems. The shift length was 13 hours and they worked 44 hours on average per week. One junior doctor felt this was very positive as it enabled them to participate in audit activities and manage their portfolio effectively. They did not feel patient safety was compromised.
- There were seven surgical consultants, supported by seven middle-grade doctors. Consultants had their own specialist interest within paediatric surgery, which demonstrated good practice. There was a daily consultant presence on surgical wards, including weekends, and surgeons provided cover at the Freeman hospital for surgical emergencies.
- We spoke with a consultant paediatric oncologist who told us there were six consultants within the service supported by one locum, six teaching fellows and one haematology registrar. The consultant team, who each took a lead in a specialist area such as leukaemia, supported each other, swapping shifts or on-call duties. There were no reported problems.
- The neonatal unit followed the British Association of Perinatal Medicine (BAPM) recommendations and adopted a tiered approach to medical staffing. Junior doctors and two consultants supported two parallel rotas, one for the ward and the other supporting the neonatal transfer service. We spoke with three families during our visit who told us they felt there were always enough doctors on duty.
- Consultants in the neonatal unit were on duty until 11.00pm most nights. If they had concerns about a baby or there were staff shortages, junior doctors told us consultants regularly stayed overnight and described them as a very cohesive team. On one occasion, a doctor from the transport team stayed in one of the patient flats on the unit to support colleagues in the anticipated delivery of premature triplets.
- Between April 2014 and March 2015, locum usage was above the trust average in the paediatric intensive care and surgery specialities, at 23% and 10% respectively.

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 via the trust intranet and we saw flow charts displayed in staff areas detailing the process.

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 good 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 and specialist clinical educators 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 GNCH adhered to guidelines from the Royal College of Nursing, the National Institute for Health and Care Excellence (NICE) and other professional guidelines such as National Burn Care Standards, Paediatric Intensive Care Society and the British Association of Perinatal Medicine.
- All evidence-based care and treatment guidelines for the neonatal service were available on the trust intranet in a specific Neonatal Formulary section. All of the documentation presented was the most up to date research-based paper from the Neonatal Formulary 7th Edition. New content within each document was highlighted in red and included the date to show when it was last updated.
- 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 conducted a comprehensive range of national clinical and local audits which was well organised. Managers and staff monitored and discussed outcomes from audit activity at monthly clinical governance meetings. National audit participation included diabetes, epilepsy and asthma. We also saw evidence of local audit activity to assess compliance with NICE quality standards.
- The children's bone marrow transplant unit was accredited with JACIE, a joint initiative of theEuropean Group for Blood & Marrow Transplantation(EBMT) and theInternational Society for Cellular Therapy (ISCT), the two leading scientific organisations in the area of cellular therapy. JACIE establishes the minimum requirements for facilities, education and training, quality management, donor and patient management and care and good cell collection and laboratory practice. Accreditation to JACIE meant the unit had undergone a rigorous inspection process and was working in line with international standards.

- The neonatal unit participated in the Bliss Baby Charter, an accreditation scheme to ensure babies received the best neonatal care and treatment. We reviewed an action plan showing the unit had met the majority of principle standards. The unit had also achieved stage one for the UNICEF Baby Friendly Initiative and the team was aiming to achieve stage two and three in 2016.
- Some services for children and young people had achieved 'You're Welcome' accreditation, a quality criteria highlighted in the National Service Framework for Children. The toolkit sets out a number of principles to ensure young people aged 11 to 19 (including vulnerable groups) were able to access services better suited to their needs. The toolkit covered 10 key areas assessed, including accessibility, publicity, confidentiality/consent, the environment, staff training, skills, attitudes and values.

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.
- 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 3D televisions on wards and units. Staff told us these were invaluable tools in calming and distracting children and young people.
- Clinicians in the neonatal unit 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.
- Staff used paediatric pain assessment tools to assess and appropriately manage pain. For example, FLACC (face; legs; action; cry and console) charts. We spoke with nurses from the paediatric intensive care unit who told us they would also contact the dedicated paediatric pain nurse if they needed further advice or support regarding assessment and plans.
- 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 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 and young people, were compliant in this action.
- Wards used the STAMP (Screening Tool for the Assessment of Malnutrition in Paediatrics) nutritional tool. 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. The child's condition and treatment also affected their enjoyment of food. Dieticians worked with children and families and staff reported positive working relationships with the trust-wide catering team. For example, following feedback from parents about the quality of food, one unit had recently held taster sessions with a selection of food for parents and staff to sample. The outcome was positive and the unit was planning to introduce some changes to the menu.

- A team of 13 dieticians worked across all services within the GNCH, each one linked to a specific ward or unit. We spoke with one dietician supporting children and young people receiving treatment for cancer who told us most treatments and medication affected the way food tasted. She worked with children and young people, explaining the reasons why they did not enjoy they food they previously had liked and introduced them to new foods they would not ordinarily eat. To maintain awareness of current and new guidance, the dietician was a member of a national paediatric oncology dietician group, which met bi-annually to present case studies and share best practice.
- Dieticians explained if any children disclosed an allergy upon admission, the team developed bespoke menus to meet their needs. Staff also met cultural and religious dietary needs, for example, kosher and halal food was prepared as appropriate.

Patient outcomes

- Children's services in the GNCH monitored and review patient outcomes. Some services, such as the children's bone marrow transplant (BMT) unit, included a data manager to collate and report the information. The team presented and reviewed data at bi-annual audit meetings with Great Ormond Street. Each review included a discussion about every child who had received a transplant plus any new protocols and guidance.
- The most recently published BMT annual report (2014) showed clinicians had performed 35 transplants on children and young people. Of these, 10 were haematology-oncology patients and 25 were immunology patients. The overall survival rate was 89%.
- The matron from oncology services told us the long-term cancer outcomes were the best in the country. Data provided to us by the trust showed the five-year survival rate for children and young people between 0 and 19 years was over 82%. This was higher than the national average and indicated the North of England Cancer Network was the best performing network out of 28 across the country.
- Children's services participated in national audits in order to monitor and improve patient outcomes, such as, diabetes, epilepsy 12 (childhood epilepsy), neonatal intensive and special care and paediatric intensive care. We saw evidence of action plans following the publication of the audits that included recommendations and what action the trust had taken.
- According to the 2013/14 national Paediatric Diabetes Audit, the median HbA1c (average blood sugar) level was similar to the England average and, proportionately, more children receiving treatment at the GNCH had their diabetes under control (Hba1c<58 mmol/mol). This meant the outcomes for children and young people were good.
- Results from the latest National Neonatal Audit Programme identified a number of areas of good practice. For example, 100% of babies had their temperature taken within the first hour after birth and compliance rates were better than the national average. Recent data also confirmed that all babies with a gestational age of < 32 weeks or < 1501g at birth had undergone retinopathy screening in accordance with national guidelines.
- Neonatal and post-neonatal care mortality rates were low. We reviewed outcomes for all admissions to the neonatal unit to 27 days by gestational age in the most recent Neonatal Service Annual Report (2014). The survival rate for babies born before 24 weeks and between 24 and 25 weeks was 100%. The overall survival rate for premature babies admitted to the unit was 98%.
- Paediatric oncologists were developing pioneering experimental therapy to help reduce deaths from aggressive childhood cancers. Early phase intervention treatments and clinical trials were underway to save children diagnosed with neuroblastoma and other rare, high-risk cancers. The team had developed a new Northern Network, which included children's cancer centres in Scotland and Northern Ireland, to increase the number of children who could be involved in the new clinical trials. The GNCH had an established clinical trials team that worked closely with Newcastle University. We spoke with research nurses from the oncology service who explained their purpose, which was improving outcomes for children and young people with cancer.
- The paediatric burns service participated in the Northern Burn Care Operational Delivery Network Peer Review. The review covered six key standards, which included patient-centred care, multi-disciplinary teamwork (MDT) and the environment and clinical

governance. The review team did not identify any immediate risks or serious concerns. The report highlighted the strength of the MDT and cooperation with other specialties to ensure continuity of high quality care/treatment as an example of good practice.

- Medical and nursing staff also undertook local audits and we heard examples of changes made as a result. For example, the outcome from the audit of unplanned admissions to the paediatric intensive care unit highlighted the need to develop a more effective PEWS system for the unit that was simple, age appropriate and embedded into the observational chart.
- The total number of admissions for children aged 0-15 years in 2014/15 was 34,561. The emergency readmission rate was 10.3%. This was an increase of 2.1% from the previous year. Between July 2014 and June 2015, the rate of multiple emergency admissions among children and young people for asthma, epilepsy and diabetes was higher than the England average. We spoke with staff and managers who all explained the 'open door' policy for children with chronic conditions. This meant families were encouraged to return to hospital if they had further concerns about their child and was a contributing factor to higher than average readmission rate.
- 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.
- 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 76% of consultants and 78% of nurses from all services had received an appraisal between April 2015 and October 2015. 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.
- 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. Nursing staff also told us there were opportunities for progression within their role and we heard many positive examples describing the training and support they received from senior nurses and managers.
- Newly qualified nurses had the opportunity to join a new development programme, which involved a 3-month rotation across all services in the GNCH. We spoke with nurses who told us this was an excellent opportunity to gain insight and experience about the different wards and services and to support the continuity of care.
- 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'. Newly qualified nurses held supernumerary status for a period of time, the length of which varied depending upon the service. Nurses who had recently transferred to the neonatal unit were very positive about the training and the support they received. They told us senior nurses tailored the training and support to meet the specific needs of each individual nurse.
- Each ward and unit had its own practice development nurse (PDN) who was responsible for sharing updates and new practice. We observed a student nurse asking a PDN for help and witnessed their immediate response. Another nurse said the PDN was invaluable, always around and "making you better at your job every day".
- 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. Every doctor we spoke with had an educational supervisor who met with him or her regularly. One experienced paediatrician, who had relocated to the

GNCH from Africa, told us he did not join the out-of-hours rota until four weeks into his post. He explained managers were keen to ensure he felt comfortable and competent in his new environment.

- Registrars told us they had very good access to external training, including life support training for all paediatric specialties, and leadership skills. Medical staff also told us managers encouraged them to attend national and international conferences and share the learning with their respective teams.
- Clinical supervision across the medical team appeared to be robust and we received many positive comments from staff.
- Nurses told us they had 1-to-1 meetings with senior nurses and received clinical supervision. Informal supervision and discussions were a regular occurrence. Nurses told us they felt supported and found 1-to-1 sessions productive and valuable.
- The neonatal unit did not have Advanced Neonatal Nurse Practitioners (ANNP), as recommended by the British Association of Perinatal Medicine (BAPM) in post. However, band 7 nurses supported the junior doctors in many tasks such as taking bloods and gases and inserting cannulas, which gave doctors additional time to focus on the medical care of babies. Information provided to us by the trust reported there were plans to introduce ANNPs in the future.

Multidisciplinary working

- Our observation of practice, review of records and discussion with staff confirmed effective multidisciplinary team (MDT) working practices were in place. Staff gave positive examples and, on some specialist units; teams formally met every week to discuss the care plan for each individual patient. On one unit, we saw a white board, displaying stickers alongside some patient's names. The senior nurse explained this was to help allied health professionals, such as physiotherapists or dieticians, identify immediately if a nurse needed to speak to them about a concern.
- The focus of MDT meetings was patient-centred and encompassed the needs of the family. We attended a meeting about a child who lived outside of the local region. After discussing the child's condition and progress, the focus moved on to the family and what support they might need. We observed every member of the MDT contributed (verbally and non-verbally) to the overall discussion, which also included outreach care and support upon discharge.
- The children's bone marrow transplant unit worked closely with adult services based at the Freeman and other specialists in the UK and Europe. The unit provided care and treatment to children and young people with complex and unique conditions and the clinical team utilised video conferencing facilities to consult with colleagues from all over the world to determine the best course of action for every child and young person.
- Nursing staff from oncology told us good links with pharmacy meant discharge was swift and effective. For example, the ward alerted the pharmacy team several days before the planned discharge date. The pharmacist lead for the service prepared individualised medication boxes and spoke with the family to explain the administration process. If additional medication was required prior to discharge, there was a fast-track system, where the pharmacy lead would take the script directly to pharmacy to prevent any delays.
- Junior doctors from the neonatal unit reported relationships with obstetricians were very good.
- Medical staff from the paediatric intensive care unit worked closely with colleagues from the neonatal unit and contributed to the overall care and treatment of babies. Many infants 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.
- We heard examples of co-ordinated planning and delivery of care. Communication between teams was excellent, focusing around the needs of the child and their family. For example, nurses from the burns unit provided outreach clinics in the community and worked closely with the children's community nursing team. For example if a child needed a dressing changed twice a week and geographical constraints meant the nurse from the burns unit could visit once a week, a children's community nurse, who had received specialist training, visited the child to ensure they received appropriate care and treatment.
- 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. We spoke with staff from different wards who could clearly explain the process to us. Children also transitioned within some specialist services when they reached a certain milestone. For example, once a child became a teenager at the age of 13, the oncology team supported the transition of the patient to the Teenage Cancer Unit. The senior nurse told us, 'we have a party, as the children are very excited to move across'.

- Some services, such as the children's bone marrow transplant unit, did not have a formal transition process. Young people had a choice between remaining within the paediatric service or moving to adult services. The team was working with adult services and the You're Welcome initiative to develop and refine the current practice.

Seven-day services

- Consultants and registrars were available out of hours and actively encouraged nursing and junior medical staff to contact them if the need arose. One nurse commented this was the first hospital she had worked where she felt so encouraged to do so. We heard many examples from nursing and junior medical staff where consultants had come into work to check on patients during their day off.
- The children's A&E department was open 24 hours per day and led by a consultant who was qualified in both paediatrics and emergency care.
- Paediatric surgery offered a 24/7, 365 days a year service to children and young people. This included planned and emergency surgery.
- Children's services accessed diagnostic services such as the x-ray department, pharmacy and laboratory services during the weekend. Staff did not raise significant concerns over accessing these services.

Access to information

- Staff we spoke with told us they were able to access patient information and reports, such as test results and x-rays, promptly. For example, we observed one nurse talk with a child and his parents through the whole discharge process using the written documentation from the care record. Patient information was also available on the trust's electronic records system.
- 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.
- Specialist units also had access to specific clinical guidelines for their area of practice. For example, the children's bone marrow transplant unit used Q-Pulse, a live database that stored all up-to-date documentation.

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 them in practice. Staff explained that the consent process actively encouraged children and young people to be involved in decisions about their care.
- We spoke with three families in the neonatal unit who told us staff had asked for their consent to share information about their baby with the respective health visitor. Parents also explained how staff obtained consent to permit their baby to participate in a clinical trial and described how they did not feel pressured into agreeing with this.
- Staff we spoke with understood mental capacity as it related to young people and consent to treatment. If they needed further advice, 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.
- 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 of children and young people and this was reflected in their care and treatment.

Compassionate care

- All staff we spoke with were very passionate about their roles and were clearly dedicated to making sure children and young people received the best patient-centred care possible. One parent told us medical and nursing staff 'looked at us holistically, not just as a medical condition, right from the word go'. Another told us, 'everyone is very caring, no matter what colour uniform they are wearing'. Domestic staff were also recognised for their care, with parents giving the title of 'Auntie' to one of the domestics we spoke with.
- 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, one family commented, 'everyone is amazing, they can't do enough'. They described the commitment from staff in relation to care. For example, when the child's condition worsened overnight, the consultant had phoned in to check on progress and then came into the hospital on his day off to help. The family told us the consultant explained to them that he would do everything he could to make sure the child was well.
- 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, one nurse told us about a patient who was struggling to cope with the pain and emotional distress caused by their medical condition. The young person had chosen to stop taking pain medication following surgery despite the discomfort. The nurse counselled the patient, clarifying the benefits of the pain relief and gave information about the treatment, explaining how it would change life for the better.
- In the neonatal unit, we saw one set of twins sleeping side-by-side in one cot. As the cots on the unit were too small to accommodate them, the parents told us staff had sourced a larger cot from one of the paediatric wards so the babies could stay together. Parents from the unit described staff as being 'very gentle' and the work they did as 'unbelievable'.
- We observed staff from the unit encourage and support mothers delivering kangaroo care to their babies. Kangaroo Care is skin-to-skin contact when a baby is placed against the parent's chest. Benefits include improvements with lactation and with establishing breastfeeding, and better weight gain for the baby. In the longer term, it helps parents to feel closer to their babies and more confident in caring for them. One mother told us the staff had become her friends and said she had been so well cared for it would be hard to leave the unit.
- The neonatal unit had also introduced the use of 'miniboos', a baby comforter that promoted infant and parental bonding, especially during times of separation. Staff gave every family on the unit two miniboos. The parents slept with one to transfer their scent so when it was presented to the baby, it simulated awareness of their parent's familiar scents. The parents, in turn, retained a miniboo that held their baby's scent.
- Staff were supportive, sensitive and encouraging towards their patients. We observed a play specialist interact with a young patient, encouraging her to select a new Bead of Courage to add to her growing collection. The play specialist told us she had researched the Beads of Courage Programme and presented her findings to managers who agreed to implement the system in the GNCH. The programme supports children going through their treatment. It allows them to tell their story using colourful beads. The beads are used as meaningful symbols of courage that commemorate different milestones such as blood transfusions, bone marrow transplants, hospital stays, and chemotherapy and

radiotherapy treatments. Their beads build up over time into a unique record of what they have experienced. Staff explained that the programme helped children of all ages.

- Responses from the Friends and Family Test collated in December 2015 showed 85% of respondents would recommend children's services at the GNCH. 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.
- Responses from teenager cancer patients from a 'So How Are We Doing' survey were very positive. 100% of responders said, overall, they were given enough support from the team looking after them and 90% said they were given enough information about their condition at the time they were first diagnosed.
- Families wrote many 'Thank You' cards to staff. The team had decorated the wards and units with the positive feedback from parents and children. In one card, a family, whose child was still receiving inpatient care, thanked staff for going 'above and beyond in everything you do' and making their child feel better.
- We observed staff preserving the confidentiality of children and families and saw staff talking to parents away from the bedside of their child and other patients. One parent told us she had never overheard conversations about other patients and felt staff were very respectful of this.
- 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.

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. We spoke with the parent of a young person with learning disabilities who was also deaf. She told us one of the team had developed a poster and displayed it on the wall in the patient's room. It included advice for other staff about how to interact, for example, not administering any treatment whilst the patient was sitting in their 'safe' chair. Another member of the team had created a booklet containing some basic communication signs in BSL (British Sign Language) to encourage staff to communicate with the young person in a way that they understood. The room also contained appropriate sensory equipment to help create a more comfortable atmosphere within the clinical surroundings.
- 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. One parent told us they had received lots of information prior to her child's admission for a bone marrow transplant. This included a video explaining what to expect and received an invitation from staff to visit the ward in advance.
- Staff also ensured families were active participants in their child's care and treatment. For example, consultants from the children's' bone marrow transplant unit involved families during meetings with international colleagues to ensure parents were fully conversant in discussions that often related to new and innovative techniques. In some cases, staff also showed parents how to administer medication.
- Families were encouraged to care for their child while on the ward. Parents of babies and children were able to feed and wash them as well as change dressings and administer medication. We spoke with parents on the neonatal unit who told us they felt very involved in caring for their baby. For example, one set of parents said, following advice from staff on how to do it, they had: changed the baby's nappy; wiped its mouth; given it a little cuddle; turned the baby over; and put fluids down the tubes. The parents explained that, when receiving the advice, nurses did not use long medical words. For instance, they would just say 'tube' or would explain that 'CPAC' related to oxygen and tell them what they were going to do. In addition, staff asked if they could do things to the baby, such as turning the oxygen down. One parent described staff involving them and chatting about anything – 'football and stuff' - to help put them at ease.
- 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. Nursing staff

told us they always gave children and young people the opportunity to talk to them about any concerns they had about a procedure. They also presented them with options so children and young people could make their own decisions, for example, if they would prefer to take medication with juice or with ice-cream.

Emotional support

- Parents told us staff understood the impact the condition and treatment had on their children and provided emotional support. Upon discharge, children and families were encouraged to maintain contact with the relevant specialist service if they need further support or advice. One patient contacted the children's bone marrow transplant unit 20 years after their transplant to seek advice after contracting chicken pox.
- Medical and nursing staff supported children with long-term conditions and who were receiving end of life care. They went beyond the call of duty to care for their patients and their families. For example, the family of a patient receiving palliative care wanted to take their child home, to spend their final days. Staff worked late into the evening to make all of the necessary arrangements and remained there until the patient arrived home. One nurse told us 'the love and care we give when a child is dying is honest and genuine'. We heard examples of staff willingly swapping shifts to ensure children and families received effective continuity of care.
- Doctors provided appropriate and timely information. For example, one doctor told us they recently discussed the condition of a child in the middle of the night when the parents called the ward. The doctor was honest and explained their concerns about the child, which the family found helpful, as they felt prepared for the next stage when they visited their child the following day. Consultants from the paediatric intensive care unit also met with every family following the death of a child for bereavement debrief.
- There were clinical nurse specialists across a wide range of services, supporting children and young people with long-term, complex medical conditions, including leukaemia, solid tumours and burns. The Children and Young People Oncology Outreach Nurse specialist team (CYPOON) cared for children and young people receiving end of life care.
- Feedback from the CYPOON parent experience survey described the service as 'excellent' and said the service 'gave us strength to make it through the darkest of days'. Staff tailored bereavement care to meet the needs of each individual family. Nurses from the CYPOON team told us they attended every funeral and continued to meet with the family two or three times following the death of their child. They also send flowers and a card to mark the first anniversary.
- Staff from the paediatric intensive care unit presented children and their families with a unique diary upon discharge from the unit. Healthcare staff wrote the diary entries, with support from family members, which contained daily entries of the patient's condition. Staff from the unit had recognised that the memories of children and their families could be distorted from the trauma and stress of their time in hospital. The diaries helped to fill the memory gap and help families understand what had happened.
- Medical and nursing staff empowered children and young people to manage their own health, care and well-being. For example, nurses showed some patients how to administer their own medication and nasogastric tubes. One patient was very articulate about their treatment regime and demonstrated a clear understanding of all it entailed. We found staff had instilled confidence in children and young people to manage their condition positively and confidently.
- One parent told us staff made her feel safe and constantly offered reassurances and support throughout the treatment process. Families told us they felt empowered to ask questions and were kept them informed at every stage by medical and nursing staff. They also felt very confident their children were receiving the best care possible.
- 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. There was additional support to help children and families cope emotionally during their stay in hospital. For example, volunteers from the Rainbow Trust and CLIC Sargent charity visited children on the wards, telling stories and singing songs.

Services for children and young people

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 children, young people and their families.
- There were innovative approaches to providing 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

- There were 70 Consultant Paediatricians delivering general paediatric care as well as regional and national services. 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 GNCH treated children from other regions in the UK, Europe and, in some cases, the rest of the world. Recognising the disruption this caused to family life, the trust provided accommodation for parents and siblings so they could remain in close proximity to their child. The liaison team supporting bone marrow transplant patients arranged 'halfway house' accommodation for families from outside of the region and co-ordinated arrangements for international patients. The trust, in conjunction with the Sick Children's Trust, also ran Crawford House, situated within the hospital grounds, which had 23 private family bedrooms. Crawford House was open 365 days a year and the house manager allocated rooms to families on a priority basis, free of charge. We spoke with one parent who described the facility as a 'godsend' and told us the facilities were excellent.
- The senior nurse from the children's outpatient department was currently working with the directorate manager to review the capacity of room space within the unit. A survey carried out in 2015 identified 23% of available rooms were not being utilised effectively and a project was launched to improve the management of the clinics. We reviewed the initial project description plan and the initial evaluation of the project, which showed an increase in activity, and the further promise of positive outcomes. This included the proposed establishment of an electronic booking system in 2016.
- The GNCH provided the North East Children's Transport and Retrieval (NECTAR) service, a standalone commissioned service that provided intensive care for children from the point of referral to the handover of care at the receiving unit. It operated 24 hours a day, 365 days a year, triaged all referrals and provided a consultant-led telephone advice service. NECTAR also transported children home for palliative care.
- We saw evidence to demonstrate good continuity of care. For example, the trust worked proactively with local GPs, providing a programme of interactive training including discussions about new paediatric guideline, safeguarding updates and reviews of common paediatric conditions.
- Clinicians held outreach clinics across the country for those children who lived outside of the region. For example, consultants from the children's' bone marrow transplant unit ran clinics in cities across the UK and Ireland for pre and post-transplant patients.

Meeting people's individual needs

- The Paediatric Oncology and Outreach Nursing (POON) teamprovided specialist palliative and end of life care for children and young people with progressive malignant disease. The team provided a 24-hour, on call service, seven days a week. Using smart pump

technology, unique to the trust, to dispense medication, children and young people could be cared for in the comfort of their own home. Nurses could change the smart pumps remotely so if a patient needed more pain relief during the night, the team could make the necessary adjustments immediately. We spoke with the team who told us the POON service had led to an increase in the number of children and young people who chose to die at home. Statistics showed that from 2009 to 2014, 86% of expected deaths occurred at home, through patient choice.

- Staff from children's services understood the cultural diversity of their patient population and provided the necessary means and support to ensure their needs were met. For example, parent rooms and those designated as 'quiet rooms' could be used to pray. Staff had displayed Mecca signs on the wall and prayer mats were available. Staff also demonstrated their understanding of the constraints faced by other communities, such as families from the Traveller community, where literacy levels can be lower than the national average. One nurse told us she always showed families the relevant patient information leaflet, talked through it with them, and gave them the opportunity to ask any questions about.
- Nurses from the surgical ward explained the Child and Adolescent Mental Health (CAMHS) team contacted them every morning to check if the ward had admitted any patients with mental health problems. If so, the child would receive a visit from CAMHS the same day. If children required psychological support during the night, nurses could contact the out-of-hours patient services co-ordinator who would arrange this.
- The senior nurse from the children's outpatient department told us they were looking at different ways to improve the service for children with learning disabilities. For example, we saw a poster displayed on the reception desk aimed at parents. It offered four options to make their wait in the department as comfortable as possible such as, waiting in the outside playground, taking a pager and go for a walk or waiting in a quiet room. There was also a dedicated learning disabilities link nurse within the department.
- A band 6 nurse from the neonatal unit had developed a parental support network called the 'Buddy Group' to meet the needs of parents and carers of sick and premature babies on the unit. The group linked parents with others parents in similar circumstances, who had volunteered to provide support and advice. The nurse had recently been recognised as NHS Patient Champion of the Year.
- Play specialists were available seven days a week. Families we spoke with described them as 'fantastic' and we saw children interacting with them positively and confidently. Clown doctors also visited patients and promoted interactive play with children of all ages.
- Some children in the GNCH were resident in the unit for a prolonged period. To meet the educational needs of every patient, the trust provided dedicated teachers 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 brought a sense of normality to their child's life.
- A clinical nurse specialist from the Burns and Plastic unit, who was also responsible for outreach clinics, had established The Grafters Club. The club provided continuity of care and a social/support network for children and their families. There were approximately 80 active members, all of whom were former patients of the unit, and most staff from the ward volunteered their services. Twice a year, staff volunteers arranged day trips and a family day plus a one-week residential camp once a year. Children left the club once they reached the age of 18, but could volunteer after 2 years. Over 150 people attended the most recent Christmas event and an ex-member had just graduated from university as a nurse.
- There were excellent facilities available for children and young people, encouraging them to play and relax, across the whole hospital. For example, the Teenage Cancer Unit had dedicated bed areas and bays with facilities for a family member to stay with them overnight. Communal areas included a 'penthouse' with a pool table, jukebox, television, DVD and games consoles. There was a quiet room and information areas plus iPod touch tablets and laptops. Staff explained there was also a program of facilitated sessions that included an exercise programme, food activities, animation and filmmaking, and themed parties. Free Wi-Fi was available throughout the GNCH.
- There were also interactive 3D television systems, designed to help distract and engage children during

treatments and a Medicinema, capable of seating 50 people as well as children in hospital beds and wheelchairs. One patient told us of his delight at seeing a new major movie before his friends at home did.

- We saw excellent facilities for parents and carers on every unit we visited. Dedicated rooms were included on the ward and included kitchen areas and lockers where appropriate.
- Wards displayed 'How are we doing' boards and used them as a communication tool to share information with children and families. For example, we saw 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.
- The GNCH had recently adopted an ambulance from the Daft as a Brush cancer charity, to transport children and their families to and from wards 4 and 14 at the hospital. The design and name of the ambulance, Happy-O-Saurus, was decided by the children themselves.
- Leaflets were available, presented in a child-friendly and readable format, describing services, health promotion and what the GNCH itself offered children and families. Although the leaflets we saw were in English, other languages were available.
- Children from all over the country visited the GNCH 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. In the GNCH, 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.
- If families needed advice or wanted to request an urgent appointment to the rapid access clinic, a specialist doctor was available, via telephone, day and night. A consultant told us they never refused an emergency admission for babies and children and staff 'would always find a suitable bed within the hospital'.
- There was a Single Point of Access pathway. The paediatric emergency department was open 24 hours every day and was supported by operating theatres and critical and high dependency care located within the same vicinity. The Childrens Emergency Assessment Unit was available seven days a week and received GP referrals. Following assessment, clinicians discharged the patient, transferred them to long or short stay in the unit or transferred 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. During our inspection, we observed there was good flow into, and out of, the hospital and between wards.
- Children and young people with long-term conditions, who required regular, urgent access to hospital-based care, had GNCH Passports. The special passes provided them with an open gateway to the specialists they needed to see, and ensured that their care was seamless and tailored to their specific needs.
- The senior nurse from the oncology day unit told us they experienced peaks and troughs in relation to patient flow. The unit was open between 8.30am and 6.30pm, Monday to Friday, and children and young people could attend at any time. Although there were no set appointment times, clinics ran at specified times throughout the day. The unit was very accommodating and never turned patients away however, it meant sometimes it was very busy. The team was currently reviewing patient activity and developing new ways to use the space in the unit more effectively. If staff needed to admit a child, they worked closely with the oncology inpatient ward to secure a bed space.
- Children and young people who required a surgical procedure were initially admitted to the nurse led surgical day unit prior to surgery. From theatre, staff transferred patients to the appropriate ward or unit. We spoke with nurses who told us this was a new process. They felt it worked more effectively than the previous system when patients were admitted directly to the surgical inpatient ward.
- Children and young people were seen in the children's bone marrow transplant (BMT) unit within six weeks from referral. The unit had developed a data spreadsheet to monitor all patient activity. This included the type of transplant, the treatment and the outcome. We spoke with the senior nurse who explained the system was a valuable tool and enabled the team to

track patient numbers effectively. Patients also had an individual passport to use when accessing urgent care services. This meant children and young people had safe and timely access to treatment.

- The most recently published bone marrow transplant (BMT) unit annual report (2014) reported all haematology and oncology patients attending the BMT unit were referred from the local region. Primary Immunodeficiency patients were mainly from the North of England and the Republic of Ireland with two patients from Wales. One patient was from Europe and another from the Middle East.
- In the neonatal intensive care unit, medical staff admitted all babies through the backshop assessment room for stabilisation. The team also stabilised babies on the unit prior to transfer to Freeman if surgery was required.
- Outreach clinics supported the access and flow of patients. For example, the 2015 Northern Burn Care Operational Delivery Network Peer Review reported the burns outreach team was 'delivering a comprehensive, very well structured and integrated service that facilitated earlier discharge and helped to avoid hospital visits'. The review team recommended the team share the good practice across the Northern Burns Network.
- Between July 2015 and December 2015, 6,910 children and young people attended new appointments at the children's outpatient department. In the same period, clinical staff reviewed 16,387 existing patients. The total number of attendances was 23,297. Of these, the hospital cancelled 26% of appointments while patients and their families cancelled 24%.
- Evidence provided to us by the trust showed the overall DNA (Did Not Attend) rate was 14%. A telephone reminder system was introduced two years ago, which had reduced the overall DNA rate, by 20%. We spoke with the trust-wide leads for safeguarding children who told us there was a new project running to track children who missed appointments over a 12-month period.
- The outpatient department used a pager system so children and parents could wait outside of the department and move around within the hospital.
- We spoke to children and families in the children's outpatients department who told us they never waited very long see a doctor, either while waiting on the unit or for an appointment following a referral from their GP. The senior nurse told us between 1200 and 1500 patients attended clinics every week. The Referral to Treatment (RTT) waiting time was 11 weeks on average and under, two weeks for cancer patients, which was within national targets. We requested further statistical data from the trust in relation to actual clinic waiting times however; we did not receive any information to include in this report.
- 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.

Learning from complaints and concerns

- Between October 2014 and September 2015, there were 51 formal complaints about children's services. There were no discernible themes or trends. We also spoke to the Patient Advice and Liaison Service (PALS) who told us they received a very low number of concerns about the GNCH.
- 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. There were posters and leaflets in visiting areas about how people could raise concerns. Upon admission, ward staff also gave children a welcome pack that included information about how to make a complaint. Staff explained, in most cases, parents spoke to nurses on the ward and issues tended to be resolved informally.

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 very 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 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

- The directorate manager and clinical directors from children's services had developed a robust strategy for children's services based around growth however; managers made it very clear to us that cost improvements would not be to the detriment of patient care. Some units were also included in national strategies in relation to the nationally commissioned services they provided, such as the children's bone marrow transplant unit.
- The leadership team from the neonatal unit, and all of the staff we spoke with, were very clear about the vision and strategy for the service. The demand for cots had exponentially increased year on year and the team were passionate about meeting that demand and reducing the number of babies transferred out of the department.
- Staff we spoke with were all clear in their understanding of the overarching trust vision and values. We saw posters displaying the values in areas around the hospital. Staff at all levels also understood the priorities of their own service. We spoke with a nurse from the paediatric intensive care unit who described the business plan and the establishment of the NECTAR retrieval service, a key priority.
- Managers reviewed the progress of the business plan at regular directorate and unit level governance meetings, involving medical and nursing staff groups.

Governance, risk management and quality measurement

- There were good working relationships with other trusts and organisations across the UK and worldwide. For example, the children's bone marrow transplant unit worked closely with Great Ormond Street and attended joint audit meetings bi-annually. The team also embraced opportunities to share good practice, based upon clinical research, such as the removal of protective headgear, which was a popular decision with patients and staff alike. Managers and clinical leads also spoke positively about relationships with the local clinical commissioning group and local authority.
- The directorate manager and clinical directors had established a series of inter-departmental meetings where two different services would get together to share good practice and learning. Staff we spoke with were very positive about their experience of attending the sessions and felt they were a valuable way of measuring quality with other services.
- Quality and safety, and directorate, meetings took place every month and the minutes shared with staff. Medical and nursing staff discussed performance and risks and considered appropriate action to improve outcomes. For example, minutes from one of the directorate meetings reported children were arriving in clinics and their notes were missing. This meant the potential cancellation of surgery. Staff agreed a new process to ensure clinicians alerted administrative staff when they removed a set of notes.
- There was a comprehensive risk register, which staff regularly reviewed at governance meetings. Staff at all levels were aware of the risks within their own unit and what action managers were taking to manage and address them. For example, senior managers identified the paediatric intensive care unit retrieval service (NECTAR) as one of the most significant risks due to the potential impact upon patient safety when the

consultant was required to go out on retrieval. Staff on the unit explained to us the actions taken to mitigate the risk, which included further recruitment of medical staff.

- We saw evidence of a rolling programme of internal quality audits undertaken routinely across children's service to ensure safe and effective care. Clinical leads told us they felt the governance and level of audit activity across the service and the trust was very robust. Some units included a manager who monitored quality and led the audit process, such as the children's bone marrow transplant unit where the post-holder worked with both children and adult services. Managers and key staff discussed lessons learned and outcomes at a monthly quality and safety forum, chaired by a co-clinical director.
- 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. Patient Safety Briefings were embedded across the GNCH and incorporated into daily handover meetings, which included incidents, complaints and risks.
- The neonatal unit worked closely with the Northern Neonatal Network. The team submitted data from the service to Badger Net, the network reporting system, which informed quarterly analysis reports about neonatal services across the region.

Leadership of service

- Medical and nursing staff told us managers, clinical directors and clinical leads 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 had those looking after them and maintaining a positive attitude.
- Staff told us leadership was 'all over', not just from the top. One registrar commented, 'there is no hierarchy and we (managers, medical staff and nurses) are always discussing patients together'. A nurse told us 'you can ask anyone, anything, at any time' while another commented about the regular presence of consultants on the ward and the positive interactions between staff.
- Staff told us they felt well supported by their immediate line manager. They felt there was a clear management structure within the team and leaders and senior staff were very approachable. If there was any conflict within the service, they would go to their line manager and seek support.

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 like coming to work, it's like a family' and 'I am proud to be in this team'. Staff we spoke with 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 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. A band 5 nurse commented, 'we are one big team, from the consultants to the domestics'.
- 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 also told us they felt safe to challenge each other, irrespective of role or seniority. We observed this in practice during a handover meeting in the paediatric intensive care unit.
- 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.
- We spoke with staff who told us about the emotional pressures they experienced caring for very sick children and young people. A senior nurse from the paediatric intensive care unit explained some children can receive palliative care for a month or more which can be very difficult for staff. To ensure staff received the right level of support managers enlisted the support of the trust's clinical psychology team and developed 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.

Services for children and young people

Public engagement

- 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. Some units had graffiti boards for young people to write down their thoughts and ideas for improving the ward environment. Other wards and units also surveyed children, young people and families every month. Rooms specially designated for parents included 'You Said, We Did' boards where staff displayed the 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.
- Recognising that some children and young people were too poorly to put their thoughts in writing, staff also engaged with them face-to-face. For example, staff from the oncology wards talked to teenage patients about the facilities on the unit. One patient fed back that the television in the bay was too high and difficult to see.
- Young people from the Teenage Cancer Unit were involved in making a DVD, designed to welcome new patients to the unit. Although the unit's animator helped them develop it, the teenagers determined the content, which included information ranging from what to eat and taking your own temperature.
- We heard about many charitable activities where staff, patients and families came together collaboratively to raise money for the GNCH. For example, a large cohort, including senior clinicians, took part in the Great North Run in 2014 and raised over £20,000.
- Staff volunteers from The Grafters Club produced a bi-annual newsletter called 'The Telegraft' to all of its members with details of fundraising events, family days out, donations and supporters.
- Children and young people were also involved in the assessments to achieve 'You're Welcome' accreditation.

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. We spoke with one staff nurse who told us about their involvement in a quality improvement project to improve the dispensation of drugs on the ward. She felt her contribution was valued when her manager asked her to feedback outcomes from the project at a patient safety briefing.
- The trust communications team distributed regular bulletins and individual services produced unit-related newsletter such as the monthly PICU Gazette. Produced by a member of staff who initially designed it to communicate feedback from incidents, over time it evolved to include other news and service updates.
- 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 leaning, improvement and innovation across children's services. A consultant told us change was encouraged at all levels. 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.
- The trust had established the Great North Children's Research Community, which included clinicians, academics, researchers and representatives from other NHS trusts, the voluntary sector and public health. The shared vision focussed on improving health outcomes for children and young people across the North East through research and collaboration.
- Paediatric oncologists were developing pioneering experimental therapy to help reduce deaths from aggressive childhood cancers. Early phase intervention

treatments and clinical trials were underway to save children diagnosed with neuroblastoma and other rare, high-risk cancers. The team were setting up a new Northern Network, which included children's cancer centres in Scotland and Northern Ireland, to increase the number of children who could be involved in the new clinical trials.

- A play specialist from oncology told us about research she had undertaken about the Beads of Courage Programme, deigned to support children going through their treatment. A senior nurse from another unit told us she was exploring the notion of creating a similar scheme for immunology and bone marrow transplant patients where each child would have a 'journey box' to fill with memorable items as they progressed through their treatment.
- The liaison team from the bone marrow transplant unit had developed an open access pathway so post-transplant patients could access urgent care quickly and safely. Children and young people presented their unique passport upon arrival in A&E, which included all information pertaining to their condition and any ongoing treatment. The team had worked with other trusts across the country, to ensure a smooth transition. Representatives from the team had presented the pathway to colleagues from across the world at the most recent European Bone Marrow Transplant conference in Istanbul. Feedback from families about the passport was very positive.

End of life care

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

Information about the service

End of life care is provided across the trust's acute hospital sites. The Royal Victoria Hospital (RVI) 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 RVI 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 SPCT had both a clinical and educational role and worked five days a week. The team was split into four teams on four sites, the RVI Hospital, the Freeman Hospital, and 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 RVI. 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 are 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 a multi-faith room on site, a mortuary and a viewing area and bereavement service.

As part of our inspection, we observed end of life care and treatment on wards and other clinical areas. We visited the emergency department, critical care, high dependency unit, medicine and respiratory wards. We also visited the chapel, the hospital mortuary, viewing rooms, and bereavement office. We spoke with eight patients and families. We spoke with 24 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 11 patients receiving end of life care and 14 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 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.
- 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 place in the mortuary to ensure good hygiene practices and the prevention of the spread of infection.

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 some areas but plans were in place for this group of staff to receive training within agreed timescales.

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 team 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 and we saw evidence of this in the form of 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 minutes.
- Staff we spoke with showed some understanding about the duty of candour regulations, they understood their responsibly to be open and transparent. They gave us verbal examples of when they had used the 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 on the trust internet system.
- We visited the mortuary at the RVI, and saw that it was clean and well maintained and that hand-washing facilities were available. Cleaning records were easily accessible and 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 and hand hygiene facilities
- 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 the 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 was protected. This was outlined in the 'Care after Death' policy.

Environment and equipment

- Staff we spoke with told us 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.

End of life care

- 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 across the trust 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.
- The mortuary also provided three separate viewing rooms for adults, children and infants. These were newly designed and sympathetic to the needs of those using it.
- We saw the mortuary was well equipped and that the capacity was adequate. There was a 105-unit body store. We saw specialist equipment that included bariatric trolleys and 30 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 Freeman Hospital 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 11 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 care 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.
- We saw evidence of safeguarding referrals made by the palliative care team.

Mandatory training

End of life care

- All staff providing end of life care and specialist palliative care had completed mandatory training. Data for mandatory training showed 100%. We were provided with data by the mortuary manager, which showed a training planning programme, this was up to date and fully completed. We saw a training database for all palliative, chaplaincy and end of life staff training, which was regularly reviewed.
- 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 for 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 30 told us she had received the training and was using the new paperwork. 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 completed.
- An on-line training package had been created for all clinical staff. This was an electronic learning portal and ensured all staff were up to date with the latest policies, procedures and practice.

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.

Nursing 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.
- 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.
- 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.

Medical Staffing

- The SPCT comprised of 4.15 whole time equivalent (WTE) consultants.
- Medical staff we spoke to 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.
- The doctors were moved into the cancer services directorate over five years ago to ensure they had the management and clinical governance structures required for all staff.

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 and prioritisation of patient needs. The mortuary manager was fully involved with Newcastle Council in business development planning.

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

- We viewed 14 DNACPR forms when visiting the wards and found on three occasions these were not fully recorded. Two did not include discussions with relatives and family and in another case a consultant did not sign the document. The service carried out audits and took action to improve processes in this area.
- 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 managed well 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 have 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.

End of life 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
- 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 who 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 RVI showed a 50% 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.
- Staff were aware of the principles and values required when delivering end of life care. 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, end of life care team and chaplaincy 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.

End of life care

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 therapy services.
- The service included spiritual support from the chaplaincy team and bereavement support from the bereavement centre. The mortuary staff attended meetings with the bereavement office and end of life teams to ensure consistency.
- 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 provide staff with support.

Seven-day services

- Although seven-day services were not fully in place, there were plans to provide a seven-day service by 2018.
- Community SPCT provided weekend support on the hospital sites 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 available to staff which ensured staff were consistent in their management of end of life processes in the absence of the full 'Caring for the dying patient' documentation.
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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 collected 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 chaplaincy, 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, we saw for example that within cancer services 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 RVI showed a 57% response rate. Results were positive showing that 47% of patients strongly agreed that they were treated with dignity and respect, 30% agreed, 5% 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 caring practice by the chaplaincy service. One example was a wedding arranged for a patient at the end of their life. The service also completed patient case studies. These were used as learning tools to identify patient's spiritual and religious needs.
- Staff working in the mortuary went the extra mile and we saw several examples of compassionate care. During discussions, staff were able to demonstrate compassion, respect and an understanding of preserving the dignity and privacy of patients following death. For example, staff had knitted clothing for a premature baby, to enable the mother to the view the baby as she had requested.

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. 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.
- We saw that bereavement packs were available in the ward areas with information about access to support.

End of life care

- 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 also 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.
- 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.

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.
- 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 the staff following issues and concerns.

However

- The trust did not formally collate data on preferred place of death but acknowledged that future audits will 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 Priories 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 mortuary had been fully involved with Newcastle Council regarding the business plans for the development of the mortuary, which resulted in the development of three individual viewing rooms.
- 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
- The SPCT team led on a number of initiatives to engage and work with local hospices and organisations. For example, 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

End of life care

- 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 where available.
- 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 patients 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 RVI was the only facility in the region, which offered a ritual washroom, and this was available for patients using other hospital sites.

Access and flow

- The SPCT were available Monday to Friday from 9:00am to 5:00pm. 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 specialist palliative care 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. A nurse told us the SPCT 'respond quickly to referrals' and were 'invaluable'.
- 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 services providers available in the community, which could delay 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 were 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%.
- 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 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 received and staff felt there was an honest an 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.
- 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 staffwere 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 and were led by the palliative care consultant.
- Patient safety and quality was addressed at the end of life strategy group meetings. We saw minutes of these meeting's 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.
- The trust told us that there were no risks for end of life and there was no risk register. However, a report was produced 'End of Life and Palliative Care update' in July 2015, which identified several risks, such as funding to continue the Allied Health Professionals project and the

completed roll out of the Caring for the Dying Patient documentation. These areas were not reflected in the risk register and therefore it was not clear how risks were being monitored or actioned.
- 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 practise 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.
- The SPC 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 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 patients 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 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.

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 or they could add value to the discussion.
- 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 SPCT had successfully been selected to take part in the National Palliative Care Funding Review Pilot. The qualitative aspect of this involved focus groups with commissioners and other providers on data collection and how this was linked to funding in the future.
- The team was one of the 11 pilot sites nationally to participate in the Public Heath England National

End of life care

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.
- The Allied Health Professionals part of the service had been shortlisted for the 3rd year in a row for the National Macmillan Achievement Awards.
- An innovative service development with 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 held 2,700 outpatient clinics each week across all sites. In the year before our inspection, they provided 1,454,375 outpatient appointments at the Royal Victoria Infirmary (RVI) across a vast range of specialties including breast, cardiology, chest, dermatology, fracture clinics including an osteoporosis service, general medicine including endocrinology and gastroenterology, haematology, neurology, pain, plastics, trauma and a women's health unit. Some specialties provided outpatient services separate from the main outpatients department. These included ophthalmology, immunology and neurophysiology. The Campus for Ageing and Vitality provided 29,924 appointments through Clinics for Research in Themed Assessments (CRESTA), which were established in 2012 by the neurosciences department with strong links with the Newcastle University Biomedical Research Centre. They provided a one-stop multidisciplinary assessment for complex patients. Specialties involved included neuro-genetics and neuro oncology and some conditions included chronic fatigue, multiple sclerosis and Parkinson's.

The trust provided outpatient services at the RVI between 8am and 8pm Monday to Friday with some added clinics held to reduce waiting lists on Saturdays. Trauma clinics were open every day, including weekends and bank holidays, across the main sites of RVI and the Freeman Hospital. A new, purpose built satellite outpatient centre had opened at Manor Walks shopping centre, Cramlington to serve the local community with specialist services including audiology, chemotherapy, ophthalmology, ear, nose and throat, and women's health clinics from Monday to Friday. The Campus for Ageing and Vitality offered outpatients services, therapies and imaging services from 8am to 5pm Monday to Friday. The trust also offered some outreach services at primary care centres including Battle Hill Health Centre, Benfield Park Healthcare and Diagnostic Centre, and Ponteland Road Health Centre.

The Radiology Directorate managed diagnostic imaging (x-ray) departments and provided 587,294 radiological examinations across all sites in the trust including the Campus for Ageing and Vitality. New x-ray facilities were due to open in Manor Walks, Cramlington. The Nuclear medicine department offered specialist scans using radiation via a wider range of modalities and systems. An average of 7,000 scans were carried out each month and these included CT, MRI, DEXA (used to measure bone density) and ultrasound scans.

We inspected services at RVI, Cramlington, and Campus for Ageing and Vitality, and did not visit the outreach sites due to lower numbers of patients due to attend there during our inspection.

We spoke with 53 patients and 7 people close to them, 38 members of staff and looked at 14 patient records.

Outpatients and diagnostic imaging

Summary of findings

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. 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 were 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. They 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. Records at most sites were completed appropriately.
- 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.

However

- Clinical or nursing staff did not consistently sign some patient notes we checked at the Campus for Ageing and Vitality.

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. A trend had been identified where blood bottles for testing had been incorrectly labelled. An investigation revealed that an abbreviation had been misinterpreted and staff were asked to write the test name in full on request forms to prevent this from happening again.
- 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.

Manor Walks, Cramlington:

- There had been no incidents to date at the clinics since the centre had opened in October 2015. Staff could access the incident reporting system, understood, and had confidence to follow trust processes for reporting.

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 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.

- 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 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.
- A patient with c. difficile had attended clinic during our inspection and clinic staff had dealt with the area appropriately following the visit. They had isolated the area, deep cleaned the room.
- Patient waiting areas and private changing rooms were clean and tidy.
- 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 each use.

Environment and equipment

- Equipment in the departments was calibrated, maintained and the medical electronics department managed maintenance contracts.
- The waste management team had carried out audits in all outpatient departments identifying some areas of non-compliance. Auditors had completed the first part of the audit documentation but action plans were blank. However, we found that errors and omissions had been rectified and there were no areas of non-compliance during our inspection.
- 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, except on one trolley where some equipment had not been checked. This was pointed out to staff and corrected immediately. 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 outpatients and diagnostic imaging departments. Staff told us they were encouraged by senior management to raise any immediate concerns to ensure they were rectified quickly or escalated to the department manager.

Manor Walks, Cramlington

- Security measures had been implemented appropriately at the new centre. Freeman Hospital security staff supported the clinic and shopping centre security teams called in at least once a day. There were CCTV cameras and staff used a swipe card for access.

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 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 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) who carried out RPA duties. 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. 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 outpatients departments. Small supplies of regularly prescribed medicines were stored in locked cupboards and where needed, locked fridges. We saw the record charts for the fridges that showed that staff carried out temperature checks daily and that temperatures stayed within the safe range. All medicines we checked were in date.
- Nursing staff followed standard procedures 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, 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 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.
- 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 10 patient records at the RVI and four at Manor Walks, Cramlington that were completed with no obvious omissions.
- Referral letters and discharge summaries were stored electronically and provided back up when patients' notes were unavailable.
- Staff at the remote sites received records in a timely manner and trust staff transported them securely to and from the main hospitals on a daily basis.

Campus for Ageing and Vitality:

- We reviewed five sets of notes from a clinic of 50 patients and found that clinical staff for each episode of care did not consistently sign records. Nurses carrying out and recording observations did not sign or date the records. This was fed back to the sister in charge of the unit who told us they would ensure this was passed on to all staff to improve record keeping and maintain a clear audit trail within patient notes.

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.
- Staff carried an information card and knew who they could ask for support if they needed it or help if they had a query. The safeguarding teams would to assist staff in clinics when required and staff gave us examples of when this had happened.
- 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 outpatients departments and senior staff were involved with the trust safeguarding committee.
- Senior nurses had good knowledge of processes and issues including domestic abuse. One sister was due to attend a course to enable them to complete Multi Agency Risk Assessment forms to feed into the Multi Agency Risk Assessment Committee (MARAC) run by Northumbria police.
- A letter from the trust safeguarding lead for children was held in the staff file, congratulating staff on a recent safeguarding intervention.
- 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 adults 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 outpatients and diagnostic imaging departments made sure staff attended training. The training and development department produced and distributed monthly reports on mandatory training and departmental managers checked compliance regularly to make sure that all staff were up to date with reviews.
- Department managers told us that staff were allowed time to attend mandatory training.
- Mandatory training compliance for outpatients 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.
- 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 at each site 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 endoscopy departments used the WHO safer surgical checklist for all interventional procedures. Checklists were audited and changes were 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

Outpatients and diagnostic imaging

- We looked at the staffing levels in each of the outpatient areas and sites.
- There were no significant vacancies to affect how departments functioned. 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 and across all sites.
- All department managers told us that staff were flexible to ensure they provided cover for each clinic and department. Senior nurses 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 patient waiting times.
- Managers told us staff sickness rates in outpatients were measured in June 2015 and the 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.

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 that 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.
- Specialist radiology nurses worked across the departments 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.
- 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.

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 to meet the needs of the trust and 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 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.

Outpatients and diagnostic imaging

- 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. 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.
- 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.
- Outpatients staff had taken part in a major incident exercise in the year before our inspection
- 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. For example, staff at the falls and syncope clinics followed NICE guideline for transient loss of consciousness (CG 109). Specialties were responsible for compliance with NICE guidelines, Public Health England directives, and specialty specific guidance such as Royal Colleges at national, regional, and local levels. All policies and guidelines were stored on the trust intranet. As staff received new guidance and directives, the department managers ensured clinical practice was updated.
- There were identified 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.
- 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.

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

- 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 in line with NICE guidance. Where audits produced results different from what was expected or needed, managers reported results and made changes to procedures. For example, ophthalmology clinics had been reorganised as capacity increased so that there were more rooms available and located nearer to the photography department.
- 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.
- Dermatology audits included the use of a photographer instead of clinicians taking their own photographs in the melanoma treatment service. Results showed that this had reduced average patient waiting times from one hour to 25 minutes and improved patient's satisfaction rates. A follow up audit showed that by carrying out a top to toe screen, one patient in ten was found to have a second melanoma. The results of this audit were presented nationally.

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.

Pathology:

- The pathology service completed an annual pathology quality assurance review and carried out national comparative audits of blood transfusion including a perinatal mortality surveillance report for mothers and babies: reducing risk through audits and confidential enquiries across the UK (MBRACE UK). They also completed Serious Hazards of Transfusion (SHOT) reporting.

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 outpatients 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 staff.
- Staff at the smaller sites were trained and experienced in outpatient services across the trust before being asked to work at the remote centres.
- 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 infection control, education and practice placement, moving and handling, real time patient feedback. There were also dignity and dementia champions.

Manor Walks, Cramlington

- A staff nurse was completing a moving and handling facilitator's course so that they could roll out the training on site for other staff on an annual basis.

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 were 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, which, 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.

Outpatients and diagnostic imaging

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. An osteoporosis nurse specialist reviewed all fracture patients and alerted consultants with a coloured card attached to patient notes. A DEXA scan could be carried out on the same day as their follow up appointment.
- 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.
- 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.

Campus for Ageing and Vitality:

- Staff maintained strong links with Newcastle University and the Clinical Research Network. Research teams and therapists worked together with clinic staff as a multidisciplinary team and met regularly to discuss patient needs, progress and outcomes.

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 outpatients 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.
- Reception staff for the INR clinic had given patients questionnaires asking if they would prefer an evening or weekend appointment. Completed questionnaires had been collected but results were not collated at the time of our inspection.

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 access 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.

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.

Compassionate care

- Staff in outpatients 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.

Outpatients and diagnostic imaging

- We spoke with 54 patients and seven 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.
- Only one patient told us they felt a nurse had spoken to them abruptly on one occasion. This had happened when they attended clinic on the wrong day and were told they would have to return for their correct appointment time. However, we saw examples of staff showing compassion and a manager told us they had been asked if staff could book a taxi home for a patient who had attended the department on the wrong day by mistake. Nursing staff took action and ensured that the patient was seen by a doctor, given some lunch and was then taken home.
- Results from the national Friends and Family test showed that during July 2015, 94% of patients who attended RVI would recommend the trust to others (higher than the England average of 92%). The outpatients department carried out their own patient satisfaction survey and used feedback kiosks for patients to give their opinions. Results showed that 98% of patients who completed the survey at the RVI 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.
- We saw a nurse in the fracture clinic respond immediately when they noticed that a patient had attended the clinic from the ward and was cold. They brought a blanket and made sure the patient was comfortable. The department doors were open to aid mobility of patients attending from outside. Staff regularly monitored clinic area temperatures in winter to try to ensure patients were warm enough.

Campus for Ageing and Vitality:

- Results from the national Friends and Family test showed that during July 2015, 83% of patients who attended the Campus for Ageing and Vitality would recommend the trust to others (lower than the England average of 92%).
- The patient satisfaction survey undertaken by outpatient staff showed that 91% of patients at the Campus for Ageing and Vitality had experienced kindness and compassion by staff.

Understanding and involvement of patients and those close to them

- Patients received an appointment confirmation letter and all relevant patient information specific to their appointment for both NHS e-booking and paper GP referrals.
- Patients told us they were involved in their treatment and care. Those close to patients said nursing and medical staff kept them informed and involved. All those we spoke with told us they knew why they were attending an appointment and agreed with their care and plans for future treatment.
- Outpatients and diagnostic imaging staff involved patients in their treatment and care. We saw staff explaining treatment and answering patients' questions.
- Staff told us they would invite families into the consulting room if possible, as long as the patient agreed.
- A patient's relative telephoned the department when they were on their way for an appointment to inform staff that the patient was agoraphobic and felt vulnerable. Staff arranged for a private and quiet consulting room to be made available on their arrival.

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 of for patients with additional needs.
- A manager told us they were very proud of their team and the care they offered to vulnerable people. Reception staff had been worried about an elderly patient who appeared to be coming in and out of the department. When staff enquired, it turned out they

were looking for their spouse. Staff checked their records to find that the patient's spouse had died. The patient told them they knew this but kept returning just in case they saw them there. Staff made them comfortable, gave them a hot drink and called the patient's relative. The patient had returned on other occasions and staff offered the same support each time.

Manor Walks, Cramlington:

- A patient was worried when the clinic was running late because she needed to buy bread before she went home. A member of staff had told them not to worry and went to the shop to buy the bread so that the patient did not have to leave the clinic.

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.
- Routine appointments were booked within acceptable timescales.
- 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 those 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.

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, for example, in breast and dermatology clinics.
- 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 pod system to transport specimens speedily direct to the labs and porters made regular hourly collections to clinics without pod facilities throughout the day.

Manor Walks, Cramlington

Outpatients and diagnostic imaging

- The service had been set up as a means to offer outpatient clinics for patients closer to their homes and within their own community. It was based 10 miles from the city centre, in a popular shopping centre. There were 15 consulting rooms over two levels and x- ray facilities were due to open once staffing was established.
- Pathology specimens were collected daily and there were plans in place to increase the frequency of collections as clinics became busier.

Access and flow

- The trust held 2,700 outpatient clinics each week across all sites.
- The previous 12 months' appointments showed the RVI outpatient departments booked 1,454,375 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.
- Many more patients than expected had used the "NHS Choose and Book" option to request an appointment at the RVI. Outpatient staff and managers recognised that capacity was at its maximum. Managers met regularly to check performance against these targets and could add waiting list initiative lists to deal with increased demand. They had arranged additional sessions for neurosurgery, pain management and one-stop breast clinics.
- 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 dipped in the second half of 2014 but rapidly improved by the end of the year and for 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.
- The percentage of patients waiting for over 30 minutes to see a clinician in outpatients was 9.3%. We heard staff tell patients about delays and the reasons for them. Following negative feedback from the most recent patient survey, staff had been asked to write delay times on whiteboards but these were seen to be unclear and patients told us they had not seen them.
- Outpatient staff did not have a waiting time escalation procedure to follow in the event of clinics running late. They had audited patient waits from the time patients booked in at reception until a doctor saw them. Out of 1,643 clinics audited, 147 had experienced delays, which amounted to 8.95% of clinics. This was similar to the figure submitted to the inspection 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 was 29.7% and the best rate was 50.2% in May 2015. Between April and September 2015 an average of 54.2% of inpatient, 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 across the trust, 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

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.
- 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.
- 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.
- There was bariatric furniture and equipment available in several departments including the new centre at Manor Walks, Cramlington (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 supported people living with dementia and had completed the trust-training programme. 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.
- The bookings teams organised face-to-face interpreter services for first appointments for patients who did not speak or understand English. They could use a language line service for subsequent appointments. Staff did not allow family members to act as interpreters, thus upholding the trust interpreting policy.

Campus for Ageing and Vitality:

- Staff had set a meeting room aside for use as a quiet room by patients with learning disabilities who needed somewhere they felt safe to wait when attending the epilepsy clinic.

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. During our inspection, clinic staff had addressed a verbal complaint before the patient had time to explain their concern to the PALS team.
- Staff understood the local complaints procedure and were confident in dealing with concerns and complaints as they arose. Managers and staff told us they discussed complaints, comments, and concerns at local team meetings, agreed actions, and shared any learning throughout the team. 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.

Outpatients and diagnostic imaging

- 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 some 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.
- Pathology staff had identified the need for a new pod system. This was an aspiration and staff were concerned that without a better system they may be unable to meet turnaround times when the new key performance indicator targets came into place in April 2015.

Manor Walks, Cramlington

- X-ray services were due to open at this facility and staff had discussed the opportunity to offer GP x-ray services from the site in future.

Diagnostic imaging:

- Radiology staff had produced a trust wide overarching imaging strategy for the future delivery of diagnostic 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.
- The breast screening service was moving to a large commercial outlet in Newcastle City Centre. This was planned to enable services to be used within the trust for diagnostic purposes. The project was ongoing but due to go live in March 2016.
- An MRI guided breast biopsy service had commenced with a digital service established in both West Cumbria and Carlisle.
- 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.
- 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 teams, 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 staff from all sites 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 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.

Campus for Ageing and Vitality:

- The administration team had received a personal touch award in 2015 for their work with patients and had been encouraged to work towards a Bright Ideas Award for service improvement. This project was well underway at the time of our inspection and staff had contributed ideas for changing systems and processes to improve their ability to meet patient needs.

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.
- Eye Clinic Liaison service staff had won a Healthwatch Award in October 2015 for their work with the charity Action for Blind people. This provided an improved link between medical and social care teams and studies carried out by staff had shown that there had been a reduction in patient falls and consultations.
- 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.
- The dermatology department provided a melanoma-screening clinic where patients were seen, lesions photographed, biopsies taken and given a follow up appointment for a week later. Patient numbers were rising annually and 400 patients had been treated in 2015. The department had attained "Centre of Excellence" status for its Mohs surgery (named after its creator Dr Frederick Mohs, a precise surgical technique used to treat skin cancer, taking away tissue layer by layer until a cancer free area is exposed). The department provided regular Mohs fellows training for visiting clinicians.

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.
- 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 tumours and sentinel node identification. One example was the training in use of Iodine 125 seeds a new procedure being trialled. Staff told us they were the only trust in the country undertaking this type of procedure. Nuclear

medicine and radiology staff worked in conjunction with breast screening, pathology and surgery teams to implant the radioactive seed to locate breast tumours. An audit was taking place at the time of our inspection and results showed that out of 58 patients who had undergone the procedure only seven-needed further surgery, which was less than if wires that are more traditional were used. Three national and three regional presentations had taken place and training workshops were planned for February 2016.

- 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 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 SPECT CT Scanner had been installed in the medical physics department on the RVI site and we saw staff testing the equipment to ensure safety before use with patients. The scanner combined SPECT (Single Photon Emission Computed Tomography) and CT (computerised tomography) scanning. The scanner produced integrated images for diagnosis, and to help plan complex radiotherapy treatments.

Outstanding practice and areas for improvement

Outstanding practice

- The home ventilation service delivered care to around 500 patients in their own home. The service led the way for patients who needed total management of their respiratory failure at home with carers. The team offered diagnostics, extensive training and patient support. The team had written the national curriculum for specialist consultant training. The domiciliary visits covered the whole of the North of England, up to the Scottish border, west coast and Teesside.
- The liaison team from the bone marrow transplant unit had developed an open access pathway so post-transplant patients could access urgent care quickly and safely. Children and young people presented their unique passport upon arrival in A&E, which included all information pertaining to their condition and any ongoing treatment. The team had worked with other trusts across the country, as many patients lived outside of the local area, to ensure a smooth transition. Feedback from families about the passport was very positive
- The Allied Health Professionals (AHP) Specialist Palliative Care Service was a four-year project currently funded by Macmillan, which embedded AHPs into the existing Acute Specialist Palliative Care Service. The primary outcomes being to improve patient experience, manage symptoms, maximise, and increase well-being and quality of life.
- There was an integrated model where palliative specialists joined the cystic fibrosis team to provide palliative care in parallel with standard care. All patients with advanced disease including those on the transplant waiting lists were seen by specialist palliative care.
- The trust had an Older Peoples Medicine Specialist Nurse led in-reach service into emergency the department. In addition, there was an Elderly Assessment Team at weekends in the emergency department, which included a social worker and specialist nurse.
- The critical care pressure ulcer surveillance and prevention group had developed a critical care dashboard for pressure ulcer incidence. A new pressure ulcer assessment tool was developed and implemented this had led to a major reduction in pressure injury.
- The Newcastle Breast Centre was at the forefront of treating breast cancer. The trust was the first unit in the UK to offer'iodine seed localisation' in breast conservation surgery. Many breast cancer patients were given the chance totake partin national and international breast cancer treatment trials, as well as reconstruction studies.
- In cardiology, the service had developed a new pathway for patients requiring urgent cardiac pacing. This developed a 24/7 consultant led service and reduced patients length of stay.
- Eye clinic liaison staff had worked with the Action for Blind people charity to improve links between medical and social care teas. Studies showed that there had been a reduction in patient falls and consultations

Areas for improvement

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

- 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.
- Continue to develop plans to ensure that staffing levels in the neonatal unit meet the British Association of Perinatal Medicine guidelines.

Outstanding practice and areas for improvement

- 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.
- Continue to develop processes to improve compliance for patients to receive antibiotics within one hour of sepsis identification.
- Ensure that Emergency Care Department display boards in waiting rooms are updated regularly and accurately reflect the current patient waiting times.
- Ensure that the departmental risk register in the Emergency Care Department and End of Life Care accurately reflects the current clinical and non-clinical risks faced by the directorates.
- 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 the maternity service implement the maternity dashboard, with appropriate thresholds to measure clinical performance and governance.
- 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.

This section is primarily information for the provider

Requirement notices

Action we have told the provider to take

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

Regulated activity	Regulation
Treatment of disease, disorder or injury	Regulation 17 HSCA (RA) Regulations 2014 Good governance Systems or processes must be established and operated effectively to : (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.

This section is primarily information for the provider

Enforcement actions

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.

This section is primarily information for the provider

Enforcement actions (s.29A Warning notice)

Action we have told the provider to take

The table below shows why there is a need for significant improvements in the quality of healthcare. The provider must send CQC a report that says what action they are going to take to make the significant improvements.

Why there is a need for significant improvements	Where these improvements need to happen
Start here...	Start here...