

County Durham and Darlington NHS Foundation Trust

Quality Report

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

Ratings

Overall rating for this trust

Requires improvement



Are services at this trust safe?

Requires improvement



Are services at this trust effective?

Requires improvement



Are services at this trust caring?

Good



Are services at this trust responsive?

Good



Are services at this trust well-led?

Requires improvement



Summary of findings

Letter from the Chief Inspector of Hospitals

We inspected County Durham and Darlington NHS Foundation Trust from 3–6 February 2015 and 27 February and undertook an unannounced inspection on 25 February 2015. We carried out this comprehensive inspection as part of the Care Quality Commission (CQC) comprehensive inspection programme.

The trust had an evolving executive team. The Chief Executive was previously the Finance Director and Chief Operating Officer, and was appointed in 2012. The Chief Nurse was leaving the trust in April 2015. The Chair had been in post since 2007 and was stepping down in February 2015 with a newly appointed Chair taking up post shortly after. There was a Chief Operating Officer starting in post in February 2015 and this role was a new development.

We inspected the following core services:

- The University Hospital of North Durham – urgent and emergency care, medical care, surgical care, critical care, maternity care, children's and young people's services, end of life care, outpatient services and diagnostic imaging.
- Darlington Memorial Hospital – urgent and emergency care, medical care, surgical care, critical care, maternity care, children's and young people's services, outpatient services and diagnostic imaging.
- Community health services, including:
 - Community health inpatient services
 - Community adult and long-term conditions
 - Community end of life care
 - Community health services for children, young people and families
 - Urgent care centres
 - Dental Services.

Overall, the trust was rated as 'Requires Improvement'. Safety, effectiveness and well-led were rated as required improvement; caring and responsive were rated as good.

Our key findings were as follows:

- Across both the acute hospitals and in the community, arrangements were in place to manage and monitor the prevention and control of infection, with a dedicated team to support staff and ensure policies and procedures were implemented. We found that

most areas we visited were clean. Rates of Methicillin-resistant staphylococcus aureus (MRSA) and Clostridium difficile (C. difficile) were within an acceptable range for the size of the trust.

- Patients were able to access suitable nutrition and hydration, including special diets, and they reported that, on the whole, they were content with the quality and quantity of food.
- There were processes for implementing and monitoring the use of evidence-based guidelines and standards to meet patients' care needs, both in hospitals and across community services.
- There was effective communication and collaboration between multidisciplinary teams.
- There were staff shortages, particularly on some medical wards and in maternity and gynaecology, mainly due to vacancies for nursing and medical staff. The trust was actively recruiting following a review of nursing establishments. In the meantime, bank, agency and locum staff were being used to make up for any deficits in staff numbers and staff were working flexibly, including undertaking overtime.
- The emergency department at Durham did not have a paediatric trained nurse on all shifts
- Mortality rates were within acceptable limits for a trust of this size, and processes for reviewing morbidity and mortality had been established and were evolving to include the core service teams. There was a weekly review of morbidity and mortality by a senior group of Clinicians and this informed the Mortality Committee.
- Equipment was well maintained, both in the hospitals and in community services.
- Incidents were reported and lessons were learnt and disseminated.
- A small proportion of community staff reported that there was no clear vision or strategy for community services, although there was a clinical strategy that was still being developed at the time of inspection.
- Care and treatment was delivered with compassion, and patients reported that they felt they were treated with dignity and respect.

Summary of findings

- Staff did not always feel engaged with the development of their services. The contract for a number of community services was due to be re-tendered, but staff reported not being engaged with this process.
- There was evidence to demonstrate that there were differences between the acute hospital sites with regard to clinical practice and leadership; these differences were seen in areas including the provision of non-invasive ventilation services and maternity services.
- There were inconsistencies in the provision of pharmacy support in hospitals and community services.
- There was inconsistent access to therapy services in the community.
- Governance processes were not fully embedded across all parts of the organisation.

We saw several areas of good practice including:

- An exceptionally caring critical care service in Darlington, where inspectors observed individualised care and attention to detail given to patients and relatives. This was shown by the trust's work with the end of life team, its visitor's charter, care of patients with learning disabilities, and implementation and consideration of the deprivation of liberty safeguards (DoLS). In addition, memory bands were used for patients and their relatives.
- Safety huddles had been implemented on the wards at the University Hospital of North Durham.
- There was consistently positive feedback from patients and relatives about community nursing teams, with care being described as 'excellent'.
- The dietetics team was committed to improving nutrition, with the work it had undertaken being published and shared nationally.
- The County Durham Rapid Early Specialist Team (CREST) service provided early senior and multidisciplinary assessment for frail older people, which facilitated safe, early, supported discharge, and managed patients with an anticipated short length of stay.
- There was a family nurse partnership established to provide intensive support for teenage mothers.
- Staff in the CT department had received 'Making a difference' award in February 2014.
- Staff on ward 52 had recently been awarded the 'Quality mark for elder-friendly hospital wards'.

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

Importantly the trust must:

- Review current governance processes to ensure they are embedded to ensure consistency across acute and community services.
- Review and ensure that all members of the board are fully aware of their lead responsibilities within the Board Assurance Framework.
- Review the achievements and actions taken to address national targets within the accident and emergency departments (A&E).
- Review consultant levels against CEM guidance.
- Ensure the A&E departments meet cleanliness, infection control and hygiene standards, particularly relating to high and low level dust, blood stains, equipment and floors. Chairs and equipment that have deteriorated must be removed and replaced.
- Ensure all toys are cleaned properly to reduce the risk of infection within the A&E department.
- Ensure sharps bins are managed appropriately to reduce the risk of needle stick injury within the A&E department.
- Ensure that all resuscitation drugs and equipment within the A&E department are regularly checked, cleaned and in date. This should include all grab bags and anaphylaxis kits.
- Ensure that all relevant staff know where the Difficult Airway Kit is kept.
- Ensure there are robust risk assessments in place for the paediatric environment within the A&E department. These must be readily accessible and available to all staff in the department. Risk mitigation must be outlined and an action plan to improve the area must be written.
- Ensure that there are sufficient numbers of suitably skilled, qualified and experienced staff, in line with best practice and national guidance and taking into account patients' dependency levels on medical wards, particularly where patients are receiving non-invasive ventilation (NIV) and require level 2 intervention.

Summary of findings

- Undertake a review of current documentation relating to the care and management of patients receiving NIV to ensure that it is consistent across both the University Hospital of North Durham and Darlington Memorial Hospital.
 - Have arrangements in place for patients receiving NIV that comply with the British Thoracic Society guidelines (2008) for the use of NIV for acute exacerbation of chronic obstructive pulmonary disease.
 - Undertake a regular audit of the provision of services to patients requiring NIV to ensure that the service is safe and of appropriate quality.
 - Ensure that patients are placed on the most appropriate ward to meet their needs, including a review of the care of patients requiring NIV to ensure that they are admitted to a suitable ward with appropriately skilled and experienced staff in line with best practice guidance.
 - Ensure that patient records, including those for patients awaiting discharge, are kept up to date, are patient-centred and contain relevant information about their treatment and care, in order to eliminate unnecessary delays.
 - Ensure that the trust undertakes a review of the skills, knowledge and capabilities of nurses to complete accurate and timely care plans that meet the needs of the patients.
 - Establish a consistent approach to critical care outreach services across the organisation.
 - Ensure that at all times there are sufficient numbers of suitably qualified, skilled and experienced medical staff within maternity and gynaecology services.
 - Ensure that there are processes in place by which to identify, acknowledge and address risks through robust management processes within maternity and gynaecology services.
 - Ensure the paediatric high dependency unit room has specific standard operating procedures or protocols available to guide suitably trained staff.
 - Ensure advanced paediatric nurse practitioners have a set of standard operating procedures available to guide their practice and care.
 - Review paediatric nurse cover in the A&E department at Durham to ensure all shifts are covered with a paediatric nurse either through service level agreement with the paediatric department or through the appointment of paediatric nurses to the department, to ensure a consistent approach across the organisation.
 - Ensure that staff know the syringe driver policy and carry out/record syringe driver checks in line with this policy.
 - Add audits of syringe driver administration safety checks to the annual end of life audit programme.
 - Ensure medical staff record mental capacity assessments for patients who are unable to participate in decisions about 'do not attempt cardiopulmonary resuscitation' (DNACPR).
 - Ensure audits of mental capacity assessments are incorporated into audits of DNACPR forms.
 - Ensure robust implementation of structural changes to the specialist palliative care team to support the development of the end of life care services.
 - Ensure data are available to identify and demonstrate the effectiveness of the end of life service.
 - Ensure that all resuscitation equipment is checked daily and stored securely, and introduce a monitoring system to ensure that checks take place within the outpatient departments.
 - Address the lack of consultant medical staff cover in end of life community services.
 - Develop access to out-of-hours advice for healthcare professionals caring for palliative and end of life patients within community.
 - Ensure there is effective leadership and management in place to maintain and develop the community end of life service.
- In addition the trust should:
- Continue to review College of Emergency Medicine (CEM) audit data to ensure patient outcomes are met.
 - Review the complaint process in terms of board oversight, CEO involvement and clinical direction.
 - Direct medical staff to check resuscitation equipment and drugs before the start of their shift even when nursing staff have completed the checks.
 - Encourage all relevant staff within the A&E department to attend violence and aggression training.
 - Ensure patients have their medicines reconciled in accordance with trust targets.
 - Review access to patient information in languages other than English.

Summary of findings

- Review dedicated management time allocated to ward managers.
- Review the patient flow of higher dependency patients throughout the hospital to ensure care is given in the most appropriate setting.
- Have an up-to-date standard operating procedure (SOP) for both acute hospitals which clearly sets out the management of admitted patients who require NIV.
- Ensure that this guidance/SOP includes clarity on the setting/specific ward in which patients can be managed.
- Ensure that this guidance/SOP includes staffing-to-patient ratios that are in line with current guidance.
- Ensure that there is a training plan in place, which is delivered to all staff involved in the care of patients receiving NIV, and that it is competency based and in sufficient detail to demonstrate competence in all aspects of NIV.
- Ensure that any guidance/SOP includes an escalation plan that includes action to be taken when a bed is unavailable in an appropriate setting and when patient numbers do not match agreed staffing ratios.
- Ensure that the intensive care unit has an outreach team to identify and monitor deteriorating patients.
- Ensure that there is clinical pharmacist input in the intensive care units on both sites in line with 'Core standards for intensive care' guidelines.
- Consider ways of improving engagement between staff and managers within the care closer to home directorate with a view to achieving a joined up approach within maternity and gynaecology services. Also, consider ways of improving responsiveness and efficiency in respect to service-level decisions within this service.
- Consider ways in which it can identify the required standards within the maternity service dashboard.
- Consider, within the maternity and gynaecology services clinical and quality strategy for 2014–16, timelines for review and achievement.
- Consider ways of developing a coherent plan for joint working on improvements in maternity and gynaecology services.
- Consider ways for improving timely and responsive human resource management processes, including personnel issues that impact on service delivery in maternity and gynaecology services.
- Formally nominate an executive or non-executive director to represent children at board level, separate from the safeguarding children executive lead role.
- Ensure actions in response to the National Care of the Dying Audit (NCDAH), and other identified actions to develop the service, are carried out in a planned and timely way with continued evaluation.
- Ensure systems support ways of identifying when incidents and complaints relate to end of life care so that specialist input can be provided and recorded in terms of investigation and learning.
- Ensure that any out of date medication is removed from stock cupboards once it has expired, in line with the trust medication management policy, and have a process for monitoring this within the outpatient departments.
- Ensure that all fridge temperatures are checked daily and that there is a system in place to monitor checks taking place within the outpatient departments. The trust should ensure that the cold chain is robust.
- Ensure that all clinicians within children and young people's community services have the appropriate level of children's safeguarding training.
- Improve audit activity to monitor quality and patient outcomes within the urgent care centres.
- Review staffing at night within the urgent care centres.
- Review the need for paediatric-trained nurses in the urgent care centres.

Professor Sir Mike Richards
Chief Inspector of Hospitals

Summary of findings

Background to County Durham and Darlington NHS Foundation Trust

County Durham and Darlington NHS Foundation Trust had been a foundation trust since 1 February 2007. In 2011 the trust integrated with community services. The organisation had approximately 7,555 whole time equivalent staff and had 1331 beds. It had a budget of £487 million and was forecasting a deficit of £8.7 million in 2015, but the trust had a forecasted cash balance of £67 million and therefore would keep a 'continuity of services risk rating' of three because of this liquidity position.

The trust was one of the largest hospital and community healthcare providers in the NHS, serving a population of approximately 600,000 people across County Durham, Darlington, North Yorkshire, the Tees Valley and South Tyneside. There were significant levels of deprivation, with Darlington being ranked 75 and County Durham 62 out of 326 local authorities, which indicates high levels of deprivation in these areas. County Durham had high levels of health deprivation with 71% of the population being classed by the Department of Health as being within the most deprived nationally. Deaths from smoking and early deaths from cancer and heart disease were higher than the England average. There were higher than average levels of obesity.

The trust had two main hospital sites: The University Hospital of North Durham and Darlington Memorial Hospital. Both hospitals provided a range of services. Between 2013 and 2014 the trust had 121,346 inpatient admissions, 874,623 outpatient attendances and 126,239 A&E attendances split between the two locations. There had been 2,711 births between April and September 2014.

Midwifery-led services at Bishop Auckland had closed due to safety concerns and maternity services were provided from the two main hospital sites. The core issue was the need to ensure that women developing complications in labour and needing medical intervention could be seen within national standards. Due to the location of the hospital and the time required for ambulances to reach the unit and/or transfer patients to Darlington Memorial Hospital, this could not be guaranteed.

As an integrated healthcare provider, County Durham and Darlington Trust provided community healthcare services for the population of County Durham and Darlington. The trust had a network of five community hospitals. Community services were delivered from a wide range of clinics and operating bases across the area.

Bishop Auckland Hospital had a 24 inpatient bedded ward that is dedicated to rehab of patients similar to the community hospitals and had been developed as a nurse-led step down ward for admissions from the acute sites for patients who had reached their optimum rehabilitation potential and were awaiting long-term care placements, as well as orthopaedic patients who were non-weight bearing and unable to return home.

Chester-le-Street Community Hospital had 23 inpatient beds with care led by consultants from The University Hospital of North Durham and Shotley Bridge Community Hospital. Out-of-hours medical cover was provided by the local GP out-of-hours service. Nursing care was led by the community matron. The services predominantly provided rehabilitation care with some palliative and respite care.

Richardson Community Hospital had two wards with 17 beds on each plus capacity for an additional 10 patients if winter pressures arose. It predominantly provided rehabilitation, step-down care for mainly elderly patients and some palliative care. The service was nurse-led with medical cover from the local GP practice.

Sedgefield Community Hospital had 26 beds (reduced at the time of our inspection to 22 due to staffing levels) and predominantly provided rehabilitation for orthopaedic trauma and stroke, and neurological rehabilitation support. This was a nurse-led unit with a locum staff grade doctor, and a palliative care specialist GP who attended once a week.

Shotley Bridge hospital provided 24 inpatient beds with care led by consultants from The University Hospital of North Durham and Chester-le-Street Community Hospital. Out-of-hours medical cover was accessed via

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the medical admissions unit at The University Hospital of North Durham or via triage over the telephone. It predominantly provided rehabilitation care including stroke and medical rehabilitation.

Weardale Community Hospital had 20 inpatient beds. The hospital was remotely situated and relied on the local GP surgery for medical cover, which was available four-and-a-half days a week. A consultant in elderly medicine visited from the acute site once every two weeks. The hospital provided step-down care and took admissions from The University Hospital of North Durham, Darlington Memorial Hospital and Bishop Auckland Hospital. Some patients were admitted directly from the A&E department or from acute wards for rehabilitation.

At Bishop Auckland Hospital there was an urgent care centre that opened 24 hours a day, 365 days per year and provided immediate care for minor injuries and ailments. There was an x-ray department on site, which provided CT scanning and x-rays from 9am to 9pm on weekdays and 9am to 5pm at weekends. There were approximately 1200 patient attendances per week, about one third of which were 111 referrals and two thirds of which were 'walk-ins'. The total number of attendances for the previous 10 months was 111,719.

At Seaham Primary Care Centre there was an urgent care centre which operated as a satellite site to Peterlee Urgent Care Centre. The centre was open from 8am to 6pm every day. The total number of attendances for the previous 10 months was 19,000.

At Peterlee there was an urgent care centre which operated 24 hours a day, 365 days per year and provided immediate care for minor injuries and illnesses. There was an x-ray department on site that provided ultrasound and x-ray services from 9am to 5pm on weekdays. Medical cover was provided by GPs. The building and other departments on the site belonged to North Tees and Hartlepool NHS Trust. Ten per cent of attendances were pre-booked by the 111 service and the remaining 90% were people walking in for care. The total number of attendances for the previous 10 months was 94,000.

At Shotley Bridge Community Hospital there was an urgent care centre which had recently undergone changes in commissioning following patient consultation to reduce the service to a minor injuries unit. The centre was open 24 hours a day and was led by advanced nurse practitioners with GP cover at night and weekends. The total number of attendances for the previous 10 months was 63,000.

Our inspection team

Our inspection team was led by:

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

Head of Hospital Inspections: Amanda Stanford, Head of Hospital Inspection, North East & Cumbria

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

How we carried out this inspection

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

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

- Is it well-led?

The inspection team inspected the following eight core services at the University Hospital of North Durham and Darlington Memorial Hospital:

- Urgent and emergency care
- Medical care (including older people's care)

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- Surgery
- Critical care
- Maternity and family planning
- Services for children and young people
- End of life care
- Outpatients and diagnostics.

At Bishop Auckland Hospital we inspected:

- Outpatients
- Surgery.

The community health services were also inspected for the following core services:

- Community end of life
- Urgent care centres
- Community health services for children, young people and families
- Community inpatient.

Before the announced inspection, we reviewed a range of information that we held and asked other

organisations to share what they knew about the hospitals. 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 and the local Healthwatch.

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

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

We carried out the announced inspection visit on 3–6 February 2015 and on 27 February at Bishop Auckland Hospital. We undertook an unannounced inspection on 25 February 2015.

What people who use the trust's services say

In the CQC in patient survey 2013 the trust was rated the same as other trusts in all areas of questioning, with scores increasing in most areas from 2012.

The Family and Friends Test response rate was 35% against an England Average of 31%. In most of the core services we inspected results from this test were positive, with patients stating that they would recommend this trust.

In the Cancer Patient Experience survey the trust was rated in the bottom 20% of all trusts that participated, in

the areas of always/nearly always enough nurses on duty, help to control pain, always treated with dignity and respect, and involved in decisions about care and treatment. The trust was in the top 20% of trusts for being given enough information from health and social services. A recent patient-led assessment of the care environment (PLACE) rated the hospitals as achieving over 90% compliance in all of the four areas of: cleanliness, food, privacy/dignity and wellbeing and condition/appearance and maintenance.

Facts and data about this trust

One of the largest hospital and community healthcare providers in the NHS, County Durham and Darlington

Summary of findings

NHS Foundation Trust served around 600,000 people across County Durham, Darlington, North Yorkshire, the Tees Valley and South Tyneside. Services included health and wellbeing services, community-based services and acute and planned hospital services.

The trust had 1,116 beds of which 1,029 were general and acute beds, 67 were maternity beds and 20 were critical care beds. The trust employed 7,555 staff across acute and community services.

Inpatient activity at this trust was 121,346, with A&E attendances being 126,239, split between Darlington Memorial Hospital and the University Hospital of North Durham. In 2014 there were a total of 584,498 outpatient appointments across the trust as a whole, split between Darlington Memorial Hospital (193,283), University


Hospital of North Durham (217,511) and Bishop Auckland Hospital. The number of outpatient attendances between April 2013 and March 2014 for paediatric medicine was 4,764.

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

There was a higher number of children in poverty than the England average and there was higher prevalence of obesity in children.

Summary of findings

Our judgements about each of our five key questions

	Rating
<p>Are services at this trust safe?</p> <p>There were systems and processes in place to promote a safety culture within the organisation. However, these were not fully embedded within the trust and there were areas where improvements were required, particularly around staffing levels in some areas, monitoring arrangements in some areas, arrangements for dealing with some medication and care planning.</p> <p>There were robust reporting arrangements for incidents across the organisation through the 'Safeguard' system, with staff articulating how incidents were disseminated and lessons learnt. There was an open culture to reporting incidents across the organisation, with staff saying that they were encouraged to report incidents.</p> <p>Patients' records and observations were mostly recorded appropriately and concerns were escalated in accordance with the trust's guidance. However, across the trust we found examples of patient care records that were not fully completed or kept up to date. We also found that supportive documentation on some wards across the trust, such as fluid balance charts and risk assessments, was not consistently completed in all cases. We found during the unannounced inspection that care planning was not robust and this was reflected in the ward documentation audits.</p> <p>All wards used an early warning scoring system for the management of deteriorating patients. There were clear directions for escalation printed on the observation charts and staff were aware of the appropriate action to be taken if patients scored higher than expected.</p> <p>Pharmacy support to wards and community services was inconsistent, although the Chief Pharmacist was fully aware of the gaps in service and informed us that a business case was in development to address gaps in provision to critical care.</p> <p>There were arrangements in place to manage and monitor the prevention and control of infection. However, in the A&E departments there was particular concern about the standards of cleanliness and the monitoring arrangements for infection control and cleanliness.</p> <p>A recent patient-led assessment of the care environment (PLACE) rated the hospital as achieving over 90% compliance in all of the four areas of: cleanliness, food, privacy/dignity and wellbeing, and condition/appearance and maintenance.</p>	<p>Requires improvement</p> 

Summary of findings

In Darlington Memorial Hospital the theatre complex was not always secure and it was possible for patients to enter theatre areas without being challenged. Information provided by the trust indicated that when the reception is closed, the room behind this area is also closed and therefore not accessible to patients.

The high dependency unit stabilisation room at Darlington Memorial Hospital was in the early stages of development and was not supported by enough suitably trained staff. Use of the room was not supported by standard operating procedures to guide staff on the management of children requiring high dependency care.

The children's section of the emergency departments used specially trained advanced paediatric nurse practitioners (APNPs) to assess and manage a child's initial care. However, the APNPs had no protocols or standard operating procedures to guide them on processes they should follow to assess, manage, treat and discharge children.

There were no protocols or standard operating procedures available for staff members who cared for children requiring high dependency care or stabilisation on the ward prior to transfer.

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

Wards at the University Hospital of North Durham undertook 'safety huddles' at the beginning of each shift. Staff told us this enabled them to communicate more effectively and raised awareness of safety issues. However, at the senior nurse focus groups, matrons informed us that this practice had not been rolled out across the organisation.

The trust had business continuity plans and major incident plans in place and staff were able to articulate these.

Some services also used an electronic records system called SystmOne, which staff in the community and in GP practices could access. This meant that information could be shared between healthcare professionals more easily.

Duty of candour

Many staff were aware of the 'Duty of Candour' and their responsibility to involve patients and families when incidents

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resulted in moderate harm or above. An example of this was that staff on the coronary care unit were able to tell us about a recent fall resulting in a fracture, and how the patient and his family had been involved. However, there were a number of staff in community who could not articulate the requirements of Duty of Candour.

Safeguarding

Staff told us they were aware of their responsibilities to protect vulnerable adults and children and described the processes to follow. They were able to describe action they would take if they had any safeguarding concerns for either children or adults.

Staff were aware that the trust had safeguarding policies and a safeguarding team they could contact for advice and support if they had any concerns.

The Chief Nurse was the accountable officer for safeguarding in the trust. The Chief Nurse was supported by an Associate Director of Nursing who was the corporate lead for safeguarding and managed the adult safeguarding lead. Other members of the safeguarding team, which was managed by the Head of Children and Families in the Care Closer to Home care group, included a named doctor, a named midwife and a specialist midwife for safeguarding children.

There had been five serious case reviews. The safeguarding team told us this had an impact on the capacity of the team because team members needed to do work in their own time. However, as these case reviews were in the planning stage at the time of the inspection, we were unable to see how the reporting mechanisms worked, although we were supplied with evidence that, in the past, the board had been supplied with details of the results of serious case reviews when the review process had been completed and had been notified of lessons learned. If these case reviews had not been at the planning stage, we would have sought evidence that the board were aware of brief details of these cases, and that it had sought assurance that recurrence was mitigated, and that it monitored progress.

Initial health assessments for Looked After Children were not completed in timescales (the numbers were low). This had been recorded recently on the risk register. Looked After Children were not in the trust's annual safeguarding report. Looked After Children reports were reviewed and discussed at the Safeguarding Group which, in turn, reported into the Quality and Healthcare Governance Committee. Nonetheless we were concerned that, as Looked After Children are some of the most vulnerable children, this approach might result in delays which may, in turn, mean that their health needs were not met.

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The trust informed us that a more robust risk assessment form was under development for safeguarding children with improvements planned such as reception staff asking more questions of patients. They told us that further development was required to fully implement all of the recommendations and a 'task and finish' group, led by paediatrics, was in place in order to complete the changes required.

Safeguarding children training was part of the mandatory training programme. Seventy-nine per cent of medical and nursing staff had completed level one safeguarding training. We read the trust's safeguarding training record, which showed that relevant staff members received level two safeguarding training. Senior nursing staff and doctors received level three safeguarding training.

Since September 2014 it had been mandatory for all acute trusts to provide a monthly report to the Department of Health on the number of patients who had had female genital mutilation or who had a family history of female genital mutilation. In addition, where female genital mutilation was identified in an NHS patient, it was now mandatory to record this in the patient's health record. The monthly report to the Department of Health was to be anonymous and no personal confidential data was to be shared as a result of the information collection. The inspection team identified that no formal reporting process had been set up and staff were not all aware of the requirements.

Infection prevention and control

Overall there were processes in place for the management of infection prevention and control with a dedicated team. The Chief Nurse was the Director for Infection Prevention and Control.

The trust hand hygiene result for quarter two was 83%. This was below WHO "my 5 moments for hand hygiene" framework target of 100%, which the trust had adopted, but was an improvement on the previous quarter (78%). Wards 3 and 5 at University Hospital of North Durham had the poorest compliance. Hand hygiene training was reported to be 93%.

The trust reported four cases of MRSA between March 2013 and September 2014. Incidences of *C. difficile* were consistently lower than the England average for the period March 2013 to September 2014.

Infection and prevention control performance was reported through the integrated governance reports for each division. We saw evidence of infection control audits being undertaken and action plans being put into place to ensure that any areas of non-compliance were addressed. In medicine we saw that monthly

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infection control audits were undertaken with regard to hand hygiene, the environment and high impact interventions, such as insertion of central venous catheters, peripheral intravenous catheters and urinary catheters. We saw that actions were planned and reviewed as a result of these audits.

We were particularly concerned about the infection prevention and control issues at both A&E departments. The inspection team found high and low level dust, blood staining around the blood gas machines, a commode soiled with blood, trolleys with visible blood staining stored in a staff room adjacent to a reception area, and dirty toys in the paediatric area. Although these issues were raised at the time of inspection the blood-stained trolleys were still present on the last day of inspection. We reviewed these issues during our unannounced inspection visit and found all equipment in the department was clean and free from dust and resuscitation medication was in date. However, there continued to be concerns about the monitoring processes.

In surgery the introduction of a housekeeper role to assist the teams and maintain cleanliness standards had been seen as a success and the trust was considering implementing the role in other areas within the hospital.

The dental service used a local hospital's central sterilising and decontamination unit for the processing of contaminated instruments after they had been used, for all sites. This system ensured that the service was meeting HTM 01 05 (guidelines for decontamination and infection control in primary dental care) best practice requirements for infection control.

Incidents

From April 2013 – May 2014 the trust reported two 'never events'. Never events are defined as 'serious, largely preventable patient safety incidents that should not occur if the available preventative measures have been implemented by healthcare providers'. One was a surgical never event and the second was reported as 'other'. There were 84 serious incidents reported through Strategic Executive Information System (STEIS) data which were mainly slips/trips and falls (25) and ambulance delays (23). Incidents reported through NRLS were 7,453; of these 107 resulted in serious or moderate harm, 11 resulted in death and the remaining 7,335 resulted in low or no harm. The trust had a better-than-England-average for the number of incidents: 5.9 per 100,000 admissions compared to 8.9 for the England average.

There were robust systems in place for reporting incidents through the 'Safeguard' system and staff were able to demonstrate how to

Summary of findings

use the system. Staff told us they were encouraged to report incidents and most received feedback on what had happened as a result. We saw the surgical never event had been fully investigated, identifying the root causes of the errors, contributory factors, lessons learnt, arrangements for sharing learning, and actions needed to prevent reoccurrence.

The NHS Safety Thermometer (a tool designed for frontline healthcare professionals to measure harm such as falls, blood clots, pressure ulcers, and urinary and catheter infections) was in use across both acute hospital sites. Safety Thermometer information was clearly displayed on boards on all wards and theatre areas visited.

Services across the organisation had processes in place to review incidents and disseminate learning, for example in children's services there was a SAGE (safeguarding, audit, governance and education) meeting held to review incidents and risks.

We saw root cause analyses being carried out in services in response to serious incidents and never events. For example, in 2014 the A&E department had reported 29 serious incidents to the STEIS. The highest number of serious incidents reported related to ambulance handover delays. Senior staff informed us that all serious incidents were investigated, a full root cause analysis was conducted and action plans were put in place as a result of the analysis.

The A&E department at Darlington had experienced 12 child deaths in 2014. It is acknowledged that these were child deaths that had occurred prior to arrival at the department. The multidisciplinary team attended case reviews organised by the paediatric rapid response team. The trust informed us that new procedures had been developed; for example, the lead consultant in charge of resuscitation would conduct debriefing sessions for staff after an event. This allowed for actions to be identified and acted upon.

In the intensive care unit data from the Safety Thermometer showed 100% compliance with harm-free care. The unit had had no pressure ulcers reported for more than two years. We observed one patient who had been on the unit for more than six months and had not experienced a pressure sore in that time.

There were areas of good practice, for example in the community dental service the dental nurses had been empowered to adopt a 'stop' approach, which meant that they could directly challenge clinicians if they saw that dentists were about to carry out any procedure that could result in patient harm. In adult community services a theme in relation to pressure ulcers had been identified

Summary of findings

within the reporting of incidents. As a result the trust's Tissue Viability Steering Group had facilitated the management of thematic reviews and actions in relation to pressure ulcer incidents and associated skin damage.

Staffing

Nurse staffing levels were established using the Safe Nursing Care tool with six-monthly reviews being carried out by the Chief Nurse. Following the latest review, nursing establishment increases had been agreed and approved by the board of directors.

Staffing levels, however, had fallen below nationally recognised levels, particularly in medicine, during the inspection week. At Darlington, ward 44 (the respiratory ward) had Registered Nurse to patient staffing ratios of between 1:9 and 1:10. The night shift planned ratio was 1:14 or 1:15. The ward manager was aware that the clinical need of patients suggested a ratio of 1:8 patients and 1:4 for NIV patients but was rarely able to achieve this due to unfilled vacancies. Ward 1 at Durham, a 40-bedded respiratory ward, had two trained staff rostered on night duty routinely, with a third trained nurse provided through the nurse bank or agency.

Midwifery staffing did not always meet the recommendations on staffing levels within 'Safer Childbirth' (Royal College of Obstetricians and Gynaecologists [RCOG] 2007). The trust reported that the midwife to patient ratio was better than the England average. For example, for March and July 2014 the ratio was 1:25 for the trust, against an average of 1:29 for England.

There was variation in the provision of paediatric nurses in the A&E departments, with Durham not having paediatric cover on all shifts. We found that there were three whole time equivalent (WTE) paediatric trained nurses.

In critical care at Durham there was no supernumerary sister or charge nurse to cover areas such as peak activity times, facilitating admissions and discharges, or coordinating nurse staffing on the unit. This was not in line with national Core Standards for Intensive Care Units 2013.

We reviewed the medical staffing skill mix compared to the England average. In the trust 38% of the medical workforce was consultants, which was the same as the England average. There was a higher proportion of junior doctors (24%) than the England average of 15%. There were gaps in medical staffing in the emergency departments; staffing was lower than the CEM recommends. Recommendations suggest a minimum of 10 consultants in each emergency department. The department at the University Hospital of North

Summary of findings

Durham had 4.5 WTE consultants and at Darlington Memorial Hospital there were 6.5 WTE. There were also a number of issues within the obstetrics team with regard to consultant staffing, which had impacted on the on-call rotas.

The radiology department was funded for 16 radiologist positions. The clinical lead radiologist and the management team told us that they had recently appointed a number of appropriately skilled consultant radiologists. Vacancies continued to be covered by long-term locums. At the time of our visit we were told there were 11 permanent radiologists employed either in full or part time positions, with five locum radiologists covering outstanding vacancies. Two further permanent appointments were made, one starting in April 2015 and the second in May 2015. Two other radiologists had been interviewed and plans were in place to secure these appointments at the time of inspection.

There were vacancies within the health visiting team, but we were informed that recruitment had taken place. The Head of Children and Families Services informed us that the trust was on track to recruit up to the new target of 179.5 health visitors by the end of the financial year. There were 168 in post at the time of our inspection. This also meant that there were high numbers of students and newly qualified health visitors in post.

One school nurse reported having a caseload of 2000 children; the nurse was therefore able to do very few home visits and had no capacity for one-to-one family support. The head of the service confirmed that school nursing was under pressure and this was partly due to having no national specification for the service.

Record keeping

At the time of our inspection we had concerns about the quality of care planning across the medical wards. We looked at 17 records during the unannounced inspection and 20 during the planned inspection. This showed care plans were not always complete and did not always state the care required. This meant the care that was delivered did not follow an agreed documented plan of care; a situation which may lead to inconsistency in care. However, documentation was under review and new integrated documentation was being implemented. Staff informed us that the new documentation was not always fit for purpose for their specific clinical areas and that it required further development.

In end of life care patients identified as being ill enough to die were cared for using guidance that had been developed by the Northern

Summary of findings

England Strategic Clinical Network, which had been created in June 2014. The guidance stated that regular assessments and daily reviews should be documented in medical and nursing notes. A review of 14 records showed that this was the case.

In community services healthcare teams completed electronic records using SystmOne. We observed 12 records and all were complete on the system and could be accessed by all healthcare professionals involved in patients' care.

In the community nursing patient-held records were kept in patients' homes. These were largely seen to be incomplete. Most noticeable was a lack of care planning and risk assessments. We were told, and observed, that some staff took out a print-out of the electronic records to use on visits. We found this placed the patient at additional risk. Some individuals were piloting mobile devices and in those cases the single record was clear, up to date and accurate. Community services policy is that the electronic record held on SystmOne represents the core record and should be relied upon.

Environment and equipment

At the University Hospital of North Durham outpatient department the inspection team noted that a number of trolleys that contained needles and drugs were not closed with security tags in place. In dermatology, for example, the trolley was located where patients could be left alone and could easily access the contents.

Within the orthopaedic department resuscitation equipment was stored in a cupboard with an Ambu bag which stated that it had expired in 2013.

We requested a copy of the latest radiation protection adviser report from the trust. This had been written in 2013. It contained a summary of key issues faced by the trust such as ageing x-ray equipment and gamma camera at Darlington Memorial Hospital, increased radiation incidents, failure of theatre staff to wear dosimeters, and lack of radiologist support, particularly at Bishop Auckland Hospital. The trust was aware of these issues and had a programme to improve compliance in place.

The dental service had a named radiation protection adviser, who was appointed to provide advice on complying with legal obligations under the Ionising Radiations Regulations 1999 (IRR 99) and Ionising Radiation (Medical Exposure) Regulations 2000 (IRMER 2000) radiation regulations. This included the periodic examination and testing of all radiation equipment, the risk assessment, contingency plans, staff training and the quality assurance programme.

Summary of findings

Medicines

There was no clinical pharmacist input to the intensive care unit daily multidisciplinary ward rounds at the University Hospital of North Durham. This was not in line with the national Core Standards for Intensive Care Units 2013. Pharmacy support was also variable in medicine and in community services, for example. There was no pharmacy support at Seaham Primary Care Centre and it was not clear who was responsible for checking practitioner competencies or carrying out medication checks and audits.

Trust-wide data from September 2014 showed that 58% of patients had their medicines reconciled with 26% seen within 24 hours. The trust target for medicine reconciliation was 90% by April 2015.

In the outpatient department at the University Hospital of North Durham we looked in the medication stock cupboards to check whether the drugs were being stored correctly and were in date. In one of the ophthalmology storage cupboards, we found three boxes of one drug that had expired in December 2014. In three other rooms, we found boxes of another drug that had expired in January 2015.

In community services at Seaham Primary Care Centre the drug fridge had not been checked on a regular basis, and a few checks in November and 17 days in December had been omitted. There was no indication that anyone in particular was taking responsibility for this. Staff knew that temperatures should be recorded but only had time to do this on some days.

In community services we saw that the trust had a transcription of drugs policy which was in line with the Nursing and Midwifery Council standards. This ensured that medication could be given safely in the absence of a new prescription based on two pieces of evidence currently on record, such as discharge letters, transfer letters or copying patient administration charts onto new charts to improve legibility.

The community specialist palliative care service used the palliative and end of life guidelines developed by the North of England Cancer Network for managing people's medicines for symptom control, pain management, nausea and other problems.

Managing anticipated risks

During the inspection, we reviewed the care and treatment of patients requiring non-invasive ventilation (NIV). The British Thoracic Society guidelines state that patients being initiated on NIV should be identified as requiring level two care and have increased nurse staffing levels that equate to a 1:2 nurse-to-patient ratio for the first

Summary of findings

24 hours. The staffing rotas we viewed did not meet this requirement. We asked staff if nurse staffing levels increased when patients were initiated on NIV and they confirmed that this did not happen. Staff told us that they could request extra staff when necessary and would cohort patients, if practical, to ensure that there was a dedicated nurse for the NIV patients. However, it was not possible to meet the recommended ratio of 1:2 in the first 24 hours of initiating NIV. There was no evidence of formal escalation plans to increase staffing levels when patients with NIV requirements were on the ward.

We were informed that staff had one-to-one training in NIV, given by an experienced staff member, and that there was an informal assessment of competence in the administration of NIV. The ward manager held her own record of staff assessed as competent and entered this onto the electronic rostering system (MAPS – Manpower Analysis and Planning System) to ensure there were always appropriately skilled members of staff on duty. Staff also received training for taking capillary blood gas samples.

As noted above, in radiology we requested a copy of the latest radiation protection adviser report from the trust. This had been written in 2013. It contained a summary of key issues faced by the trust such as ageing x-ray equipment and gamma camera at Darlington Memorial Hospital, increased radiation incidents, theatre staff failure to wear dosimeters, and lack of radiologist support, particularly at Bishop Auckland Hospital.

In urgent care services there was no lone-worker policy, although when the team discussed this with the matron she considered that this might be a good policy to adapt for staff in urgent care centres. Risk assessments had been undertaken.

There were no risk assessments in place around paediatric care and prescribing by non-paediatric trained nurses and practitioners, security for staff out-of-hours when the centre was the only service open in the building, or lone-working. There was a lack of staff acknowledgement that these were risks to staff, patients and the service.

Multidisciplinary safety huddles and board rounds took place each morning on all wards. This was observed as an effective means of discussing patient safety issues and coordination of care and treatment.

At Bishop Auckland there was a well established orthopaedic surgical service. There was a clear escalation plan if patients required transfer to the main hospital site at Durham. There was also provision for blood transfusion if this was required.

Summary of findings

Are services at this trust effective?

Policies and procedures for care and treatment were based on guidance from the National Institute of Care and Health Excellence (NICE), and national and Royal College guidelines. These were accessible to staff across the trust through the trust's intranet site.

The trust had a clinical audit programme and categorised its centrally coordinated clinical audit activity according to priorities. We saw evidence that further clinical audits had been carried out and the results and actions from these were awaited. The trust also contributed to national audits. The trust had taken part in the 2013/14 NCDAH, in which it had not achieved 6 out of 7 organisational key performance indicators. A draft action plan had been developed to address the issues, including identifying a non-executive director to lead on end of life care. The British Thoracic Society audit data for 2013 for the University Hospital of North Durham showed that 14 of the 16 patients initiated on NIV (87.5%) failed to respond successfully to treatment. This was compared to treatment given at Darlington Memorial Hospital, for which data showed that treatment failed in six out of a total of 20 patients (30%). The national average failure rate was 29.8%.

Across the core services pain was managed effectively and most areas used a pain scoring tool. However, in critical care at Durham pain was assessed but there was no pain score used unless the patient was on a patient-controlled analgesia pump. A generic care plan for pain was used but lacked individualisation. The children's service had its own paediatric pain nurse available, which was good practice for a children's service based in a district hospital. The paediatric pain nurse was also supported by the adult pain team.

The trust used the Malnutrition Universal Screening Tool (MUST) core for assessment of nutrition and hydration. We noted the work that had been done by the dietetic team across the organisation to improve the care and management of nutritional and hydration requirements of people in hospital.

The trust had processes in place to ensure that patients who were outliers received appropriate medical review. Twenty-two per cent of patients had had one ward move and 12% had had two or more ward moves during their stay.

There were robust multidisciplinary processes across the core services

Evidence-based care and treatment

Requires improvement



Summary of findings

The trust had a clinical audit programme and categorised its centrally coordinated clinical audit activity according to priorities. We saw evidence that further clinical audits had been carried out and the results and actions were awaited.

Medical staff undertook clinical audits and these were discussed at clinical governance meetings. There was recognition of the need to improve the number of audits being undertaken. Surgical patients were treated based on national guidance from NICE, the Association of Anaesthetists, Great Britain and Ireland, and the Royal College of Surgeons.

NICE guidance was implemented in all core services. We found that the care of women using the maternity services was in line with RCOG guidelines (including 'Safer Childbirth: Minimum standards for the organisation and delivery of care in labour') and NICE guidance was implemented. New guidance came to the children's service via the Care Closer to Home group and was discussed via the SAGE meetings. We reviewed SAGE meeting minutes for 2014 and found that these included various examples of where the service had reviewed clinical pathways to ensure they reflected clinical practice.

We viewed a guideline document for end of life care that had been ratified in January 2015. The guidance included identifying patients at the end of life, holistic assessment, advanced care planning, coordinated care, and the management of pain and other symptoms. Documentation had included national guidance from sources such as the Leadership Alliance for the Care of Dying People, the Department of Health End of Life Care Strategy, NICE and the Gold Standards Framework (GSF). 'Guidance for care of patients who are ill enough to die' had replaced the Liverpool Care Pathway.

Patient outcomes

Morbidity and mortality meetings had been implemented but were still in development, with approximately 30% of all deaths reviewed at a weekly meeting attended by a group of senior clinicians and the Medical Director. The Medical Director was working towards ensuring that all deaths would be reviewed. The trust was part of the North East Mortality Group. Mortality and Morbidity reviews had not been established consistently across core services although there were examples of good practice in place. However, in Durham the mortality review meeting in critical care was described as being in a 'state of flux' by staff.

Policies and pathways were based on NICE and Royal College of Physicians guidelines and were available to staff and accessible on the trust intranet site. These were evident across the acute core services. Any relevant NICE guidance was implemented as it was

Summary of findings

issued. NICE guidance was discussed at monthly clinical governance meetings and at Sisters' meetings. NICE implementation was monitored on a monthly basis by the trust-wide quality team, which alerted departments that were non-compliant.

There was a trust-wide nursing quality and clinical strategy, 'Quality Matters', and a 'High Impact Intervention' audit programme for ward sisters to complete. Staff confirmed that they had completed audits and we were able to see results and action plans in ward files. Action plans were updated regularly and progress could be seen.

To improve patient outcomes acute stroke services for County Durham and Darlington NHS Foundation Trust had been centralised at the University Hospital of North Durham. The stroke unit received patients directly from emergency services, A&E and from other local hospitals. The trust achieved an overall organisational score of D, on a scale of A to E with E being the worst, in the Sentinel Stroke National Audit Programme (SSNAP) 2014. This was an improvement on its previous rating. An action plan to continue improving the service was in place.

As noted above, the trust had taken part in the 2013/14 NCDH, in which it had not achieved 6 out of 7 organisational key performance indicators. A draft action plan had been developed to address the issues, including identifying a non-executive director to lead on end of life care.

In the Emergency Department there was a clinical audit annual programme dated 2014/15. It showed that the department had a clear clinical audit programme with timescales for each clinical audit activity. The CEM severe sepsis and septic shock audit had been repeated in November 2014 and a summary and action plan was available. There was a number of CEM standards that the trust had not met but it was noted that these were dated 2011. Results of CEM audits were discussed at a quarterly clinical governance meeting and actions were written to improve outcomes for patients.

The medical directorate at the University Hospital of North Durham had care plans and pathways for a number of presenting conditions, which included stroke, deep vein thrombosis, cellulitis, rapid access chest pain and sepsis. The trust participated in the Myocardial Ischaemia National Audit Project which showed variable performance, with 47% of patients being referred for angiography compared to the England average of 73%.

The British Thoracic Society audit data for 2013 for the University Hospital of North Durham showed that 14 of the 16 patients initiated

Summary of findings

on NIV (87.5%) failed to respond successfully to treatment. This was compared to treatment given at Darlington Memorial Hospital for which data showed that treatment failed in six out of a total of 20 patients (30%). The national average failure rate was 29.8%.

In critical care at the University Hospital of North Durham there were no care bundles for ventilator-associated pneumonia or catheter-related bloodstream infection (both of these conditions are the most frequent infections attributed to intensive care units). However, the ITU care plan for ventilated patients had been written to reflect the ventilator-associated pneumonia bundle and observations were recorded in line with this. The unit took part in the regional peer review system run by the North of England Critical Care Network.

Five standards of the National Neonatal Audit Programme for 2013 indicated that the University Hospital of North Durham scored lower than the standard benchmark.

Outpatient departments displayed information about key performance indicators. We saw results displayed in the dermatology department.

The National Bowel Cancer Audit (2013) showed better than England average results for clinical nurse specialist involvement (99.7%; England average 87.7%), discussion with the multidisciplinary team (100%; England average 97.8%), scans undertaken (98.7%; England average 89.1%); and patients undergoing major surgery who stayed in the hospital for an average of more than 5 days (69.3 %; England average 68.9%).

The trust participated in the National Hip Fracture Audit. Findings from the 2014 report showed the trust was better than the national average in areas such as patients being admitted to an orthopaedic ward within 4 hours (60.4%; national average 47.4%), falls assessment (98.4%; national average 94.6%), senior geriatric review within 72 hours of admission (85.5%; national average 81.6%), abbreviated mental health test performed (99.4%; national average 93.7%), bone health medication assessment (98.7%; national average 96.1%), and the mean length of total trust stay (acute and post-acute) (19.3 days; national average 19.8 days).

Multidisciplinary working

Across the trust and in all core services we saw evidence of multidisciplinary working with different healthcare professionals. Cancer multidisciplinary teams were in place. An example of this was in the emergency department at the University Hospital of North Durham, where there was joint working with a local mental health trust – Tees, Esk and Wear Valleys NHS Foundation Trust.

Summary of findings

Over the winter period this involved staff from the mental health teams working closely with the department, 24 hours a day, 7 days a week. The objective was to provide patients with timely assessments and referrals as well as trying to reduce or avoid unnecessary admissions to hospital. Staff also had access to the Child and Adolescent Mental Health Services (CAMHS).

Nursing and medical staff reported good multidisciplinary working and all medical wards participated in multidisciplinary board rounds, which were observed to be an effective means of flagging potential patient issues and updating all staff on management plans. This facilitated a holistic approach to treatment plans and decisions.

The pharmacy department at the University Hospital of North Durham provided a 'buddy' system for all new junior doctors to give informal support around prescribing when needed.

A number of teams provided support to the medical specialities, including CREST. This was an early senior multidisciplinary assessment for frail older people, which facilitated early supported discharge and managed people with an anticipated short length of stay. The team also identified and transferred patients requiring longer stays to the appropriate specialist team.

The specialist palliative care team told us it met daily to discuss patient care and workloads and that wider team meetings across both hospital sites were held every few weeks.

Consent, Mental Capacity Act & Deprivation of Liberty safeguards

We observed patients being asked for verbal consent to care and treatment. Patients told us that interventions were explained in a way that they could understand before the intervention was carried out. Medical staff were observed asking for consent to undertake assessments and to share information. Patients told us that staff were very good at explaining what was happening to them before asking for consent to carry out procedures or examinations.

The trust had in place policies covering the Mental Capacity Act (2005) and deprivation of liberty safeguards. There was access to an independent mental capacity advocate for when best interest decision meetings were required. Training on these had been planned throughout 2014 and 2015 and 88.87% of staff had completed the training.

Summary of findings

In the emergency department at the University Hospital of North Durham there was a dedicated room where mental health patients could be accommodated. Patients who were at risk of harm were cared for in the room, where they would be closely supervised.

In surgery staff told us that mental capacity assessments were undertaken by the consultant responsible for the patient's care and deprivation of liberty safeguards were referred to the trust's safeguarding team.

Of the 42 (20 in Durham and 22 in Darlington) DNACPR forms we viewed across a variety of wards in both Durham and Darlington Hospitals, seven were for patients whom staff identified as lacking the mental capacity to be involved in resuscitation decisions. In most cases we saw that the decision was discussed with the patient's family. There were no mental capacity assessments recorded as part of the decision-making process where patients had been identified as unable to participate in discussions. This meant that the process of identifying patients who lacked mental capacity was unclear.

Competent staff

Medical revalidation was carried out by the trust. There was a process in place to ensure all consultants were up to date with the revalidation process. Medical staff reported that training and academic support was good and they had access to lunchtime teaching sessions three times a week.

Allied health professionals told us that new staff were given a shadowing period as part of induction to ensure staff were competent and confident to carry out their duties before undertaking unsupervised practice. It was reported that the trust was supportive of training but that staff were required to travel out of the area to access specialist training.

Junior pharmacists and junior doctors received good support from senior members of the pharmacy team.

In nursing, we saw induction processes and preceptorship arrangements to support newly qualified nursing staff. Preceptorship and training was supported by practice placement facilitators.

At the University Hospital of North Durham there was no evidence to support any detailed competency-based assessment for the initiation and on-going management of patients requiring NIV.

Midwifery supervision was seen to be well established and described by staff as being 'very strong'.

Summary of findings

All staff working within elderly medicine had received a dementia awareness pack and had undertaken e-learning.

Are services at this trust caring?

Most patients and relatives spoke very highly of staff and told us that they, or their relatives, had been treated with dignity and respect. It was reported that patients felt safe and relatives said that their loved ones were well cared for. Nutrition, hydration and comfort needs were met. An example of this was ward 52 at Darlington Memorial Hospital, which had recently been awarded the 'Quality mark for elder-friendly hospital wards'.

Patients' privacy and dignity was seen to be maintained

We saw evidence of plans to proactively develop the chaplaincy service in terms of pastoral and spiritual care, which involved providing spiritual, pastoral and emotional support for patients and families from a number of faiths and for those who did not follow any faith.

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

We observed respectful and courteous interactions with patients, which indicated that they were treated well and with compassion.

The NHS Family and Friends Test (a survey that measures patients' satisfaction with the healthcare they have received) had a response rate of 35%, which compared favourably with the England average of 31%. The Friends and Family Test information showed a lower percentage of patients who would recommend the services than the national average in February 2015. The trust performed around the same as other trusts in respect of relevant questions in the national inpatient survey of 2014.

Compassionate care

We observed staff caring for patients in a way that respected their individual choices and beliefs. An example we saw included nursing staff asking family members what was important to the patients in terms of their wishes at the end of life.

An observation of care was carried out on ward 6 at the University Hospital of North Durham in a bay with a group of patients who had dementia and were at high risk of falling. The observation was carried out using the Short Observational Framework for Inspection

Good



Summary of findings

(SOFI). There was a dedicated healthcare assistant providing care to a group of four patients. The staff member was observed to interact warmly with the patients when performing activities or tasks such as undertaking clinical observations or making patients comfortable.

We observed staff on the intensive care unit introducing themselves to patients and relatives. They also used a 'getting to know you' form for relatives to fill in so that staff could learn and get to know more about their patients interests, pets, hobbies and so on. This meant that staff could talk with patients, even those who were sedated or ventilated, about their interests.

We undertook 14 home visits and observed three patients at one leg ulcer clinic. We saw that people were treated with kindness, dignity and respect. We observed that staff introduced themselves to patients and explained the care to be undertaken during that contact.

Understanding and involvement of patients and those close to them

We saw that wards displayed 'You said, we did' posters to show actions resulting from NHS Friends and Family Test feedback.

Wards had quiet rooms where relatives could speak to staff in private, or to use when distressed.

Relatives told us that they had received information about their loved ones' care and felt listened to. Patients and relatives told us that information and explanations were given to them in a way that they could understand.

In the community we spoke with 24 patients and, without exception, the feedback we received was overwhelmingly positive; one person described the district nurses as "angels without wings". We saw that care was centred around the patient and that interventions were coordinated to ensure that care was seamless between the services. Patients and their relatives were involved in care planning and their wishes were respected. We were told by patients that care was mainly delivered at a time that was suitable for them.

Emotional support

We observed respectful and courteous interactions; patients were treated well and with compassion.

The elderly care wards were introducing volunteers who would focus on the social and emotional needs of patients with dementia.

Summary of findings

Trust-wide Sage and Thyme training for clinical staff had been implemented. The Sage and Thyme model is focused on supporting staff to listen and respond to patients/carers who are distressed or concerned.

Comfort packs were given to relatives who were staying with patients at the end of life. These packs included toiletries, snacks and other items.

We saw evidence of good practice in the intensive care unit, where memory boxes were used to support relatives and friends following bereavement. The memory boxes were designed by staff to give mementos such as locks of hair and handprints. There were prompts for staff as to the types of mementos they could offer, allowing them to develop a personalised memory box based on individuals and their wishes.

In the A&E department, staff were offered counselling and additional support following a difficult/traumatic death.

Are services at this trust responsive?

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

The trust did not consistently meet the four-hour target in the emergency department. Staff informed us that the main cause of delay was waiting for beds to become available.

Systems were in place to plan and deliver services to meet the needs of local people. Staff were responsive to people's individual needs. Services were available to support patients, particularly those with dementia, a learning disability or a physical disability.

In the community there was evidence of integrated clinical pathways, for example, a diabetic foot pathway.

There was a short-term intermediate care team in place. This was called the "Intermediate Short-term Intervention service (ISIS) team. This team provided a responsive service for people who deteriorated in the community or who were being discharged from acute services.

There were differences in provision of community matron services across the community geographical area, with some areas no longer having community matrons in post. As this change had been very recent, it was not clear what impact this had had on patient care.

Good



Summary of findings

Service planning and delivery to meet the needs of local people

In terms of deprivation, Durham is ranked 62 and Darlington 75 out of 326 local authorities, which means there are high deprivation levels within these areas. Deaths from smoking, early deaths from cancer and early deaths from heart disease and stroke are all higher than the England average.

The services at County Durham and Darlington NHS Foundation Trust were predominantly commissioned by NHS North Durham, Durham Dales, Easington and Sedgefield and Darlington clinical commissioning groups, to meet the needs of the local people.

Due to a national shortage of sonographers the trust had developed a three-year scheme with a relevant training college to support radiographers to become sonographers. The scheme was in its second year and staff reported that it was working well.

The emergency department at the University Hospital of North Durham had limited facilities for managing and caring for seriously ill children. The executive team had acknowledged that the facilities were no longer fit for purpose and there were plans being developed to build a new emergency department by 2018.

The trust had well established links with tertiary referral centres at James Cook Hospital in Middlesbrough and Newcastle Hospitals for a range of medical and surgical services and for out-of-hours MRI scanning.

The hospital had an escalation and surge policy and procedure to deal with busy times. Capacity bed meetings were held to monitor bed availability and review planned discharge data to assess future bed availability. During high patient capacity and demand patients having elective surgery were reviewed in order of priority for cancellation to prevent urgent operations from being cancelled.

Critical care recently formed a trust-wide critical care delivery group to ensure that critical care provision met the needs of the population. Both units also participated in a regional 'securing quality in health services' project along with trusts in the Tees Valley.

As part of the teen mother pathway there were sexual health practitioners (young parent support). Within the trust there were two WTE posts dedicated to preventing second or subsequent unintended teen pregnancies.

Community services had been adapted to meet the needs of patients; adaptations included community matrons changing their operating hours from Monday to Friday 9am to 5pm to 7 days per week 8am to 8pm to improve patient access.

Summary of findings

Meeting people's individual needs

There was a dementia strategy in place across the organisation and there were examples where wards had been re-designed taking into account the requirements of people with dementia. For example, red door frames and toilet seats were visible on the elderly care wards. These wards had developed practices to meet the needs of patients living with dementia. There was recognised good practice in place, such as memory boxes and the 'forget me not scheme'.

The trust had a dedicated learning disabilities nurse, who was available across both sites, and a lead nurse for dementia had recently been appointed.

In surgery, all wards had dementia champions as well as a learning disability liaison nurse who could provide advice and support in respect of caring for people with these needs.

The trust had access to interpretation services for people who did not speak English as their first language. We noted that, within medicine, patient information was not readily available in languages other than English. However, information leaflets could be printed in different languages if required.

The trust had a passport system for people with learning disabilities. These passports set out the specific needs of the individual and gave staff in any department that the person attended the appropriate information to enable them to care for that individual.

There was no overarching policy statement on the coordinated development of adolescent transitional services for children and there was no formally nominated lead member of staff to develop adolescent services. However, transition arrangements were in place for the transfer of children to some medical specialities, for example, diabetes.

We were told that the intermediate short-term intervention service (ISIS) team responded to patients within 2 hours in the event of a health crisis, and within 1 day for hospital discharges.

Access and flow

Bed occupancy for the trust was between 80 and 85%, which suggested that there were sufficient beds to meet demand.

RTTs were better than the England averages for non-admitted patients (98.5% against the 95% England average) and incomplete pathway patients (95% against the England average of 92%).

Summary of findings

RTT times for the admitted pathway were not met within trauma and orthopaedics (85.3%), urology (89.3%) or general surgery (86.4%). The reasons for these shortfalls had been identified. Recruitment to additional consultant posts had been undertaken and locum cover had been arranged to reduce backlogs.

The trust was better than the England average for the two-week cancer wait target (97% against an England average of 95%), 31-day wait from diagnosis to first definitive treatment (99% against the England average of 97%) and 62-day urgent GP referral to first definitive treatment (90% against the England average of 84%).

The average length of stay for elective patients was above the England average for general surgery (4.2 days, England average 3.5 days) and trauma and orthopaedics (4 days, England average 3.5 days). Average length of stay for patients having non-elective surgery was the same as or below the England average across all specialties.

There were 20,248 delayed transfers of care between April 2013 and July 2014, of which 59% were due to delays in completion of assessment. This is much higher than the England average of 18%.

There was variation in medical review of patients in intensive care between medicine and surgery; this approach meant some patients did not have a seamless transfer from the unit to the ward. There was a need to establish a process to overcome this situation.

There was variation in access to critical care outreach services, with the university Hospital of North Durham having no outreach services.

Between October 2013 and October 2014, the emergency departments did not meet national targets of admitting, transferring or discharging 95% of patients within 4 hours. The average performance for this target ranged from 87% to 94% (October 2013 to October 2014). The trust also had a higher than England percentage average for patients waiting 4–12 hours in the department from the decision to admit until being admitted into an inpatient bed. In addition, the standard that 95% of ambulance patients should be handed over within 15 minutes of arrival was not met; average performance for this target ranged from 37% to 82% (October 2014 to February 2015).

Access and flow varied within the children's services provided throughout the trust. The emergency department at Darlington Memorial Hospital had dedicated facilities for children. These included a separate waiting, assessment and treatment area with suitable child-friendly décor and facilities. This was different to the University Hospital of North Durham, where facilities were limited and seriously ill children were cared for in the adult areas. An APNP

Summary of findings

was allocated to the children's emergency department area 7 days per week between 10am and 10pm. The APNPs were part of the children's service team at Darlington Memorial Hospital but this arrangement was not in place at the University Hospital of North Durham.

Learning from complaints and concerns

There was evidence in most areas of the trust that there was literature informing service users about how to make a complaint, however there was no information in the emergency department at Darlington Memorial Hospital. This was raised at the time of inspection with the Emergency Department management team.

Complaints trends were reported and monitored through the quarterly integrated governance report that was presented to the trust's quality and healthcare governance committee.

The Complaints and Concerns Policy was thorough and clearly written. Section 4.1. stated that the Chief Executive Officer (CEO) would either respond in writing to all complaints and sign the final response or would ask a named delegate to do so. This is normal within the NHS so that final responses are not delayed when, for example, the CEO is on annual leave.

We reviewed 30 complaints and final responses. None were signed by the CEO and, in fact, a wide range of staff had signed off final responses. We were not assured that the policy of the CEO delegating to named individuals was being followed.

It was not clear whether the 30 complaints that we reviewed were upheld or not.

The co-chairs of the Quality and Healthcare Governance Committee told us that the Chief Nurse was responsible for the quality of complaint responses, although this responsibility was not detailed in the policy. However, there was an Associate Nurse Director of Patient Experience who was responsible for managing complaints.

The Associate Nurse Director told us that clinical directors and governance leads normally signed off final responses but acknowledged that they had not had formal training in complaints management. She said that the CEO did not sign off complaint responses, however, we were informed that complex complaints would be signed off by the Chief Executive Officer.

There was concern that the board was not fully aware of the level of quality of complaint responses and so could not hold the executive directors to account in respect of the quality of investigations and responses. However the Director of Nursing's Monthly Board Report outlined significant complaints, including the

Summary of findings

main issues arising and the actions to be taken. Similar summaries were provided in Care Groups' integrated governance reports reviewed in detail by the Quality and Healthcare Governance Committee. The board was also provided with details of complaints referred to the Ombudsman and the outcomes of the Ombudsman's decisions. We were informed that a family had been invited to a board meeting to present their story but we were aware that this had only happened once and was not routine.

The review of complaints drew our attention to an unusual method of sending final responses. Specifically, the detailed investigation notes were sent together with a covering letter of apology. An example was a complaint which raised some serious concerns about dignity, end-of-life care, delegation to students and clarity about resuscitation status. The complaint response included the investigation notes which contained detailed clinical information. Complaint responses reviewed provided an overarching apology, as well unreserved apologies and acknowledgement of failures for the specific issues raised by complainants.

In maternity a listening service was provided to women and their partners, to which they were able to self-refer. We saw from information recorded that nine such discussion meetings had taken place between July and September 2014 for women who used the University Hospital of North Durham. In each case the reason for referral was recorded. This included, for example, women wanting to know the reasons for a caesarean section and understanding the cause of a traumatic birth. The outcome from the discussion was also evaluated and recorded.

Specialist palliative care staff were not always made aware of complaints relevant to end of life care, as complaints were not recorded in a way that categorised end of life care, meaning that learning from complaints may not always have had specialist input.

Are services at this trust well-led? **Vision and strategy**

There was a clear vision, strategies and plans in place for service delivery and future development within the trust. The trust's vision and strategy was well embedded with staff. Staff were able to articulate to us the trust's values and objectives across the surgical wards and they were clearly displayed in ward areas.

There was an evolving clinical and quality strategy 'Right First Time 24/7'; this was developed with the involvement of clinical staff

Requires improvement



Summary of findings

through discussion groups and engagement with key stakeholders. The development of the clinical strategy was supported by the establishment of the Clinical Strategy Steering Group. The purpose of this was to focus on the delivery of acute care over 7 days.

The trust had a number of underpinning strategies that supported the overarching strategic direction including a nursing strategy 'Quality Matters 2015-17' that had been developed with input from staff across the care groups and in the community. The trust also had an organisational development strategy 'Staff Matters'.

The pharmacy department had a strategy document for 2012/2015 and was updating this. The department was a pilot site for the development of the Royal Pharmaceutical Society 'Professional standards for hospital pharmacy services: optimising patient outcomes from medicines' and had assessed its services against them. There were plans in place to address any identified shortfalls.

The children's management team had a clear vision and strategy for the provision of children's services in the Durham and Darlington areas. We reviewed a draft strategy in development entitled 'Quality improvement in the delivery of paediatric care within County Durham and Darlington 2015'. The Head of Child Health explained how various stakeholders had been involved in the development of the strategy and that the timescale for publication would be the summer of 2015.

Governance, risk management and quality measurement

There was a Governance and Risk Strategy that set out the governance structures across the care groups up to board level and information flows for the management and oversight of quality within the organisation. The trust had an embedded Risk Management Strategy with annual monitoring reports. Weekly Patient Safety meetings had been established to supplement the formal committee structure to provide a mechanism for actions to be chased on an exception basis. These arrangements had been in place for under two months at the time of the inspection.

There were multiple committees, working groups, conference calls and sub-groups concerned with clinical governance and as a result there was a lack of assurance that these committees and groups worked efficiently together. Some members of staff with whom we spoke during the inspection felt that there were too many committees and that this led to confusion.

Each care group had a governance lead who attended two regular governance meetings; a patient safety and patient experience group attended by care group matrons and lead nurses and a quality and clinical governance meeting, which was attended by consultant

Summary of findings

leads and heads of service. Any issues were escalated from these meetings to the relevant meeting within the Care Group's governance structure. We reviewed notes of meetings and saw there was generally good clinical engagement and attendance.

Each care group produced an integrated governance report that was reviewed on a monthly basis at a performance meeting. The report covered the key elements for quality including infection control issues, complaints and incidents.

The inspection team were assured that key members of the Quality and Healthcare Governance Committee explained that the board and they regularly received and reviewed the Board Assurance Framework (BAF) and reports on risk. It was also stated that the BAF and risk registers had been brought up to date and aligned following the appointment of the Senior Associate Director of Assurance and Compliance. The inspection team noted that some of the 'controls' identified were, in fact, actions and during discussions with the senior team there was a lack of clarity and agreement about the trust's agreed key risks.

The Interim Director of Human Resources, who had been in post for nine months, advised us that she was unaware that she was responsible for delivering a number of key actions on the Board Assurance Framework. She said that these actions were not in her objectives and that she had not agreed them.

The Senior Associate Director of Assurance and Compliance was responsible for clinical and internal audit and was responsible for writing the BAF in conjunction with the Executive Team. At interview he acknowledged that the BAF were not automatically linked to the other risk registers. The relationship between the BAF and the risk registers was, however, set out in the trust's risk management strategy: the BAF captured the trust's principal objectives and its principal inherent/strategic risks; the risk registers captured operational risks. As this was a manual process it was not possible to automate it within the Safeguard risk management system.

Evidence showed that the Chief Nurse and Medical Director were accountable for clinical governance for the trust. The senior associate director of assurance and compliance was responsible for establishing, maintaining and reporting on the risk management process.

Different individuals at sub-director level had different explanations about the ways in which risks were escalated, including individuals responsible for managing significant areas of risk such as safeguarding. For example, some people said that risks were escalated to the 'executive clinical leaders group' and others to the

Summary of findings

‘risk management committee’ and others to the newly formed ‘patient safety forum’. Assurance about the purpose of escalation (for action or information, for example) within each group could not be established, nor could it be demonstrated that these groups formed a consistent pathway of escalation to the board.

In maternity and gynaecology services at Darlington Memorial Hospital there were weekly multidisciplinary risk meetings. In maternity the meeting was run by clinical governance midwives and included good consultant input. During this meeting there was presentation and open discussion of all events reported during the week. Patient notes were fully reviewed and lessons learned were discussed. The duty of candour test was applied, ensuring that any harm identified would be escalated, including sharing of information with respective individuals.

We were concerned about the leadership in the emergency departments. There was a lack of monitoring systems and processes and as a result of this, resuscitation medication was out of date, not all resuscitation drugs, equipment and fridge temperatures were checked regularly and the environment was not clean.

There was no non-executive director nominated as the lead for end of life care within the trust. There was no trust-wide end of life strategy in place, although we saw evidence of action plans being drawn up to address issues identified from external audit and local reviews. The results of the National Care of the Dying audit had been used to develop an action plan that was led by the end of life steering group. However, timely action had not been taken in a number of areas. For example, an audit of end of life care guidance implemented in July 2014 was scheduled to begin in quarter 4 of the 2014/15 financial year but did not happen due to lack of capacity within the SPC team. It was undertaken during quarter 1 of the 2015/16 financial year.

There was no evidence that safeguarding issues were reported directly to the board. The trust executive lead did not chair the safeguarding group or attend Local Safeguarding Children Boards. There was a child death overview panel (mandatory review of all child deaths) but there was no reference to this in the annual report. There was no evidence of robust governance arrangements to ensure that action plans were in place and were being monitored.

We were told that risks at care group level could remain on the risk register for prolonged periods of time with little evidence of actions being taken to address them. However there was work on-going

Summary of findings

between the directorates and Quality and Assurance teams to review all risks which provided challenge, closure of risks and identifying new risks. This work had been overseen and reported to the Risk Management Committee.

We reviewed the risk register for maternity services. The one risk reported related to sickness absence. This was accompanied by an action plan, a designated responsible person and review dates. However, in our discussion with senior clinical staff they described another risk related to the pregnancy assessment clinics, linked to the ultrasound service. We asked why this was not on the risk register and it was explained to us that sitting beneath the risk register was an 'issues log'. Items were said to be moved to this once the mitigation of risk was identified. The use of the issues log was a Care Group practice designed to keep in view any circumstances which may give rise to risk. In this case, it was considered that the mitigation put in place might need to be monitored to ensure that it remained sustainable.

The maternity service dashboard did not have much detail on it and it was not clear where the standards had come from. Maternity dashboards are generally used to provide an early alert to the maternity service and the trust board. It would usually be expected that performance of the maternity service would be benchmarked and assessed against 'Mothers and babies; reducing risk through audits and confidential enquiries-UK' (MBRRACE-UK) reports, RCOG and Royal College of Midwives guidance, National Patient Safety Awareness (NPSA) Never Events, and patient experience/complaints.

Leadership of the trust

At service level there were clear leadership arrangements with core services reporting high visibility of matrons. However we had concerns about the complexity of the management structures above service level. Staff described these as complex. At the consultant focus group it was felt that current management arrangements slowed down decision making and, consequently, it could take long periods of time to progress business cases and implement them.

Several people expressed concern that the Care Closer to Home directorate did not work as effectively as they felt it should. The care groups were said by a number of senior staff to be made up of large divisions with too many layers, which impacted on efficiency. We were told that complicated decisions got lost or were delayed in escalation. Another comment made to us by a separate senior member of medical staff was that it was difficult to be "listened to". Examples of difficulties included the time taken to consider matters, such as agreement to expand the consultant team. The plan was

Summary of findings

said to have been put forward more than four years previously and a business case and funding had been agreed but had since been lost in the system. Clinical staff at senior level said channels of communication needed to be reviewed but they “made it work”. They added, “A flatter structure works better for us” and “staff want to be valued and this impacts at a local level”.

We were told there was no formal board-level director to promote children’s rights and views as required by the National Service Framework (NSF) for Children standard for hospital services.

For all core services at ward level staff told us there was clear leadership of the services. For example, the ward manager on ward 42 at Darlington Memorial Hospital had been nominated by staff for a leadership award.

The consultant focus group told us that the recently appointed Medical Director had made a significant difference since starting in post. An example was the development of the medical advisory group, at which attendance was due to be made mandatory.

During the inspection concerns were raised by hospital staff about two specific core services. We spoke to the Medical Director about both of these issues and he informed us that, where appropriate, medical staff were managed in accordance with the ‘Maintaining high professional standards’ guidance. Appropriate steps had been taken to begin addressing the issues.

Culture within the trust

Most staff acknowledged that there had been a need for change and reported that the trust’s culture had begun to change positively over the last few years. In the main staff were positive and enthusiastic about the changes made to service delivery and could clearly articulate the benefits for patients.

Staff reported that there was a strong culture of learning and improvement and training and development was actively encouraged. This was reflected in focus groups held both with consultants and with senior nurses.

Staff spoke positively about the service they provided for patients. High quality, compassionate patient care was seen as a priority.

Staff told us about the ‘breakfast with Sue’ initiative in which the Chief Executive met with staff on a regular basis to talk through concerns.

There was a perception from a clinical director that, despite the merger of previous bodies to form the trust, both locations were working separately with regard to maternity and gynaecology

Summary of findings

services. We were made aware of a number of issues related to performance and working practices, which medical staff said had not been addressed early. As a result there was an impact on working relationships, increased demands on some medical staff and inflexibility from others.

Consultants overall described having positive relationships with the executive team and their colleagues. They were encouraged and supported to develop and trainees were keen to return as consultants.

In the community we were told of 'Back to the Floor Fridays' when senior managers would work on the front line, providing direct care to service users. This culture of working alongside staff was seen as positive and kept managers in touch with everyday issues.

Fit and Proper Persons

The trust was prepared to meet the 'Fit and Proper Persons Requirement (FPPR) (Regulation 5 of the Health and Social Care Act [Regulated Activities] Regulations 2014). This regulation ensures that directors of NHS providers are fit and proper to carry out this important role. The trust had in place a policy relating to these new requirements.

We reviewed all of the files of the executive directors in post at the time of our inspection, but it is important to note that they were appointed prior to the new regulations coming into force. The files we checked that all appropriate checks had been taken throughout the appointment processes for these individuals.

Staff Engagement

The trust had in place an organisational development strategy referred to as 'Staff Matters 2015 – 2017' The strategy outlined County Durham and Darlington NHS FT organisational development priorities in support of the implementation of the Clinical and Quality Strategy, the trust's Five Year Business Plan and its Trust Workforce Strategy and Plan. However, it is noted that implementation of the strategy had only just started in January 2015 and therefore further embedding into the organisation was required.

There were opportunities for staff to engage with the executive team through initiatives such as 'breakfast with Sue', at which staff could meet with the Chief Executive to discuss issues and ask questions. We were informed by staff that the Chief Nurse was highly visible in the clinical areas and was approachable.

Summary of findings

Staff, commissioners and stakeholders had been consulted about the trust-wide clinical strategy 'Right first time 24/7'. This had resulted in a public discussion document being produced in January 2014.

Public Engagement

The hospital's NHS Friends and Family Test response rate varied from 26% to 68% (averaging 34%; England average 31%) between April 2013 and July 2014.

NHS staff survey data (2013) showed that the trust scored as expected in 19 out of 30 areas and better than expected in nine areas. There were two negative findings: the percentage of staff feeling satisfied with the quality of work and patient care they were able to deliver; and the percentage of staff receiving job-relevant training, learning or development in last 12 months.

The emergency departments had strong links to a young people's 'good to talk about health issues' group. Representatives from the group had recently visited the department for an educational session.

A system had been set up to gain the views of children, young people and families about their experiences via a quality assessment tool. This was a formal survey undertaken bi-monthly in each area, which asked a sample of parents and children for their views about their experiences. These surveys resulted in a monthly report which was made available for parents and families to review.

Across inpatient and community services a clinical quality improvement framework (CQIF) had been implemented. This initiative enabled teams to review quality standards against a framework and provided a selection of improvement tools for the team to use. The framework built in patient feedback and comments, which were vital to improving services.

Innovation, improvement and sustainability

The trust informed us that, over the preceding two years, A&E staff had taken the opportunity to improve the service for patients. They had gathered information from a range of sources, including over 300 patients. The team had identified the need to make improvements from the first point of contact and beyond. With support from the transformation team, they had run improvement events to redesign the patient journey and moved the senior decision makers to the front of the process. Live trials had been held

Summary of findings

to test new ways of working and results had shown significant improvements to assessment, diagnosis and treatment. The team was working with partners in urgent care and paediatrics to deliver a fully integrated front of house service.

The trust had set up a 'Dragon's Den' initiative which allowed staff to submit ideas that would improve services for their patients and bid for funding to make their ideas happen.

The pharmacy department had implemented a 'buddy' system for all new junior doctors, where a pharmacist was assigned to a junior doctor to provide informal support where necessary. This initiative was commended by the president of the Royal College of Physicians on a recent visit. The president had requested additional information, feeling that this may be a scheme that could be promoted more widely through the Future Hospital Programme. (The Future Hospital Programme exists to implement the recommendations of the Future Hospital Commission. These recommendations are based on the very best of our hospital services, taking examples of existing innovative and patient-centred services to develop a comprehensive model of care).

The children's services had developed a 'rapid response service'; were any child to die in the community or acute setting within the County Durham and Darlington area a senior skilled nurse from the team would attend the death to provide support and ensure appropriate skilled interaction from other agencies such as the police.

The trust had been a finalist for a North East Leadership Academy Award for service improvements to change practice.

There was an initiative to move to a 'paperlite' system where paper-based records were to be replaced by electronic records. Feedback from staff showed that they were supportive of the initiative but there had been a number of teething problems and the system had been rendered slower than prior to the initiative. The system did not link to the IT system in the A&E departments; the trust was aware of this.

Ward 44 at Darlington memorial Hospital was piloting an innovative e-observations tool using smartphone technology, which could directly alert medics of patients with deteriorating NEWS scores. Staff had found the system easy to use and effective.

Overview of ratings

Our ratings for University Hospital of North Durham

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

Overview of ratings

Our ratings for Darlington Memorial Hospital

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

Overview of ratings

Our ratings for Community health services

	Safe	Effective	Caring	Responsive	Well-led	Overall
Community health services for adults	Good	Good	Good	Good	Good	Good
Community health services for children, younger people and families	Good	Good	Good	Good	Good	Good
Community health inpatient services	Good	Good	Good	Good	Good	Good
End of life care	Good	Good	Good	Good	Requires improvement	Good
Community dental services	Good	Good	Good	Good	Good	Good
Urgent care centres	Requires improvement	Good	Good	Good	Good	Good
Overall	Good	Good	Good	Good	Good	Good

Our ratings for County Durham and Darlington NHS Foundation Trust

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

Notes

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

Outstanding practice and areas for improvement

Outstanding practice

- There was an exceptionally caring critical care service in Darlington Memorial Hospital, where inspectors observed individualised care and attention to detail given to patients and relatives. This was demonstrated by the service's work with the end of life team, its visitor's charter, care for patients with learning disabilities, and implementation and consideration of the deprivation of liberty safeguards (DoLS). In addition the service used memory bands for patients and relatives.
- Safety huddles had been implemented on the wards at the University Hospital of North Durham.
- There was consistently positive feedback from patients and relatives about community nursing teams with care being described as excellent.
- The dietetics team was committed to improving nutrition; work it had undertaken had been published and shared nationally.
- The County Durham Rapid Early Specialist Team (CREST) service provided early senior and multidisciplinary assessment for frail older people, which facilitated safe, early supported discharge and managed patients with an anticipated short length of stay.
- There was a family nurse partnership established to provide intensive support for teenage mothers.
- Staff in the CT department had received a 'Making a difference' award in February 2014.
- Staff on ward 52 had recently been awarded the 'Quality mark for elder-friendly hospital wards'.

Areas for improvement

Action the trust MUST take to improve

- Review current governance processes to ensure they are embedded to ensure consistency across acute and community services.
- Review, and ensure that all members of the board are fully aware of their lead responsibilities within, the Board Assurance Framework.
- Review consultant levels against CEM guidance.
- Ensure that the A&E departments meet cleanliness, infection control and hygiene standards, particularly relating to high and low level dust, blood stains, equipment and floors. Chairs and equipment that have deteriorated must be removed and replaced.
- Ensure that all toys are cleaned properly to reduce the risk of infection within the A&E department.
- Ensure that sharps bins are managed appropriately to reduce the risk of needle stick injury within the A&E department.
- Ensure that all resuscitation drugs and equipment within the A&E department are regularly checked, cleaned and in date. This should include all grab bags and anaphylaxis kits.
- Ensure that all relevant staff know where the difficult airway kit is kept.
- Ensure that there are robust risk assessments in place for the paediatric environment within the A&E department. These must be readily accessible and available to all staff in the department. Risk mitigation must be outlined and an action plan to improve the area must be written.
- Ensure that there are sufficient numbers of suitably skilled, qualified and experienced staff, in line with best practice and national guidance and taking into account patients' dependency levels, on medical wards, particularly where patients are receiving non-invasive ventilation (NIV) and require level 2 intervention.
- Undertake a review of current documentation relating to the care and management of patients receiving NIV to ensure that it is consistent across both the University Hospital of North Durham and Darlington Memorial Hospital.
- Have arrangements in place for patients receiving NIV that comply with the British Thoracic Society guidelines (2008) for the use of NIV for acute exacerbation of chronic obstructive pulmonary disease.

Outstanding practice and areas for improvement

- Undertake a regular audit of the provision of services to patients requiring NIV to ensure that the service is safe and of appropriate quality.
 - Ensure that patients are placed on the most appropriate ward to meet their needs, including a review of the care of patients requiring NIV to ensure that they are admitted to a suitable ward with appropriately skilled and experienced staff in line with best practice guidance.
 - Ensure that patient records, including those for patients awaiting discharge, are kept up to date, are patient-centred, contain relevant information about their treatment and care and serve to eliminate unnecessary delays.
 - Ensure that it undertakes a review of the skills, knowledge and capabilities of nurses to complete accurate and timely care plans that meet the needs of patients.
 - Establish a consistent approach to critical care outreach services across the organisation.
 - Ensure that, at all times, there are sufficient numbers of suitably qualified, skilled and experienced medical staff within maternity and gynaecology services.
 - Ensure that there are processes in place by which to identify, acknowledge and address risks through robust management processes within maternity and gynaecology services.
 - Ensure the paediatric high dependency unit room has specific standard operating procedures or protocols available to guide suitably trained staff.
 - Ensure that advanced paediatric nurse practitioners have a set of standard operating procedures available to guide their practice and care.
 - Review paediatric nurse cover in the A&E department at the University Hospital of North Durham to ensure all shifts are covered with a paediatric nurse, either through service level agreement with the paediatric department or through the appointment of paediatric nurses to the department, to ensure a consistent approach across the organisation.
 - Ensure that staff know the syringe driver policy and carry out/record syringe driver checks in line with this policy.
 - Add audits of syringe driver administration safety checks to the annual end of life audit programme.
 - Ensure that medical staff record mental capacity assessments for patients who are unable to participate in decisions about 'do not attempt cardiopulmonary resuscitation' (DNACPR).
 - Ensure that audits of mental capacity assessments are incorporated into audits of DNACPR forms.
 - Ensure robust implementation of structural changes to the specialist palliative care team to support the development of the end of life care services.
 - Ensure that data are available to identify and demonstrate the effectiveness of the end of life service.
 - Ensure that all resuscitation equipment is checked daily and stored securely, and introduce a monitoring system to ensure that checks take place within the outpatient departments.
 - Ensure that there are sufficient numbers of suitably skilled, qualified and experienced staff in the urgent care centres.
 - Address the lack of consultant medical staff cover in end of life community services.
 - Develop access to out-of-hours advice for healthcare professionals caring for palliative and end of life patients within community.
 - Ensure that there is effective leadership and management in place to maintain and develop the community end of life service.
- In addition the trust should:
- Continue to review College of Emergency Medicine (CEM) audit data to ensure patient outcomes are met.
 - Review the complaint process in terms of board oversight, CEO involvement and clinical direction.
 - Direct medical staff to check resuscitation equipment and drugs before the start of their shift even where nursing staff have completed the checks.
 - Encourage all relevant staff within the A&E department to attend violence and aggression training.
 - Ensure that patients have their medicines reconciled in accordance with trust targets.
 - Review access to patient information in languages other than English.
 - Review dedicated management time allocated to ward managers.
 - Review the flow of higher dependency patients throughout the hospital to ensure care is given in the most appropriate setting.

Outstanding practice and areas for improvement

- Have an up-to-date standard operating procedure (SOP) which clearly sets out the management of patients requiring NIV who are admitted to both acute hospitals.
- Ensure that this guidance/SOP includes clarity on the setting/specific ward in which patients can be managed.
- Ensure that this guidance/SOP includes staffing-to-patient ratios that are in line with current guidance.
- Ensure that there is a plan in place to deliver training to all staff involved in the care of patients receiving NIV, and that it is competency-based and in sufficient detail to demonstrate competence in all aspects of NIV.
- Ensure that any guidance/SOP includes an escalation plan that includes action to be taken when no bed is available in an appropriate setting and when patient numbers do not match agreed staffing ratios.
- Ensure that the intensive care unit has an outreach team to identify and monitor deteriorating patients.
- Ensure that there is clinical pharmacist input in the intensive care unit in line with 'Core standards for intensive care' guidelines.
- Consider ways of improving engagement between staff and managers within the Care Closer to Home directorate, with a view to achieving a joined-up approach within maternity and gynaecology services. Also, consider ways of improving responsiveness and efficiency in respect of service-level decisions within this service.
- Consider ways in which it can identify the required standards within the maternity service dashboard.
- Consider timelines for review and achievement within the maternity and gynaecology services clinical and quality strategy for 2014–16.
- Consider ways of developing a coherent plan for joint working on improvements in maternity and gynaecology services.
- Consider ways of implementing timely and responsive human resource management processes, including in respect of personnel issues that impact on service delivery in maternity and gynaecology services.
- Formally nominate an executive or non-executive director to represent children at board level, separate from the safeguarding children executive lead role.
- Ensure that actions in response to the National Care of the Dying Audit (NCDAH) and other identified actions to develop the service are carried out in a planned and timely way with continued evaluation.
- Ensure that systems support ways of identifying when incidents and complaints relate to end of life care so that specialist input can be provided and recorded in terms of investigation and learning.
- Ensure that any out of date medication is removed from stock cupboards once it has expired, in line with the trust medication management policy, and have a process for monitoring this within the outpatient departments.
- Ensure that all fridge temperatures are checked daily and that there is a system in place to monitor checks taking place within the outpatient departments. The trust should ensure that the cold chain is robust.
- Improve audit activity to monitor quality and patient outcomes within its urgent care centres.
- Ensure that all clinicians within children and young people's community services have the appropriate level of children safeguarding training.
- Review staffing at night within its urgent care centres.
- Review need for paediatric trained nurses in the urgent care centres.

Requirement notices

Action we have told the provider to take

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

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

This section is primarily information for the provider

Requirement notices

Ensure there is effective leadership and management in place to maintain and develop the community end of life service.

Regulated activity

Treatment of disease, disorder or injury

Regulation

Regulation 18 HSCA (RA) Regulations 2014 Staffing

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

Address the lack of consultant medical staff cover in community end of life services.

Regulated activity

Treatment of disease, disorder or injury

Regulation

Regulation 9 HSCA (RA) Regulations 2014 Person-centred care

Ensure that patients are placed on the most appropriate ward to meet their needs, including a review of the care of patients requiring NIV to ensure that they are admitted to a suitable ward with appropriately skilled and experienced staff, in line with best practice guidance.

Ensure that patient records are maintained and up to date, are patient centred and contain the relevant information about their treatment and care, including patients awaiting discharge to eliminate unnecessary delays.

Regulated activity

Treatment of disease, disorder or injury

Regulation

Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment

This section is primarily information for the provider

Requirement notices

Ensure the A&E departments meet cleanliness, infection control and hygiene standards, particularly relating to high and low level dust, blood stains, equipment and floors.

Ensure the areas outside the A&E decontamination facilities are free from dirt, litter and debris.

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