South Tees Hospitals NHS Foundation Trust

The James Cook University Hospital

Quality Report

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

Ratings

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

Summary of findings

Letter from the Chief Inspector of Hospitals

James Cook University Hospital was one of two acute hospitals forming South Tees Hospitals NHS Foundation Trust. The trust provided acute hospital services to the local population as well as delivering community services in Hambleton, Redcar, Richmondshire, Middlesbrough and Cleveland. The trust also provided a range of specialist regional services to 1.5 million people in the Tees Valley and parts of Durham, North Yorkshire and Cumbria. It had a purpose-built academic centre with medical students and nursing and midwifery students undertaking their clinical placements on site. In total, the trust had 1,351 beds across two hospitals and community, and employed around 9,000 staff. James Cook University Hospital had 1,046 beds.

James Cook University Hospital provided medical services, surgical services, critical care services, maternity services, children and young people's services for people across the Hambleton, Redcar, Richmondshire, Middlesbrough and Cleveland areas. The hospital also provided emergency and urgent care (A&E) and outpatient services.

We inspected James Cook University Hospital as part of the comprehensive inspection of South Tees Hospitals NHS Foundation Trust, which included this hospital, the Friarage Hospital and community services. We inspected James Cook University Hospital on 9 to 12 and 16 December 2014.

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

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

Our key findings were as follows:

- Arrangements were in place to manage and monitor the prevention and control of infection, with a dedicated team to support staff and ensure policies and procedures were implemented. We found that all areas we visited were clean. Rates of Methicillin-resistant Staphylococcus Aureus (MRSA) and Clostridium difficile (C. difficile) were within an expected range for the size of the trust.
- Patients were able to access suitable nutrition and hydration, including special diets, and they reported that, on the whole, they were content with the quality and quantity of food.
- There were processes for implementing and monitoring the use of evidence-based guidelines and standards to meet patients' care needs.
- There was effective communication and collaboration between multidisciplinary teams.
- There were staff shortages, particularly in A&E, on some medical wards and in children's services, mainly due to vacancies for nursing staff. The trust was actively recruiting following a review of nursing establishments. In the meantime, bank and locum staff were being used to fill any deficits in staff numbers, and staff were working flexibly, including undertaking overtime.
- The composite of the Hospital Standardised Mortality Ratio (HSMR) indicators was slightly higher than the national average in this trust. The Summary Hospital-level Mortality Indicator (SHMI) was as expected.

We saw several areas of outstanding practice including:

- In the integrated medical care centre, a team of therapeutic volunteers had been created which was led by a therapeutic nursing sister who had been in place for 18 months. The volunteers had mandatory and dementia training and were in operation 24hours a day. The role of the volunteers was to support patients who may be living with dementia or other illnesses which affected their behaviour and level of supervision required. This included

engaging with patients, such as playing board games or other interests patients may have. They also supported patients who required help with eating or wanted to explore their environment. This included supporting them overnight if they were disorientated. The volunteers predominantly worked on wards 10, 12 and 26. The team had been regionally recognised for its work.

- In maternity services, the Families and Birth Forum was involved in the design of the induction of labour suite and championing the take-up of breastfeeding rates through the use of peer supporters, as well as improving information to raise awareness and promote the service to women when they had left the hospital.
- In maternity services, lay representatives were actively involved in the patient experience rounds and 15 Steps Challenge – a series of toolkits used as part of the productive care work stream. The toolkits helped look at care in a variety of settings through the eyes of patients and service users, to help determine what good quality care looks, sounds and feels like.
- In maternity services, a 'baby buddy' mobile phone app was being piloted by the community midwives to inform women of pregnancy issues, common ailments and reasons to seek advice.
- We found outstanding areas of practice in the care and involvement of young people, including a young people's unit, participation and accreditation in the You're Welcome toolkit in four clinical areas, the development of a young person's advisory group, inspections of services by young people and the involvement of young people in staff interviews.

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

Importantly, the trust must:

- Ensure there is a robust safeguarding assessment process in A&E. The safeguarding assessment tool must be consistently completed and regularly audited for all types of presentation. If there are concerns recorded in the safeguarding tool, there must be a contemporaneous (notes made at the time or shortly after an event) documented outcome within the care record.
- Ensure the paediatric environment in A&E is reviewed so it is fit for purpose; including a process to make sure that robust risk assessments are readily accessible and available to all staff in the department.
- Review and address nurse staffing levels in the A&E department.
- Continue to ensure that paediatric care records are contemporaneous, appropriately completed and regularly audited to monitor staff compliance.
- Ensure all toys in A&E are cleaned regularly to reduce the risk of infection.
- Ensure that there is sufficient numbers of suitably qualified and experienced staff particularly in the A&E department, medical wards, surgical wards and children's wards, particularly the paediatric intensive care unit (PICU).
- Ensure that there are sufficient assisted bathing facilities and moving and handling aides within the children's and young people's ward areas.
- Ensure the timely completion of the refurbishment of the medical block, especially wards 10 and 12, to enable people living with dementia to be cared for in a safe environment.
- Ensure that staff have received an appraisal and appropriate supervision so that the trust can be assured they staff are competent to undertake their role.
- Ensure that there are appropriate arrangements in place for the safe handling and administration of medication, including the reconciliation of patients' medications that all controlled drugs are appropriately checked particularly on CCU and that medication omissions are monitored, investigated and reported in line with trust policy.
- Ensure that all patients' records are maintained up to date, including the recording of identification and stored confidentially in accordance with legislative requirements.
- Ensure that the system for nurse calls is reviewed to ensure that there is no confusion over patients calling for assistance and the emergency alert for cardiac arrest potentially causing delays in treatment.

Summary of findings

- Ensure that, where a patient is identified as lacking the mental capacity to make a decision or be involved in a discussion around resuscitation, a mental capacity assessment is carried out and recorded in the patient's file in accordance with national guidance.
- Review arrangements for the recording of do not attempt cardio-pulmonary resuscitation (DNA CPR) decisions, including records of discussions with patients and their relatives to ensure that they are in accordance with national guidance.
- Ensure robust monitoring of the safe use of syringe drivers, with sharing of results and learning from safety audits.
- Ensure that an appropriate concealment trolley is in use for the transfer of the deceased, that risks have been assessed, and that all staff using the trolleys are aware of safe moving and handling practices.
- Ensure staff receive appropriate training, including the completion of mandatory training, particularly the relevant level of safeguarding and mental capacity training so that they are working to the latest up to date guidance and practices, with appropriate records maintained.
- Ensure that ward-based nursing staff are educated in the use of syringe drivers, including best practice in the use of continuous administration of medication for the management of key symptoms at the end of life.
- Provide training for ward-based medical and nursing staff in the assessment of nutrition and hydration for people at the end of life and monitor how assessments are carried out and decisions made.
- Ensure that resuscitation equipment in surgical wards and in outpatients and diagnostic imaging areas is checked in accordance with trust policies and procedures and that this is monitored.

In addition the trust should:

- Review College of Emergency Medicine audit data to ensure that good patient outcomes are met.
- Continue to review and reduce mortality outliers for the Hospital Standardised Mortality Ratio (HSMR)
- Consider the commencement of a restraint-training programme for staff in A&E.
- Introduce a formal toy-cleaning schedule in A&E.
- Identify a formal board-level director who can promote children's rights and views. This role should be separate from the executive safeguarding lead for children.
- In medical care services, patients who are medically fit are discharged in a timely manner to the appropriate setting to reduce the number of delayed discharges.
- Review the content and access of risk registers in medical care to ensure that these are robust to appropriately inform decision making regarding actions taken to mitigate any risk. Review the systems in place for learning lessons from complaints to improve the patient's experience.
- Review the progress of mitigating actions taken to prevent patient falls and the development of pressure ulcers, including ward based action plans, on medical care wards.
- Review the care of patients receiving non-invasive ventilation to ensure that care is delivered in line with national guidance, particularly nurse staffing ratios.
- Ensure that there are mechanisms for reviewing and, if necessary, updating patient information, particularly in the outpatients department.
- Introduce patient surveys specific to the outpatients department.

Professor Sir Mike Richards
Chief Inspector of Hospitals

Summary of findings

Our judgements about each of the main services

Service	Rating	Why have we given this rating?
Urgent and emergency services	Good	Overall, we rated urgent and emergency care services at this hospital as good. The department was visibly clean and we observed good hand hygiene. Systems were in place for investigating incidents, learning the lessons of those incidents and communicating those lessons to staff. A programme of mandatory training was in place and managers were working towards training targets. Policies and protocols were underpinned by national guidelines but the department did not meet several patient outcome targets. The trust had a clinical audit programme and categorised its centrally coordinated clinical audit activity according to clear priorities. We saw evidence that further clinical audits had been carried out and the results and actions were awaited. Patients told us they were provided with adequate pain relief. There was a rolling programme of regular training and appraisal for staff and the trust was ranked third in the country for their junior doctors' training programme. Multidisciplinary team arrangements were in place. Patients received a caring service in the department. We observed respectful and courteous interactions with patients that showed patients were treated well and with compassion. Between 2013 and 2014, the department almost met the standard of admitting, transferring or discharging 95% of patients within four hours. From April to October 2014, the standard that 95% of ambulance patients should be handed over within 15 minutes of arrival was met. It was evident that staff understood that access and flow was a top priority and they worked well together to try to maintain compliance with national standards. Paediatric facilities were limited and children often used the adult waiting area; ambulatory paediatric patients were treated in areas where adults were cared for. There was clear leadership in A&E and senior managers worked closely together to monitor and improve care. Regular governance and information-sharing meetings were held and there

Summary of findings

was an open and effective culture throughout. All staff exhibited high morale and pride in their work and were focused on giving patients a positive experience.

Medical care

Good

We rated medical care as good, although safety required improvement. Nurse staffing levels, especially overnight were concerning with levels on some wards of one nurse to 16, 14.5 and 13.5 patients. The trust had already highlighted this as a concern and plans were in place to improve the ratios. Attendance at mandatory and safeguarding training was low on some specific wards. The Hospital at night service provided a co-ordinated system for medical handovers and managed requests for support from the doctors working overnight.

Hospital Standardised Mortality Ratio compares number of deaths in a trust with number expected given age and sex distribution. HSMR adjusts for a number of other factors including deprivation, palliative care and case mix. HSMRs usually expressed using '100' as the expected figure based on national rates. In 2013/14 the Trust had a slightly higher figure of 108, this was lower than the previous year. The Summary Hospital-level Mortality Indicator (SHMI) for 1-July 2013 to 30 June 2014 was as expected.

The hospital participated in national clinical audits. At the time of the inspection 52% of staff had received an appraisal and approximately 60% of staff working within the integrated medical care centre had received staff development reviews. The trust was proactive in planning discharge dates, there were delays in discharging people who were medically fit to leave the hospital but required a transfer to other packages of care.

Systems were in place to report incidents, analysis and feedback was provided to staff. Wards monitored safety and harm free care and results were positive, overall. Wards were clean and staff were observed adhering to infection control principles. Patients' records and observations were mostly recorded appropriately and concerns were escalated in accordance with the trust guidance.

Summary of findings

Policies based on NICE and Royal College of physicians guidelines were available to staff and accessible on the trust intranet site. Audits were undertaken to monitor compliance with guidance. Almost all patients and relatives told us that they or their relatives had been treated with compassion and that staff were polite and respectful. Patients were aware of what treatment they were having and understood the reasons for this and, in many cases, had been involved in the decisions. The trust had prioritised and developed a number of initiatives to improve the care of people living with dementia, including the use of therapeutic volunteer workers.

There had been very recent changes to the leadership of the integrated medical care centre as part of a wider trust restructure. Staff were generally positive about the leadership and the recent appointments. Most staff were clear about the vision and strategy for the service.

Clinical governance meetings were held at speciality, group and clinical centre levels. There was generally good clinical engagement and attendance. The clinical centre risks register included most but not all the issues identified as risks during the inspection.

Surgery

Good

Overall, we rated surgical services as good. There were effective arrangements for reporting patient and staff incidents and allegations of abuse. Staff were encouraged to report incidents and most received feedback on what had happened as a result. Staffing establishments and skills mix had been reviewed for the number and acuity of patients.

There were arrangements for the effective prevention and control of infection and the management of medicines. Equipment was routinely examined in the daily checks for anaesthetic equipment. However, resuscitation equipment had not been routinely checked on some wards and signatures were missing from documentation. Care records were completed accurately and clearly.

Surgical services participated in national clinical audits and reviews to improve patient outcomes. Mortality indicators were within expected ranges.

Summary of findings

Processes were in place to identify staff's learning needs and opportunities for professional development. There was effective communication and collaboration between multidisciplinary teams who met regularly to identify patients requiring visits or to discuss any changes to patients' care.
We observed positive, kind and caring interactions on the wards and between staff and patients. Patients spoke positively about the standard of care they had received. Most patients we spoke with felt they understood their care options and were given enough information about their condition. There were services to ensure that patients received appropriate emotional support.
Services were available to support patients, particularly those living with dementia, a learning disability or physical disability or those whose first language was not English. There were also systems to record concerns and complaints raised within the centre, review these and take action to improve patients' experience.
The trust's vision, values and strategy had been disseminated to wards and departments and staff had a clear understanding of what these involved. Staff were aware of their roles and responsibilities and there was good ward leadership. Staff felt supported and had seen positive changes to improve patient care.
The service recognised the importance of patient and public views and had mechanisms to hear and act on patients' feedback. Staff were encouraged and knew how to identify risks and make suggestions for improvements.

Critical care

Good

We rated critical care services as good. Effective arrangements were in place for reporting patient and staff incidents and allegations of abuse, which was in line with national guidance. Nurse staffing levels were determined using an acuity tool and national guidelines were followed. Although an additional coordinator was factored into staffing rotas in line with the Core Standards for Intensive Care Units 2013, this did not always happen due to staff sickness. The safety of patients was not compromised as a result of this. The complement of medical staff and the skills mix of the medical team were suitable and were in line with national

Summary of findings

guidance. There were arrangements for the effective prevention and control of infection and the management of medicines. Checks were carried out on equipment and care records were completed accurately and clearly.

There were processes for implementing and monitoring the use of evidence-based guidelines and standards to meet patients' care needs. The unit performed well in comparison with similar units in terms of patient outcomes, and there were no concerning patient outcome figures. Processes were in place to identify staff's learning needs and opportunities for professional development. There was effective communication and collaboration between multidisciplinary teams, who met regularly to identify patients requiring visits or to discuss any changes to patients' care.

All the critical care units were caring. We saw people and their relatives being treated with understanding, compassion, dignity and respect. Patients spoke positively about the care that they received. Patients and their relatives felt they understood their care options and were given enough information about their conditions. Services were provided to ensure that patients received appropriate emotional support.

The staff groups were also responsive to the changing needs of patients and worked effectively to manage the workload. Quality indicators, including early readmissions, late readmissions and post-unit hospital deaths were within acceptable limits on all units. Average length of stay for all admissions and for unit survivors were also within acceptable limits. The units had a very low number of complaints. The vast majority of concerns and complaints were managed at a local level without the need for issues to be formally escalated. Any learning from complaints was disseminated to staff through staff meetings and directorate updates.

The trust's values and objectives had been communicated to all staff and they had a clear understanding of what this involved. Governance processes were embedded and there were appropriate processes for managing risk. The leadership teams were approachable and open, and

Summary of findings

were viewed positively by staff. The management teams had a number of effective ways of engaging with staff, and patient engagement and feedback was actively sought on the units.

Maternity and gynaecology

Good

Overall, maternity services were good in all areas reviewed, with services rated as 'outstanding' for being well-led. We observed exemplary practice in the care and treatment of women.
The service provided safe and effective care in accordance with recommended practices.
Outcomes for women using the service were continuously monitored and, where improvements were required, action was taken.
Resources, including equipment and staffing, were sufficient to meet women's needs. Staff had the correct skills, knowledge and experience to do their job.
Women's individual needs were taken into account in planning the level of support throughout their pregnancy. Women were treated with kindness, dignity and respect. The service took account of complaints and concerns and implemented action to improve the quality of care.
The maternity and gynaecology services were led by a highly committed, enthusiastic team, each sharing a passion and responsibility for delivering a high-quality service. Governance arrangements were embedded at all levels and enabled the effective identification and monitoring of risks, and the review of progress on action plans. There was very strong engagement with patients and staff. There was evidence of innovation and a proactive approach to performance improvement.

Services for children and young people

Good

We rated services for children and young people as good, although safety required improvement. The levels of nursing staff did not meet nationally recognised guidelines within the children's clinical areas, although we did not identify evidence showing that this impacted negatively on patient care. The paediatric intensive care unit (PICU) staffing numbers were not always sufficient to meet the dependency needs of children. Medical staffing had some gaps but was adequate in comparison with other hospital services. The children's services actively monitored safety, risk and cleanliness.

Summary of findings

Children's services had made improvements to care and treatment where the need had been identified using assessment programmes or in response to national guidelines. The medical staff had a proactive clinical audit programme.
Children, young people and parents told us they received compassionate care with good emotional support. Parents felt fully informed and involved in decisions relating to their child's treatment and care.
We found that a recent service reconfiguration was being closely monitored and managed in partnership with commissioners and other healthcare providers. We found access and flow was good within the children's inpatient areas, facilitated by regular medical handovers and reviews. However, patient flow on the paediatric day unit (PDU) was impeded at times due to the environment.
The service had a clear vision and strategy based on the National Service Framework for Children. The service was led by a positive management team who worked well together. The service regularly introduced innovative improvements with the aim of constantly improving the delivery of care for children and families. We found several areas of outstanding, innovative practice in the care and involvement of young people.

End of life care

Requires improvement

Overall, we rated end of life services as requiring improvement. End of life services were caring, responsive and well-led but required improvement in order to be safe and effective. Do not attempt cardio pulmonary resuscitation (DNA CPR) forms were not always being completed in line with national guidance and the trust's policy, and patients who were identified as lacking mental capacity were not always having their mental capacity assessments documented. Monitoring of the safe use of syringe drivers for end of life medication was not being recorded consistently. Training and education for ward-based staff had been problematic due to issues in releasing staff from the wards to attend. The specialist palliative care team (SPCT) had approached this issue by delivering more informal ward-based training,

however, this hadn't been recorded so its effectiveness was difficult to evaluate. Education was one of the key themes identified as part of the end of life steering group work programme.
The trust had a care pathway in place which was being used during the transition from the phase out of the Liverpool Care Pathway and the introduction of a new regional pathway. We saw that the last days of life care pathway in use did not include specific prompts around nutrition and hydration assessments and that these were sometimes missing in the pathways we reviewed. However, this had been addressed to ensure specific prompts were incorporated into the new guidance.
The specialist palliative care team supported ward-based staff with end of life care and they were committed to the development of end of life care skills to improve care for patients. We saw evidence of plans to address issues identified in both internal and external audits and we saw service planning in progress centred around seven key themes identified by the end of life steering group.
There was evidence of innovation in the form of a bereavement service and a pilot to review patients at the end of life who were highlighted on admission. The focus of these innovations was to improve support to relatives and care to patients at the end of life.
Staff were caring and compassionate and we saw the service was responsive to patients' needs. There were prompt referral responses from the specialist palliative care team and rapid discharge for patients at the end of life wishing to be at home.

Outpatients and diagnostic imaging

Good

Overall the care and treatment received by patients in the James Cook University Hospital outpatients and imaging departments was effective, caring, responsive and well-led, although safety required improvement . Medication in the imaging department was not stored correctly and there was no stock control in place. Checking of resuscitation equipment in the imaging department and some outpatient departments was inconsistent. A number of patient information leaflets across the departments were past their review date.
Patients were happy with the care they received and found it to be caring and compassionate. Staff

Summary of findings

were supported and worked within nationally agreed guidance to ensure that patients received the most appropriate care and treatment for their conditions. Patients were protected from the risk of harm because there were policies to make sure that any additional support needs were met. Staff were aware of these policies and how to follow them. Different outpatient departments and imaging sub-specialties carried out local satisfaction surveys and looked at patients' feedback as a way to improve services provided. Services offered were delivered in an innovative way to respond to patients' needs and ensure that the departments work effectively and efficiently.

Requires improvement

The James Cook University Hospital

Detailed findings

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

Contents

Detailed findings

Background to The James Cook University Hospital

James Cook University Hospital was one of two acute hospitals forming South Tees Hospitals NHS Foundation Trust, a foundation trust since May 2009.The trust provided acute hospital services to the local population as well as delivering community services in Hambleton, Redcar, Richmondshire, Middlesbrough and Cleveland. The trust and hospital also provided a range of specialist regional services to 1.5million people in the Tees Valley and parts of Durham, North Yorkshire and Cumbria. In total, the trust had 1,351 beds across two acute care hospitals and community hospitals, and employed around 9,000 staff. James Cook University Hospital had 1,046 beds.

James Cook University Hospital provided medical services, surgical services, critical care services, maternity services, and children and young people's services across the Hambleton, Redcar, Richmondshire, Middlesbrough and Cleveland areas. The hospital also provided emergency and urgent care (A&E) and outpatient services. The A&E department was open 24 hours a day, seven days a week; of 102,870 patients, 17,772 children attended between April 2013 and March 2014. Patients were cared for in three main areas: ambulatory care, which included 'see and treat', majors and resuscitation. The resuscitation area had four bays, majors had 20 cubicles and the ambulatory care area had five cubicles.

The hospital provided elective and non-elective treatments for neurosurgery, cardiothoracic surgery, ear, nose and throat, ophthalmology, colorectal surgery, trauma and orthopaedics, nephrology, urology and vascular surgery.

The James Cook University Hospital had a general intensive care unit (ICU), a cardiothoracic intensive care unit, a general high dependency unit (HDU), a cardiothoracic high dependency unit as well as spinal and neurological high dependency units. These units covered a catchment population of around 678,800.

The hospital offered a full range of maternity services for women and families as well as in the community setting, ranging from specialist care for women who needed closer monitoring to a home-birth service for women with low-risk pregnancies. There were teams of community midwives who delivered antenatal and postnatal care in women's homes, clinics, children's centres and GP locations across the South Tees region.

The directorate of paediatrics and neonatology was responsible for services for babies, children and young people at James Cook University Hospital. Services at the hospital included three children's wards: Ward 21, a 30-bed ward for paediatric medicine which included an 11-bed young people's unit; Ward 22, a 17-bed ward for paediatric trauma and surgery; and the PDU, a seven-bed assessment area which accepted children from the A&E department and general practice. The service included the children's outpatient department and the neonatal unit, which included 10 intensive/high dependency cots and 20 special care baby cots. The directorate was also responsible for the PICU which included four critical care beds and three high dependency beds. There was also a nine-bed paediatric surgery day unit managed by the anaesthetic/theatre directorate. The directorate also provided community paediatric services.

The hospital did not have any wards that specifically provided end of life care. Patients requiring end of life care were identified and cared for in ward areas throughout the hospital with support from the specialist palliative care team. The specialist palliative care team comprised one full-time palliative care consultant and one half-time respiratory consultant with an interest in palliative care. There was an end of life lead nurse and three additional palliative care nurses. The team worked as part of a wider multidisciplinary palliative care team that provided specialist palliative care support to patients at this hospital, the Friarage Hospital and across two community regions.

The James Cook hospital had outpatient departments in 12 locations across the site. There was a main outpatients department and 11 other outpatient departments where specialty-specific clinics such as cardiology, dermatology and neurology were held. There was one main radiology and imaging department and a number of other specialist imaging departments such as neuroradiology. PET Computerised tomography (CT) scans were carried out on site by Allied Healthcare on behalf of the trust.

Detailed findings

Our inspection team

Our inspection team was led by:

Chair: Sandra Christie, Director of Nursing, Wirral Community NHS Trust

Head of Hospital Inspections: Julie Walton, Care Quality Commission (CQC)

The team included CQC inspectors and a variety of specialists: a consultant in emergency medicine, a consultant paediatrician, a consultant clinical oncologist, a consultant obstetrician and gynaecologist, a consultant anaesthetist, a consultant in oncology, a junior doctor, a clinical nurse specialist, senior nurses, student nurses and experts by experience.

How we carried out this inspection

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

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

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

- Urgent and emergency services (or A&E)
- Medical care (including older people's care)
- Surgery
- Critical care
- Maternity and gynaecology
- Services for children and young people
- End of life care
- Outpatients and diagnostic imaging.

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

We carried out an announced visit between 9 and 12 December 2014. During the visits we held a focus group with a range of hospital staff, including support workers, nurses, doctors (consultants and junior doctors), physiotherapists, occupational therapists and student nurses. We talked with patients and staff from all areas of the trust, including from the wards, theatres, critical care, outpatients, maternity and A&E departments. We observed how people were being cared for, talked with carers and family members and reviewed patients' personal care or treatment records.

We completed an unannounced visit on the night of 16 December 2014.

We held a listening event on 2 December 2014 in Middlesbrough 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.

Facts and data about The James Cook University Hospital

James Cook University Hospital provided services to 1.5 million people in the Tees Valley and parts of Durham, North Yorkshire and Cumbria.

The hospital had around 186,172 inpatient and day case admissions during 2013/14. In 2013, the outpatient departments had around 486,091 attendances for both consultant- and nurse-led clinics.

Detailed findings

During the period April 2013 to October 2014, the James Cook University Hospital had 24,022 children and young people admissions and 4,216 day case admissions. In the same period, the trust reported that it had 129,362 outpatient and 2,495 ward attendances.

The outpatients department saw a total of 667,652 new and review outpatient appointments between April 2013 and March 2014. Of these, 440,650 were new appointments and 173,589 were review appointments. The service delivered about 5,247 babies in 2013/14.

Deprivation in South Tees was higher than average, with some areas of considerable deprivation on a par with the most deprived areas of the country. Significant numbers of children lived in poverty, with more than one in four children in Redcar and Cleveland and one in three children in Middlesbrough living in poverty (more than 18,000 children across South Tees). There was substantial variation in life expectancy between the most and least deprived areas of South Tees (12.5 years lower for men and 8.5 years lower for women in Redcar and Cleveland; 14 years lower for men and 9.3 years lower for women in Middlesbrough).

Detailed findings

Our ratings for this hospital

Our ratings for this hospital are:

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

Notes

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

Urgent and emergency services

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

Information about the service

The James Cook University Hospital was formally designated as a major trauma centre for the south area of the North East region of England since April 2012, for an initial period of three years. The Accident & Emergency department (A&E) was open 24 hours a day, seven days a week. Patients were cared for in three main areas: ambulatory care, which included 'see and treat', majors and resuscitation. The resuscitation area had four bays, majors had 20 cubicles and the ambulatory care area had five cubicles. The department also had two relatives rooms located near to the resuscitation area.

Between April 2013 and March 2014, A&E provided a service to 102,870 patients, including 17,772 children. The trust anticipated that this figure would rise by 3% per annum. The department was originally established for the purpose of caring for and treating 78,000 patients and has currently seen 71,273 people between April 2014 and November 2014.

During our inspection, we spoke with around 16 patients and their relatives, 30 staff, including doctors, nurses, allied healthcare professionals, managers and domestic staff. We observed care and treatment and reviewed 53 sets of care records. Prior to and following our inspection, we reviewed a range of performance information about the department.

Summary of findings

Overall, we rated urgent and emergency care services at this hospital as good. The department was visibly clean and we observed good hand hygiene. Systems were in place for investigating incidents, learning the lessons of those incidents and communicating those lessons to staff. There was also a programme of mandatory training and managers were working towards training targets. Nurse staffing levels were below average when benchmarked against other A&E departments.

Policies and protocols were underpinned by national guidelines but the department did not meet several patient outcome targets. The trust had a clinical audit programme and categorised its centrally coordinated clinical audit activity according to clear priorities. We saw evidence that further clinical audits had been carried out and the results and actions were awaited. Patients told us they were provided with adequate pain relief. There was a rolling programme of regular training and appraisals for staff and the trust was ranked third in the country for their junior doctors training programme. Multidisciplinary team arrangements were in place.

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

Between 2013 and 2014, the department almost met the standard of admitting, transferring or discharging 95% of patients within four hours. From April to October

Urgent and emergency services

2014, the standard that 95% of ambulance patients should be handed over within 15 minutes of arrival was met. it was evident that staff understood that access and flow was a top priority and they worked well together to try to maintain compliance with national standards.

Paediatric facilities were limited and children often used the adult waiting area; ambulatory paediatric patients were treated in areas where adults were cared for. There were systems for investigating complaints, learning the lessons of those complaints and communicating lessons to staff.

There was clear leadership in A&E and senior managers worked closely together to monitor and improve care. Regular governance and information-sharing meetings were held and there was an open and effective culture throughout. All staff exhibited high morale and pride in their work and were focused on giving patients a positive experience.

Are urgent and emergency services safe?

Good

The safety of care to adults was good. The department was visibly clean and we observed good hand hygiene. Medicines were mainly handled in accordance with legislation and guidelines. Nurse staffing level were below average when benchmarked against other A&E departments. There were systems for investigating incidents, learning the lessons of those incidents and communicating those lessons to staff. A programme of mandatory training was in place and managers were working towards training targets.

Incidents

- Nursing staff were knowledgeable about the reporting process for incidents. Staff said they were encouraged and supported to report incidents. We saw evidence of post-incident feedback to staff through our review of departmental communication processes.
- Staff told us they were aware of the new statutory Duty of Candour, introduced for NHS bodies in England in November 2014. The new regulation sets out key principles, including a general duty on the organisation to act in an open and transparent way in relation to care provided to patients and, as soon as reasonably practicable after a notifiable patient safety incident occurs, tell the patient (or their representative) about it in person.
- There were no Never Events (serious, largely preventable patient safety incidents, which should not occur if the available, preventable measures have been implemented) in the department between April 2013 and December 2014.
- In 2013/14 two serious incidents were reported by the department through the Strategic Executive Information System (STEIS). Senior staff informed us that all serious incidents were investigated, a full root cause analysis was conducted and action plans implemented as a result. We reviewed the self-harm multidisciplinary integrated care pathway for children aged 8–17 years, which was developed as a result of the review of one of the serious untoward incidents. This was an example of learning from incidents taking place at the strategic and operational level.

Urgent and emergency services

- Between 1 April 2013 and 31 March 2014 there had been 448 incidents reported in the department through the National Reporting and Learning System (NRLS). Of these, 282 incidents were rated as 'no actual harm', 105 were rated as 'minor' and one as 'moderate'.
- Departmental mortality and morbidity meetings were held every fortnight to review the care of patients who had experienced complications or an unexpected outcome. In addition, a major trauma multidisciplinary team meeting was held every six weeks to identify any mortality and morbidity themes within trauma. All mortality and morbidity was strategically reviewed in a directorate meeting once a month, which meant there was a formal process within the department to share learning and inform practice.

Cleanliness, infection control and hygiene

- The environment was clean and tidy. We read the cleaning schedule and spoke with the domestic staff who were employed by the trust's contractor; they said their work was checked by a supervisor.
- Hand-washing facilities were readily available and we saw staff wash their hands and use hand gel in between attending to patients. Personal protective clothing, such as gloves and aprons, were available in all clinical areas and the 'bare below the elbow' policy for best hygiene practice was observed to be adhered to.
- The department carried out infection control audits, including hand hygiene technique and peripheral intravenous cannula insertion. We looked at the department's audit results and saw that they had achieved between 90% to 100% compliance from December 2013 to October 2014. A clinical manager told us that staff who did not meet the required standard were quickly identified and 'on the spot' training was provided. This meant that the department had a system for auditing practice and developing staff.
- A manager reported there had been no cases of hospital-acquired Clostridium difficile (C. difficile) or Methicillin –Resistant Staphylococcus Aureus (MRSA) or Methicillin-Sensitive Staphylococcus Aureus (MSSA) between April 2013 and December 2014.
- The Minors/Majors (for minor or major injuries) areas had appropriate facilities for isolating patients with an infectious condition.
- Some of the plastic toys in the paediatric waiting area were dirty around the edges. We asked to see a copy of a toy-cleaning schedule, but this was not provided.

Environment and equipment

- There was a dedicated ambulance entrance that ensured patients had direct access to the resuscitation and Majors areas. There was a restricted access route to and from the hospital's helipad. People who self-referred used a separate entrance and all entrances were clearly signposted.
- The resuscitation areas were equipped appropriately. We checked a range of resuscitation equipment and found it was accessible and fit for purpose.
- Equipment available in the ward had 'clean' labels attached documenting the time and date when it was last cleaned. This meant that staff and patients could be assured that the equipment they used was clean.
- In-service and testing of electrical equipment (portable appliance or PAT inspection) had been carried out in the department. 'PAT tested' labels on electrical equipment examined confirmed this.
- All equipment was serviced on a rolling programme basis by the medical engineering department and we saw stickers attached on some equipment that confirmed servicing and maintenance had been completed.

Medicines

- Medicines were stored correctly in locked cupboards or fridges. Fridge temperatures for the A&E department were checked regularly and records showed these were correct during December 2014..
- Medical gases were found to be stored appropriately in a locked room.
- Emergency drugs were accessible.
- We asked nursing staff about standards of checking medications before, during and after administration and found they understood (and we saw them following) the Nursing and Midwifery Council (NMC): Standards for Medicines Management.

Records

- Patient care records were in paper format and all healthcare professionals documented care and treatment using the same document. The hospital had plans for the introduction of an electronic records system. The implementation of the system was planned for April 2015.
- We reviewed 10 adult patient records and found that the records had the appropriate assessments recorded,

including risk assessments, observations, care and treatment and, where necessary, discharge plans. This meant records we reviewed for adults were completed appropriately.
- We read and reviewed a documentation audit for record-keeping standards dated January 2014; the department had not conducted a further audit since this date. There was no conclusion drawn from the audit and no indication of an agreed audit schedule.
- We reviewed 47 paediatric care records in the see and treat area of the department and found inconsistencies in the way some were completed. A number of records contained adult care pathway documents, the safeguarding tool was either incomplete or not completed at all, and a few records had no record of the care and treatment provided, including pain scores. We raised this with senior managers who told us there was a process for dictating care and treatment, which was typed up within 24 hours of discharge or transfer and then placed with patients' notes. We found that dictation services were about seven days behind schedule due to staff sickness. Following on from our discussions and while we were at the hospital, the managers had taken action to improve paediatric documentation by arranging for extra staff to work to clear the dictation backlog. Staff were auditing the paediatric records to ensure that they were completed correctly.

Safeguarding

- Staff told us they were aware of their responsibilities to protect vulnerable adults and children and described the process to follow.
- We read the safeguarding A&E action flowchart and associated 'traffic light' system that helped staff assess concerns. However, we found there were gaps and inconsistencies in documenting safeguarding assessments.
- We reviewed 47 paediatric care records in the see and treat area of the department and found that, in the majority; the safeguarding tool was incomplete or had not been completed at all. In addition, in these cases, there was no further documentary evidence in the records to show that a safeguarding assessment had been conducted.
- We were informed by the trust that where a safeguarding concern was identified the relevant children would be transferred to the majors area. Senior managers told us that these assessments would be recorded on the dictation machines and transcribed as part of the of the dictation process. However, this process was behind schedule and there was no contemporaneous record available of the safeguarding assessments. We were informed that once the new IT system was implemented, staff would not be able to progress through the records system until a safeguarding assessment had been recorded.
- Before we left the hospital, managers had already started to make improvements by formally instructing staff to document evidence of safeguarding assessments and implementing an audit process until compliance was assured.
- Safeguarding children training was part of the mandatory training programme. For medical staff: 61% had completed the core initial level 3 training; and 41% had completed the safeguarding children level 3 core update. All medical staff had completed safeguarding children training at level 2.
- For nursing staff: 76% had completed the core initial level 3 training; 30% had completed the level 3 core update; 63% had completed safeguarding children training at level 2; and 21% had completed level 1 safeguarding training.
- There was a safeguarding adults training programme for April 2014 to March 2015, and 47% of medical staff and 80% of nursing staff had completed their training.

Mandatory training

- We looked at departmental data for staff mandatory training relating to the period April to December 2014. Records showed that 52% of medical staff and 51% of nursing staff were up to date with their overall mandatory training.
- 66% of nursing staff and 59% of medical staff had completed fire safety training.
- 50% of nursing staff and 65% of medical staff had completed health & safety training.
- 80% of nursing staff and 62% of medical staff had completed information governance training.
- 80% of nursing staff and 59% of medical staff had completed infection prevention and control training.
- The department had a lead trainer and managers informed us they were taking steps to ensure that all staff completed their mandatory training modules by the deadline of March 2015.

Urgent and emergency services

Assessing and responding to patient risk

- We observed assessment processes and found these to be appropriate. Adult patients were assessed and managed using a variety of risk assessment tools, which included the use of the National Early Warning Score (NEWS). Children were risk assessed by the use of the Paediatric Early Warning Score system (PEWS).
- We also reviewed paediatric triage information sheets, developed for staff to use when a children's trained nurse was not available in the department. This meant that nurses trained in adult care could use the information sheets to support their clinical decision-making for high-priority, time-critical conditions that required urgent medical attention.

Nursing staffing

- Nursing numbers were assessed using the Baseline Emergency Staffing Tool (BEST). Ideal and actual staffing numbers were displayed for each shift in the department.
- We read a business case dated June 2014 outlining that the department had a nurse staffing level below average when benchmarked against other A&E departments. There was also no dedicated nursing team assigned to the resuscitation area which was staffed by using nurses from the rapid assessment and treatment area when required. The business case detailed the need to increase the nurse staff numbers from 65.84 whole time equivalent (WTE) to 98.14 WTE. Managers told us the recruitment process had begun and emergency nurse practitioners (ENPs) and band 5 nurses were being recruited.
- The paediatric nurse staffing level was challenging and not all shifts had a paediatric-trained nurse on duty. We found that during the hours of 9.20am–10pm, six days a week, the department had a paediatric ENP on duty. The department was under-establishment for band 5 paediatric nurses as two were on long-term leave. There were plans to increase the paediatric nursing establishment using the existing recruitment process.
- The overall adult care nursing skills mix was appropriate and included clinical sisters, senior sisters/charge nurses, ENPs, band 5 nurses, healthcare assistants and emergency department nursing assistants.
- ENPs are advanced trained nurses able to see, treat and discharge certain categories of patients so that patients do not have to wait to see a doctor. At the time of our visit, there were only 3.8 WTE ENPs and 2.0 WTE paediatric ENPs in post in June 2014. We read a business case that had been submitted to the trust which aimed to increase the adult ENP numbers to 11.8 WTE. ENPs were not counted in the shift nursing numbers due to their role being to assess, diagnose and treat patients.
- Senior managers informed us that agency staff were not used as the existing staff covered shifts through an overtime agreement.
- Handovers and information-sharing sessions were held, with clinical staff responsible for patient care twice a day. Any complaints, concerns or incidents were also discussed at these sessions.

Medical staffing

- The College of Emergency Medicine (CEM) recommends a minimum of 10 consultants in each emergency department, rising to 16 or more in major trauma centres. The trust had 15.4 WTE consultants in the department.
- Two consultants worked on the 'shop floor', Monday to Friday from 8am to 6pm and 5pm to 12 midnight. In addition, another consultant worked in the resuscitation area from 12 midday to 7pm. Consultant staff were on call for the A&E department and were available within 10 minutes.
- At weekends and bank holidays, a consultant worked between the hours of 8am to 6pm and another worked from 4pm to 12 midnight. There were no consultants on duty after 12 midnight.
- There was a lack of middle-grade doctors in post and the department was unable to cover the middle tier rota 24 hours a day, seven days a week. Recruitment is a national problem for this grade.
- Since August 2013, the department only had five trainees on the higher training programme (where eight trainees were normally allocated). Two of the trainees were CT3 grade.
- The hospital was trying to mitigate any risk and we read a business case dated November 2014, which set out a proposal to increase consultant cover to 24 hours a day, seven days a week. We noted the risk register documented that CT3 trainees employed in the department were working as part of the middle-grade rota and were not supervised out of hours.
- In the interim period, middle-grade locums were employed through a single agency to ensure the

standards and requirements of induction, training and revalidation were met. Consultants from the department also worked extra shifts on an overtime agreement.
- A consultant undertook a daily ward round which included reviewing x-rays and safeguarding processes.

Major incident awareness and training

- Staff in the department were well-briefed and prepared for a major incident. They could describe processes and triggers for escalation, including the arrangements for the bronze and silver-level command structure. Similarly, they described the arrangements to deal with casualties contaminated with hazardous materials (HAZMAT) such as chemical, biological or radiological materials.
- There were appropriate security arrangements in the department. Security staff were employed within the hospital 24 hours a day, seven days a week, and could be summoned easily to support staff as they were located close to the department.

Are urgent and emergency services effective?

(for example, treatment is effective)

Requires improvement

Policies and protocols were underpinned by national guidelines, but the department did not meet several patient outcome targets. The trust had a clinical audit programme and categorised its centrally coordinated clinical audit activity according to clear priorities. We saw evidence that further clinical audits had been carried out and the results and actions were awaited. Patients told us they were provided with adequate pain relief. There was a rolling programme of regular training and appraisal for staff and the trust was ranked third in the country for their junior doctors' training programme. Multidisciplinary team arrangements were in place.

Evidence-based care and treatment

- The department used a combination of National Institute for Health and Care Excellence (NICE) and CEM guidelines to determine the treatment they provided. Local policies were written in line with this and were updated if national guidance changed.
- At the monthly departmental meetings, any changes to guidance and the impact it would have on practice was discussed. There was a doctor in the department who was the lead for compliance with NICE and CEM guidelines. If the department was found to be non-compliant with the guidelines, this was escalated to the Board. Subsequent amendments were made to practice and policy after being formally signed off by the Board. We saw evidence of this process and read a NICE guidance care pathway that had been developed in February 2014 for the care of people who present with self-harm conditions.

Pain relief

- All of the patients we spoke with told us that they were offered and/or provided with appropriate pain relief and adult patients' records confirmed this.
- Patient group directions (PGDs) were protocols used in the department. A recognised pain scale for children and adults was also in use. Nursing staff confirmed they used PGDs to manage pain and provided us with documentary evidence that confirmed the lead pharmacist had reviewed all PGDs in December 2014. We witnessed pain relief being administered correctly to patients.

Nutrition and hydration

- Patients told us that they were offered food and drink. We saw this recorded in their records.

Patient outcomes

- The hospital participated in national CEM audits so it could benchmark its practice and performance against best practice and other A&E departments.
- Audits included consultant sign-off, which covered three types of patient groups that should be reviewed by a consultant: adults with non-traumatic chest pain; febrile children less than one-year old; and patients making an unscheduled return to the department with the same condition within 72 hours of discharge. The trust was performing better against the England average.
- We reviewed the CEM audits. Although it was acknowledged these were not recent, they were the

latest audit data available at the time of inspection. In the CEM vital signs in Majors audit of 2010/11, the department did not meet the six standards for measuring and recording vital signs after arrival and triage. The department did not meet any of the five standards for observations being repeated and recorded within 60 minutes. The department also failed to meet the standard for abnormal vital signs being communicated to the nurse in charge or the standard for appropriate investigations being carried out and recorded before patient discharge.

- The department did not meet 10 of the 17 CEM standards for renal colic in the 2012 audit.
- Two standards relating to the re-evaluation of pain were not met, and neither was the standard for recording an initial pain score. The A&E department did not meet standards for the 20- and 30-minute targets for providing analgesia to patients in severe pain but were still in the upper England quartile. In the CEM fractured neck of femur audit of 2012, the department were in the upper England quartile for prompt provision of analgesia to patients after they arrived in A&E at 20 minutes, 30 minutes and within one hour. A&E was in the median for re-evaluating pain. The department was in the upper quartile for appropriate investigations being carried out with results being recorded in the notes before discharge and exceeded the CEM percentage target for an x-ray being performed within 60 minutes.
- In the CEM severe sepsis and septic shock audit of 2011, the department achieved 100% for meeting the standard for vital signs being measured and recorded in the notes, placing it in the upper England quartile. Twelve other standards were not met, with six in the lower England quartile. These included: capillary blood glucose measurements taken and recorded on arrival to A&E (on arrival and within 20 minutes); evidence in the notes that high-flow oxygen was initiated; evidence in the notes that blood cultures were obtained; administration of antibiotics before leaving A&E; and evidence that urine output measurements were instituted in A&E.
- The department ranked between the upper and lower quartiles for standards relating to evidence in the notes that first intravenous crystalloid fluid bolus was given in A&E, evidence that serum lactate measurements were obtained and the administration of antibiotics within the hour. It was in the upper England quartile for the administration of antibiotics within two hours.
- The department met four of the 11 CEM fever in children standards in their re-audit conducted from August to November 2012. Other standards were above or the same as the national average but fell slightly short of the CEM percentage standard.
- In the CEM pain in children audit (2011), the hospital only scored 20% for asking children their pain score (CEM standard 100%). They scored 73% for giving analgesia within 60 minutes, (CEM standard 100%) and only scored 8% for reassessing children's pain scores, (CEM standard 100%).
- We spoke with managers about the trust's most recent clinical audit programme and we read the clinical audit annual report dated 2013/14. It showed that the trust categorised its centrally coordinated clinical audit activity according to clear priorities. We saw evidence that some further CEM audits had been carried out and the results and actions were awaited.
- The trust met the national standard of 5% unplanned re-attendance to A&E within seven days (April to October 2014), apart from a slight increase in the number of re-attendances in July and October 2014.

Competent staff

- There was a rolling programme of regular training for staff in the department led by a dedicated training lead. Medical and nursing staff told us they felt well-supported with training.
- The trust was ranked third in the country in the latest junior doctors' training survey.
- Staff were appraised regularly. Within the department, 82% of nursing staff and 46% of medical staff had had an appraisal (April 2013–October 2014) and managers were working towards 100% completion by the end of March 2015.

Multidisciplinary working

- The hospital had an alcohol and drugs team (the hospital inpatient liaison team, also known as HILT) on duty between the hours of 7am and 8pm. Members from the team reviewed every patient within the department to identify drug or alcohol issues.
- The department had its own dedicated occupational therapist and physiotherapists who worked until

midnight. They assessed, for example, people's mobility and equipment needs and made referrals to other services as appropriate to facilitate a safe and speedy discharge; we saw evidence of this in patient records.
- Allied healthcare professionals were included in the twice-daily updates and information-sharing sessions.
- Staff had access to mental health teams including Child and Adolescent Mental Health Services (CAMHS). Managers acknowledged that the CAMHS service was not always timely in its response, but said it was supportive and the adult mental health service or social services covered any gaps in provision.

Access to information

- The trust was awaiting implementation of a real time electronic patient record system.
- Adult patient records contained all the necessary information required for ongoing care.

Consent, Mental Capacity Act and deprivation of liberty safeguards

- We observed patients being asked for verbal consent to care and treatment. Patients told us that interventions were explained in a way they could understand before being carried out.
- Staff training on the Mental Capacity Act 2005 was conducted every three years. From January to the beginning of December 2014, 37% of medical staff and 38% of nursing staff had completed training. Staff we spoke with were clear about their responsibilities in relation to patient capacity, consent and the Act's associated deprivation of liberty safeguards.
- There was a dedicated secure room where high-risk mental health patients could be accommodated. Patients who were at risk of harm or absconding were cared for in the Majors area where they would be closely supervised. Staff told us that security staff could be called to assist with patient supervision and to prevent a patient from absconding. We saw no evidence of a clinical holding (restraint) training programme and staff told us they were not trained to restrain patients.

Are urgent and emergency services caring?

Good

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

Compassionate care

- The trust used the NHS Friends and Family Test to record patients' feedback. Low response rates were common for A&E departments and managers were investigating the use of a text messaging tool to improve response rates. From April 2013 to July 2014, the trust scores were better than the England average, apart from in January 2014.
- Throughout our inspection we witnessed patients being treated with compassion, dignity and respect. We saw that patients were attended to promptly when staff were called to assist them. Two patients told us, "The staff are respectful and courteous", and "I am getting good care".
- We spoke with many staff of all grades who consistently displayed a passion for delivering good quality care and gave us an overall sense of caring about patients. This was also evident during our observations of interactions between patients and staff.
- We looked at patient records and found they were completed sensitively, including detailed discussions that had taken place with patients and relatives.

Understanding and involvement of patients and those close to them

- The results of the 2014 CQC A&E patient experience survey put the trust among the best in the country. Responses to key questions asked about a safe, effective, caring, responsive and well-led service indicated that the trust's performance was better than expected when compared to other trusts.
- Patients and relatives told us that their care and treatment was explained to them in a way they could understand and we observed this type of interaction throughout our inspection.

Emotional support

Urgent and emergency services

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

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

(for example, to feedback?)

Good

Paediatric facilities were limited and children often used the adult waiting area; ambulatory paediatric patients were treated in areas where adults were cared for. Between 2013 and 2014, the department almost met the standard of admitting, transfering or discharging 95% of patients within four hours. Between April and October 2014, the standard that 95% of ambulance patients should be handed over within 15 minutes of arrival was met. It was evident that staff understood that access and flow was a top priority and they worked well together to try to maintain compliance with national standards. There were systems for investigating complaints, learning the lessons of those complaints and communicating lessons to staff.

Service planning and delivery to meet the needs of local people

- Trauma patients across the southern region of the North of England were brought by ambulance or helicopter for specialist care and treatment. There was a well-established system for managing these patients. The service was due to be reassessed in 2015.

Meeting people's individual needs

- Staff showed us two relatives' rooms that were located in a quiet area and available for use by family members.
- Interpreting services were used for patients whose first language was not English. There was a member of staff employed within the department who could communicate with hearing-impaired patients by using a recognised sign language.
- We read a dementia audit dated March 2014 that had an aim for the trust to become a dementia-friendly organisation with environments and processes that caused no avoidable harm to patients living with dementia.
- The service had a dementia care pathway and a relevant learning package for staff.
- Staff knew about the Hospital Passport document system for people with learning disabilities used at the trust. These passports set out people's specific needs and copies were taken and placed in the care record.
- There was no separate children's entrance into the department, which meant children who attended with their parent or guardian used the same entrance as adult patients.
- We found the paediatric environment was not fit for purpose. The children's waiting area was situated where adults were treated for minor complaints or injuries and conversations with adult patients could be overheard. The children's waiting area was small and only had nine chairs to seat families. We saw the area was crowded on several occasions. During our three-day inspection, we saw children sitting in the waiting area with adult patients, including an injured adult patient. We asked for the paediatric environment risk assessments but were told these were not readily available or accessible as they were on a member of staff's laptop and not backed-up to the hospital's hard drive.
- From October 2014, some paediatric patients who were previously seen at the Friarage Hospital, Northallerton were treated in the department at James Cook University Hospital, (except those who self-referred at the Friarage with minor injuries). This meant there was an increase of children being seen and treated in the department.

Access and flow

- There were triage (prioritising) systems for the initial assessment and management of patients who self-refer. The national standard requires 95% of patients to be seen and receive treatment by a registered healthcare professional within 60 minutes. The trust was consistently performing better than this standard.
- Dedicated patient flow coordinators employed within the department were responsible for recording the hourly departmental status which included current wait times and the reasons why patients were not being seen and assessed within the target times. Managers said missed targets were usually caused by insufficient inpatient beds being available. We saw examples where the escalation plan was implemented. This meant that the department had used its internal escalation plans to manage the number of patients queuing.

Urgent and emergency services

- Trusts within England are set a government target of admitting, transferring or discharging 95% of patients within four hours of their arrival in the A&E department. The department's average performance for the four-hour waiting time target was 94.50% for April 2013 to March 2014.
- The total time in the department for 95% of patients who were admitted was less than 5 to 6.5 hours. The national standard for patients who arrived by ambulance states they should receive an initial assessment by a registered healthcare professional within 15 minutes. We read departmental data (April to October 2014) that showed how patients within the 95th percentile who arrived by ambulance did receive an initial assessment within the 15-minute target. However, the longest time to initial assessment was recorded in July 2014 at about 158 minutes.
- Managers told us that the main issue with maintaining compliance with the four-hour target was patient flow, particularly related to patients who were waiting for beds. We saw evidence of staff working well together to monitor patient flow on an hourly basis and the escalation plan being implemented when necessary.
- Staff told us that the trust had started a project to look at patient flow across the hospital and there were plans to employ a project manager.
- A&E departments across England have to record the rate of people who leave the department without being seen. The quality threshold is 5%; the department had a rate of less than 3% of people who left without being seen by a doctor or a nurse (April to October 2014).

Learning from complaints and concerns

- We saw information displayed around the department that explained to patients how they could make complaints and give feedback.
- Staff were aware of how to manage complaints and how to support patients who wished to complain. We talked with nursing staff who told us they knew how to put patients in touch with the Patient Advice and Liaison Service. Information about this service was displayed in patient areas.
- Managers told us that any verbal complaints would be discussed with staff at the twice-daily 'huddle' (update) meetings and we read the department meeting standing agenda which contained an item for complaints management. This meant that staff were informed of any complaints so they could learn from them.

Are urgent and emergency services well-led?

Good

There was clear leadership in A&E and senior managers worked closely together to monitor and improve care. Regular governance and information-sharing meetings were held and there was an open and effective culture throughout the department. All staff exhibited high morale and pride in their work and were focused on giving patients a positive experience.

Vision and strategy for this service

- The trust's vision was present throughout the department.
- Staff were able to repeat the vision to us during individual conversations.

Governance, risk management and quality measurement

- Regular governance meetings attended by senior A&E staff were held within the directorate. Complaints, incidents, audits and quality improvement projects were discussed. In addition, monthly nurse-led governance meetings were held which included safety updates.
- A twice-daily 'huddle' meeting was held with all staff for updates and information sharing. We observed this happening and noted that an issue we raised during the inspection was discussed so that improvements could be made.
- A weekly meeting was held to discuss any breaches of national targets and to improve services.
- There was a risk register for A&E including documentation of appropriate actions needed.

Leadership of service

- There was clear leadership for the department and the directorate as a whole. The lead consultant, managing

director and department manager worked closely together. They were all visible in the department and we saw them working quickly on issues where quality or patient care needed improvement.
- Managers took learning from cases and incidents seriously. We saw evidence of improvements made.

Culture within the service

- There was open and effective culture in which staff said they felt empowered to take responsibility, make suggestions and report any incidents.
- Staff exhibited high morale, pride in their work and a drive to give a positive experience to patients.

Public and staff engagement

- Senior doctors reported a cohesive consultant body that engaged well with the more junior staff, especially regarding staff training and development. Junior staff confirmed this and said that senior support was always available.
- Nursing staff said they were part of a team that was not hierarchical and where all managers engaged with them. The department had an official A&E social media page for staff and managers to use to communicate with each other.
- There was a strong drive to use patient feedback to improve the service.

Innovation, improvement and sustainability

- Innovation was encouraged from all staff members and staff were able to give examples of practice that had changed as a result.
- A number of initiatives had been instigated to try to keep people out of hospital and at home – for example, the trust was working closely with commissioners and local authorities on a whole-system approach to prevent hospital admissions, improve patient flow and expedite patient discharge.
- Almost 50 discharge workshops had been held to embed the improvements made.

Medical care (including older people's care)

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

Information about the service

The South Tees Hospitals NHS Foundation Trust provides medical care, including older people's care across two sites; The James Cook University Hospital (JCUH) in Middlesbrough and the Friarage Hospital in Northallerton. There were 69,331 medical admissions to the trust in 2013-14 of which 47% of these were emergency admissions and 6% elective. The remainder were day cases.

The trust had a number of clinical centres through which it managed the delivery of services. Overall there was approximately 1860 medical staff. Medical care was provided though the integrated medical care centre, the speciality medicine centre and the tertiary services centre. On the James Cook University Hospital site there were 20 medical wards, including male and female acute assessment units (AAU), and a coronary care unit (CCU). There were a number of different medical specialties provided, such as general medicine, care of the elderly, cardiology, respiratory medicine, gastroenterology, haematology, neurology, spinal injury and stroke care.

We looked at the care records of over 20 patients and 23 prescription charts. We spoke with 34 patients and relatives, 92 staff, including doctors, nurses, therapists, pharmacists and managers. We visited 13 wards, and carried out observations on the areas we visited. Before the inspection, we reviewed performance information from and about the trust.

Summary of findings

We rated medical care as good, although safety required improvement. Nurse staffing levels, especially overnight were concerning with levels on some wards of one nurse to 16, 14.5 and 13.5 patients. The trust had already highlighted this as a concern and plans were in place to improve the ratios. Attendance at mandatory and safeguarding training was low on some specific wards. The Hospital at night service provided a co-ordinated system for medical handovers and managed requests for support from the doctors working overnight.

Following substantial pharmacy staff investment all clinical areas will have dedicated pharmacist support by 1 January 2015.

Hospital Standardised Mortality Ratio compares number of deaths in a trust with number expected given age and sex distribution. HSMR adjusts for a number of other factors including deprivation, palliative care and case mix. HSMRs usually expressed using '100' as the expected figure based on national rates. In 2013/14 the Trust had a slightly higher figure of 108, this was lower than the previous year. The Summary Hospital-level Mortality Indicator (SHMI) for 1-July 2013 to 30 June 2014 was as expected.

The hospital participated in national clinical audits. At the time of the inspection 52% of staff had received an appraisal and approximately 60% of staff working within the integrated medical care centre had received staff development reviews. The trust was proactive in

Medical care (including older people's care)

planning discharge dates, there were delays in discharging people who were medically fit to leave the hospital but required a transfer to other packages of care.

Systems were in place to report incidents, analysis and feedback was provided to staff. Wards monitored safety and harm free care and results were positive, overall. Wards were clean and staff were observed adhering to infection control principles. Patients' records and observations were mostly recorded appropriately and concerns were escalated in accordance with the trust guidance.

Policies based on NICE and Royal College of physicians guidelines were available to staff and accessible on the trust intranet site. Audits were undertaken to monitor compliance with guidance.

Almost all patients and relatives told us that they or their relatives had been treated with compassion and that staff were polite and respectful. Patients were aware of what treatment they were having and understood the reasons for this and, in many cases, had been involved in the decisions. The trust had prioritised and developed a number of initiatives to improve the care of people living with dementia, including the use of therapeutic volunteer workers.

There had been very recent changes to the leadership of the integrated medical care centre as part of a wider trust restructure. Staff were generally positive about the leadership and the recent appointments. Most staff were clear about the vision and strategy for the service.

Clinical governance meetings were held in integrated medical care centre at centre, service group and directorate level. There was generally good clinical engagement and attendance. The clinical centre risks register included most but not all the issues identified as risks during the inspection.

Are medical care services safe?

Requires improvement

Nurse staffing levels, especially overnight were concerning with levels on some wards of one nurse to 16, 14.5 and 13.5 patients. The trust had already highlighted this as a concern and plans were in place to improve the ratios. Attendance at mandatory and safeguarding training was low on some specific wards.

Following substantial pharmacy staff investment all clinical areas will have dedicated pharmacist support by 1 January 2015.

Systems were in place to report incidents, analysis and feedback was provided to staff. Most staff were aware of learning. Wards monitored safety and harm free care and results were positive, overall. The results were displayed and available to staff or patients. There were higher levels of falls on wards 10 and 12.

Wards were clean and staff were observed adhering to infection control principles.

Patients' records and observations were mostly recorded appropriately and concerns were escalated in accordance with the trust guidance.

Incidents

- In 2013/14 there were 46 serious incidents (SI) reported within medicine across the trust, 25 of which related to pressure ulcers.
- There had been 128 (2.9%) incidents graded moderate or above across the Integrated Medicine Care Centre between April 2014 and September 2014. This was monitored monthly.
- There were systems in place to report incidents. Incidents were reported using an electronic reporting system. Staff told us they were aware of how to use the system to report incidents.
- We saw in staff meeting notes from the wards that incidents had been discussed. For example on one ward there had been a recent incident regarding a patients' time sensitive medicine for Parkinson's Disease being

given late. The lessons learnt from this had been discussed. On some wards the lessons learnt were also displayed on the staff communications board and in the ward communication book. We saw this on ward 1.
- All incidents relating to people living with dementia or with a learning disability were highlighted and sent to the dementia and safeguarding leads for the trust where themes or trends were then reviewed.
- Some staff told us about lessons learnt bulletins which were circulated by the trust to increase learning from incidents.
- There were centre-wide mortality and morbidity meetings and on a bi-monthly basis these also covered clinical incidents. There were also weekly mortality reviews which were run by an intensivist doctor.

Safety thermometer

- The safety thermometer was clearly displayed and up to date on all wards except for ward 28.
- The rates of pressure ulcers (total 528) and falls (total 223) was relatively consistent throughout the 12 months to July 2014.
- The were 151 catheter acquired urinary tract infections during the 12 months to July 2014 and these showed slight fluctuations by month throughout the year.
- There were a higher number of falls on care of the elderly wards 10 and 12, especially at night, and also on ward 2. The figures for ward 12 indicated that the number of falls ranged from five to 16 from April to November 2014 with an average of 11 falls per month. On ward 10 there had been 86 falls since April 2014 with an average of 10.75 falls a month. The falls showed a slightly improving trend.
- Staff were able to show us that the falls had been analysed previously to see if there were any themes or trends. We saw information dating from March 2012 of the analysis. The majority of the falls occurred during visiting times and overnight. Some staff were able to tell us of local initiatives to reduce falls including falls assessments, checking footwear, enhanced observation status of some patients and, correct type of bed used. However, there were no local action plans on the wards to reduce falls that staff could tell us about.
- There was a falls strategy group that met quarterly and wards had fall link nurses who provided local leadership for falls prevention.
- The staff used an enhanced observation tool, especially for patients who were living with dementia and may be confused, to determine what levels of support were required from staff. Staff were able to request additional staff members/therapeutic volunteers if patients were scored as requiring level 3 support. This included patients who were at high risk of falls.
- The CCG had agreed a CQuIN (Commissioning for Quality and Innovation) with the trust to reduce pressure ulcers. The trust had set up a collaborative to reduce the number of pressure ulcers, which has included education and training of staff. This has seen a reduction in 7% of grade 2 pressure ulcers and 25% of grades 3 and 4. However, in the minutes of the integrated medical care centre board meeting in September 2014 concern were raised around the pressure ulcer target. The minutes stated that the position was 8.31 against a target of 5.43 for month five.

Cleanliness, infection control and hygiene

- All areas that were inspected were visibly clean. There was routine deep cleaning of areas and wards. During the inspection we saw what had been an empty ward being used to "decant" other wards into whilst they were deep cleaned.
- We saw staff wash their hands and use hand sanitising gel between patients. 'Bare below the elbow' policies were adhered to.
- We observed that staff wore personal protective equipment and staff applied the principles of infection prevention and control.
- Infection control information was visible in most ward and patient areas.
- Clear signs, which were understood by staff, were present on the ward where there was an infection risk.
- Equipment was clearly marked as clean.
- In 2014/15 there were three cases of Methicillin-resistant Staphylococcus aureus (MRSA) attributed to the trust up to September 2014. Post infection reviews had been held with the CCGs and action plans implemented. From August 2013 to July 2014, five cases had been reported.
- The trust did not achieve its C. difficile target of having less than 37 cases in 2013/14. There were 57 cases reported.
- There were six C. difficile cases reported from end of March to October 2014, taking the total to 30, which was one above trajectory for a full year target of 49.

- The trust had put measures in place which included additional short term senior support, review panels, the creation of an in house dashboard and comprehensive action plans.
- Over 95% of staff in the medical centres responded positively in the 2013 staff survey to the way that they had training, learning or development in infection prevention and control (e.g. guidance on hand-washing, MRSA, waste management, disposal of sharps / needles)

Environment and equipment

- The trust had identified that the medical wards in the tower block required refurbishment and a programme of work had commenced which was required to start on the ground floor. The refurbished environment on ward 3 had won a national award. Refurbishment for ward 4 was planned for spring 2015.
- Dementia environmental audits had been completed and we saw some improvements had been made, including signage, wall clocks, and the colour and design of curtains.
- Wards 10 and 12 were on the top floor of the medical block and were wards for the care of elderly patients. At the time of the inspection these wards had no toilet facilities within the six bedded bay areas. These wards were generally not dementia-friendly environments. Some signage had been changed to be more dementia friendly as had the toilet seats. We were told that these wards would be refurbished as part of the seven year planned medical block programme, but would be last as the programme required that the building work was completed from the ground floor upwards.
- The toilet buzzer in the medical block (wards 1 – 12, apart from ward 11) sounded the same as the cardiac arrest alert which might have led to confusion by some staff as to whether to respond or not to an alert.
- We saw resuscitation equipment was mostly checked and recorded daily apart from on ward 26 where there had only been six recorded checks since the 29 July 2014.

Medicines

- Clinical pharmacists and pharmacy technicians provided medicines management support including medicines reconciliation on admission and regular prescription review to most clinical areas.
- Following substantial pharmacy staff investment all clinical areas will have dedicated pharmacist support by 1 January 2015.
- The chief pharmacist told us that currently 60% of patients had medicines reconciled by pharmacy staff. NICE guidance recommends that all patients should have medicines reconciled within 24 hours or earlier if clinically necessary.
- Pharmacists completed monthly audits of antibiotic use on each ward and shared the results with the ward teams. Audits demonstrated good compliance with trust policy for the use of antibiotics.
- We looked at the medicine records for seven people on wards 1 and 10 and found no discrepancies. However, on ward 9 we found nine omissions on the records for two patients where administration, or an appropriate non-administration code, had not been recorded. We were told that there was no regular pharmacist support to this ward but this would be rectified in January 2015. The ward manager told us that medicine omissions were not part of regular nursing ward checks. We found that these omissions had not been picked up, investigated and reported in line with trust policy.
- Medicines were stored safely. The annual medicines storage and security audit of all clinical areas in the trust had been completed in March 2014 and action plans to address shortfalls had been developed within each core service.
- Controlled drugs were stored securely and fully recorded on the wards we visited except for CCU where there had been no recording of checks for over a month. Stocks were regularly checked by nursing and pharmacy staff. A full audit of the management of controlled drugs on medical wards had been completed in September 2014 and the results followed up by the clinical pharmacist.
- Overall reporting and acting on errors was good. Staff who made medication errors were then supported by a WASP (Witnessed, assimilation, supervised and proficient) competency framework.
- During the inspection a near miss regarding giving medication was highlighted by a patient. We informed the ward sister and appropriate actions were taken immediately.
- Weekly stock checks were observed.
- Medicine fridges were locked with temperatures, minimum and maximum, recorded daily.

Medical care (including older people's care)

Records

- The trust had just completed the roll out of an electronic system, which was used to record people's observations such as heart rate and blood pressure. This helped to monitor more effectively changes and trends in these observations.
- We saw that on ward 12 all the medical notes trolleys were open and on the corridor. This could have led to breaches in confidentiality. We were told that there was no log in required to access the electronic recording of patient's observations used by medical staff on ward 12, which may also have led to confidentiality breaches.
- The Patient Status at A Glance (PSAG) board on each ward used a combination of symbols to help anonymise patient information from the understanding of visitors and passers-by. On most wards the PSAG boards were in full view.
- The majority of the nursing care records we reviewed were comprehensive and included completed risk assessments and care plans for such areas as oral hygiene, malnutrition, moving and handling, pain management and falls. A small number of records had some omissions; this was mainly in relation to patient identifiers on notes. For example a small number had a patient's name but no other identifier and on a few fluid balance charts there was no patient name or identifier.

Safeguarding

- There were a number of safeguarding courses, relating to both children and adults, which staff were required to complete dependent on their roles. Figures provided by the trust indicated that uptake of the training by ward was variable. Only 41% of staff on ward 1, the female acute assessment unit and ward 3, had completed their adult safeguarding training compared to 93% on ward 9, 71% on ward 12 and 75% on ward 10.
- Both the nursing and medical staff we spoke with were aware of who to contact regarding safeguarding concerns.
- Guidance information was readily available.

Mandatory training

- Courses included as part of mandatory training were fire safety; health and safety; infection prevention and control; information governance; the mental capacity act; patient safety; safeguarding; basic life support; moving and handling and; dignity at work- valuing equality and diversity.
- Overall the integrated medical care centre staff had achieved 68% compliance with mandatory training requirements.
- The training completed varied considerably from ward to ward. On ward 28 it was 51% overall compared with 58% on wards 3 and 12, 75% on ward 10, 56% on ward 15 (the male acute assessment unit) and as low as 45% on ward 1, (the female acute assessment unit).
- There was a CQUIN (Commissioning for Quality and Innovation) target in place to provide dementia training for all 9,000 staff over a five year period. We saw records that indicated that 2,500 had received training in 2013/14 and that the trust was on target to deliver training to a further 2,500 during 2014/15.
- Some staff commented that it was sometimes difficult to do essential training due to staffing levels.

Assessing and responding to patient risk

- Every ward used an early warning score (EWS) system to help identify and manage patients whose condition deteriorated. Patient observations were mostly recorded appropriately and concerns were escalated in accordance with the guidance.
- Nursing staff reported good responses from medical staff when a patient's condition deteriorated.
- A critical care outreach team was available to support staff with patients who were at risk of deteriorating.
- The hospital at night handover included discussing individual patients who were most critical or likely to deteriorate to ensure continuity of care and management of their risk of deterioration.
- Overnight there were two band 7 senior nurses on duty; one was the co-ordinator for hospital at night whilst the other was the bed manager. These roles helped to assess and respond to any clinical risks overnight.

Nursing staffing

- The hospital used the Safer Nursing Care Tool to determine the required levels of nurse staffing for each ward. Nursing acuity audits were started in the late spring/early summer 2014. Data was collected for 4 weeks every quarter.

Medical care (including older people's care)

- We were told there were 20 registered nurse (RN) vacancies within the integrated medical care centre, most of which were on the acute medical wards.
- The stroke ward had a six bedded bay specific for patients in the hyper-acute phase of a stroke. Whilst not staffed separately to the rest of the ward there were two RNs rostered to work in the bay each day which was in line with national guidelines.
- We were concerned about the nurse staffing levels overnight, especially on ward 2 (13.5 patients: 1 nurse), ward 3 (14.5 patients: 1 nurse), ward 10 (13.5 patients: 1 nurse), and ward 12 (16 patients: 1 nurse). The trust had already highlighted this as a concern and plans were in place to improve the ratios. This included moving to a model of three nurses on nights where there were more than 24 patients on a ward or if the acuity of patients required more nurses. This was noted in the minutes of the integrated medical care centre board meeting in September 2014. The proposals for wards 10 and 12 were to be implemented by the end of December 2014 and for wards 1 and 2 by the end of January 2015.
- Staff on a ward 12, which was for care of the elderly and had 32 beds, told us that they had been given permission to increase the number of staff on night duty from the 1 November 2014. Records showed that from the 3 to the 30 November 2014 only six night shifts had three nurses. From the 22 – 29 October 2014 six out of eight nights had two RNs. The shifts had been offered to the agency NHS Professionals but had not been filled.
- We checked night time staffing at the unannounced visit on the 16 December 2014. Records showed that during the week commencing 15 December ward 12 had three of the seven night shifts with three RNs and the rest with two RNs. An extra bed had also been opened.
- On the 16 December ward 10 had two RNs and two HCAs for 26 patients. Of the 26 patients two patients were assessed as requiring enhanced observations at level 3 and one patient at level 2 because of their dementia-related confusion. A therapeutic support worker (Band 1) had been requested and was working on the ward overnight. On the 12, 13 and 14 December 2014 there had been two RNs on duty each night with two HCAs. However on two of the nights they had two additional therapeutic support workers.
- On ward 2 which was a ward for short stay patients the planned staffing overnight was two RNs and two healthcare assistants for 27 patients and on ward 3 (infectious diseases and diabetes) there were two nurses overnight for 29 patients.
- There was a four bedded acute respiratory bay within ward 9. At the time of our visit there were four patients requiring non-invasive ventilation and day time staffing levels were in accordance with national guidance with a ratio of one nurse to two patients. However, overnight these levels were reduced.
- There were 14 beds on CCU and the facilities for a further 12 patients to be monitored using telemetry throughout the hospital. The planned staffing levels were seven RNs during the day (including a co-ordinator) and five RNs at night. The planned levels of staffing included an additional nurse to assist with Percutaneous Coronary Intervention (PCI). From the 1 – 14 December 2014 there were two day shifts which had seven RNs, three day shifts with six RNs and one with five RNs on duty. Staffing levels did not always meet the requirements of the acuity level of the patients on CCU. Additional to this a nurse may be away from the ward area either whilst responding to a cardiac arrest bleep or whilst assisting with Percutaneous Coronary Intervention (PCI), which is one of the two coronary revascularisation techniques currently used in the treatment of ischaemic heart disease. There were 2 qualified nurses on nights on Ward 30 for maximum of 13 patients. Staff told us that "CCU supported breaks overnight if they were not busy".
- Nursing handovers occurred at least twice a day on wards. We attended two handovers and reviewed handover sheets and found that these provided enough detail for staff to care for patients. The handovers took place in a separate room, which allowed information to be shared confidentially. They also covered any staffing issues as well as detailed information about each person's care needs and the acuity of their illness.
- The trust did not have its own internal bank staff. The majority of the staff used were from NHS professionals; many of which were their own staff working additional shifts.

Medical staffing

- The ratio of consultants to other medical staff was better than the England average. There were 276 whole time equivalent (WTE) medical staff within medicine of which

41% were consultant posts, which was better than the England average of 33%. Middle career and registrar groups were similar to the England average; however there were 15% junior doctors compared to 22% nationally.

- There was appropriate consultant cover and junior doctor availability. Consultants were very visible and junior doctors commented positively on supervision, senior support and availability of consultants.
- There were no consultants routinely on site overnight. Consultant cover was provided by an on call system.
- There was a medical registrar on duty overnight with support from three FY2 (Foundation Year 2) doctors and an FY1 doctor, all of which were part of the hospital at night team. Two of the FY2 doctors were based on the male and female assessment units whilst the other covered the medical specialities, oncology and renal services.
- Medical staff reported good communication and handover of patients.

Major incident awareness and training

- There was a major incident plan in place and staff we spoke with were aware of this.
- The trust and its partners had escalation/resilience plans which were enacted when required - North East Escalation Plan (NEEP).
- On the unannounced visit on the 16 December we saw that the resilience plan was being used with a declared level 2 NEEP, which indicated that there were some capacity and demand issues in one to two key areas but the trust remained on a "Green" status.
- Daily teleconferences were held to manage winter pressures, which included the trust's silver on call managers, the local CCGs, the local authorities and other local NHS trusts.
- Winter pressure arrangements were in place. At the time of the inspection ward 2 was decanted to Ward 11 to support the planned deep clean programme. Once completed Ward 11 would open with 16 beds and a discharge lounge to support the need for extra beds during winter.

Are medical care services effective?

Good

Policies based on NICE and Royal College of physicians guidelines were available to staff and accessible on the trust intranet site. Staff were aware of the local policies and procedures. Audits were undertaken to monitor compliance with guidance. Pain relief, nutrition and hydration needs were met.

Hospital Standardised Mortality Ratio compares number of deaths in a trust with number expected given age and sex distribution. HSMR adjusts for a number of other factors including deprivation, palliative care and case mix. HSMRs usually expressed using '100' as the expected figure based on national rates. In 2013/14 the Trust had a slightly higher figure of 108, this was lower than the previous year. The Summary Hospital-level Mortality Indicator (SHMI) for 1-July 2013 to 30 June 2014 was as expected.

At the time of the inspection 52% of staff had received an appraisal and approximately 60% of staff working within the integrated medical care centre had received staff development reviews. Training on MCA was variable across the wards ranging from 16% to 77%.

The Hospital at night service provided a co-ordinated system for medical handovers and managed requests for support from the doctors working overnight.

The trust participated in national clinical audits. Staff reported good working relationships within the multidisciplinary teams.

Evidence-based care and treatment

- Policies based on NICE and Royal College of physicians guidelines were available to staff and accessible on the trust intranet site. Staff were aware of the local policies and procedures.
- Audits were undertaken to monitor compliance with guidance, for example audits regarding the use of antibiotics, cardiac rehabilitation and Troponin testing, which measures the levels troponin proteins in the blood. These proteins are released when the heart muscle has been damaged, such as occurs with a heart attack. These audits were discussed at clinical governance meetings.

- The trust had also audited itself against the NICE guidance for dementia in 2013 and as a consequence put action plans in place. For example to deliver training to FY1 and FY2 doctors in the prescribing of medication for dementia.
- There were local policies and procedures in place which staff followed to ensure that patients received the right care and treatment, for example the multi-disciplinary integrated care pathway for deep vein thrombosis and the diagnostic pathway for a patient with suspected pulmonary embolism.

Pain relief

- An internal audit of patients living with Dementia was completed in August 2014 against 48 standards, which highlighted the main issue as being poor pain management. Each clinical centre developed an action plan. Actions taken included the development of a flow chart to seek mental health support and a pain assessment tool using Facial Location Assessment
- We found pain assessments were carried out and recorded. Pain scores were included on the medical assessment proforma.
- Pain relief was provided as prescribed and there were systems in place to make sure that additional pain relief could be accessed via medical staff, if required.
- Patient records indicated that there were care plans in place to manage people's pain and four hourly checks were recorded
- Patients told us they were asked about their pain and if they required any pain relief. Patients we spoke with had no concerns about how their pain was controlled.

Nutrition and hydration

- Protected meal times were in place and we observed these were adhered to in most cases.
- Patients were assessed regarding their nutritional needs and care plans were in place.
- Systems were in place to identify patients who needed additional support with eating and drinking, such as the 'red tray' system.
- We observed patients being supported to eat and drink.
- Drinks were readily available and we saw that drinks were in easy reach of patients.
- Food and fluid intake were recorded in almost most cases.
- The Patient-led assessments of the Care Environment (PLACE) 2014 survey indicated that the trust (91%) was slightly better than the national average (90%) with regard to patient's comments on the food provided.

Patient outcomes

- Hospital Standardised Mortality Ratio compares number of deaths in a trust with number expected given age and sex distribution. HSMR adjusts for a number of other factors including deprivation, palliative care and case mix. HSMRs usually expressed using '100' as the expected figure based on national rates. In 2013/14 the Trust had a slightly higher figure of 108, this was lower than the previous year. The Summary Hospital-level Mortality Indicator (SHMI) for 1-July 2013 to 30 June 2014 was as expected.
- According to the trust's Quality Accounts there were 35 national clinical audits and five national confidential enquiries during 2013/14, which covered relevant health services that the trust provided. During that period the trust participated in 97% of the national clinical audits and 100% of the national confidential enquiries of the national clinical audits and national confidential enquiries which it was eligible to participate in.
- The national Heart Failure Audit 2012/13 showed results that were better than the England average. For example 99% of patients were seen by a specialist compared to 78% nationally and consultant input was at 87% compared to 57%.
- The Myocardial Ischaemia National Audit Programme (MINAP) audit 2012/13 also indicated that results were better than England average. For example for the care of patients with non-ST-elevation infarction (nSTEMI) a 100% of patients were seen by a cardiologist or a member of their team compared to 94% nationally and 91% of nSTEMI patients were admitted to a cardiac unit or ward compared with 53% nationally.
- The Sentinel Stroke National Audit Programme (SSNAP) showed a decline from an overall SSNAP level of "C" for October to December 2013 to a "D" for January to March 2014. Most areas were rated B or C. However, access to speech and language therapy (SALT) scored an E and physiotherapy had deteriorated from a C to a D.
- There was an acute stroke integrated care pathway and record in place for patients. We visited the stroke ward

and were told there was access to some therapy services over the weekend which included SALT and physiotherapy for one day and usually occupational therapy over both days.

- The national diabetes inpatient audit (NaDIA) September 2013 indicated that out of 21 indicators the hospital was better than the England median in 12 areas and worse than in nine. Of specific concern were three of the indicators in relation to foot risk assessments. We visited the diabetic ward and spoke with staff who were aware of the audit and the plans in place to improve care. A business case was written for extra specialist nurse support but not approved at the time of the inspection.
- The relative risk of re-admission for both elective and non-elective medicine was higher than England average of 100 for 2013-14, especially in elective clinical haematology (123) and gastroenterology (127). Non-elective cardiology (119) and general medicine (118) were also worse than the England average. Non-elective geriatric medicine (74) was better than the England average.
- The number of medical admissions was higher than the national average. The trust had been working with the CCG to develop alternate pathways for patients who may not require an emergency admission, including developing an ambulatory care model. Also local GPs had direct access via a phone and pager system to medical clinicians to obtain clinical advice. We were told that one in six calls resulted in an admission to medical wards.
- The percentage of cancer patients waiting less than 62 days from urgent GP referral to first definitive treatment was better than the England average.
- The percentage of cancer patients seen by a specialist within 2 weeks (urgent GP referral) and the percentage of cancer patients waiting less than 31 days from diagnosis to first definitive treatment were both similar to the England average.
- All the national cancer targets were met in quarter two of 2014/15 apart from the 62 day screening Cancer wait times.
- Improvements had been made to cancer services supported by weekly clinical meetings, allocation of key workers and escalation process to the head of performance and the board.

Competent staff

- At the time of the inspection 52% of staff had received an appraisal and approximately 60% of staff working within the integrated medical care centre had received staff development reviews.
- Figures from the 2013 staff survey indicated that 81-82% of staff in the medical divisions had in the last 12 months, had an appraisal, annual review, development review, or Knowledge and Skills Framework (KSF) development review.
- There was a clinical guideline for the clinical supervision for professionally registered staff.
- Clinical supervision of nursing staff was variable across the integrated medical care centre. There were monthly meetings held which focussed on a specific topic and had an open session for staff to raise clinical issues. Ward 3 held regular Friday meetings for group clinical supervision. Some nursing staff told us they did not receive clinical supervision.
- Trainee doctors told us that were supported and supervision was good.

Multidisciplinary working

- Staff across the medical care centre reported very good working relationships within the multidisciplinary teams.
- There was internal multi-disciplinary working (MDT) both between specialities and with allied health professionals. For example between medical cardiology and cardiothoracic surgery, stroke services and neuro-rehabilitation.
- There is an acute liaison psychiatry service which is provided by another local trust. The team is based at James Cook University Hospital and available 24hours a day by phone. There is a four hour referral agreement in place.

Seven-day services

- Medical staff reported positively about senior medical and consultant cover. Ward rounds were undertaken daily Monday - Friday. On some wards, such as the assessment units, CCU and gastroenterology there were daily consultant-led ward rounds.
- There was an hospital at night system in place which co-ordinated the medical handovers and managed requests for support from the doctors working overnight (See medical staffing above). We observed the 9pm hospital at night handover which included verbal and written handovers of acutely ill patients from the day

shift to the night shift. Senior nurses were employed as hospital at night co-ordinators and helped to ensure doctors were able to prioritise their workload according to the clinical needs of patients. Doctors we spoke with commented positively about the effectiveness of the hospital and night system.

- Allied health professionals, including physiotherapy, occupational therapy (OT), dietetics and Speech and Language therapy (SALT) were employed by the Trust. All services were available Monday – Friday with more limited cover over weekends. There was 24hour physiotherapy cover for acute respiratory patients. The stroke ward (ward 28) had some therapy services over weekends, with occupational therapists usually available both days. However, there was no other routine weekend or on call occupational therapy cover.
- Pharmacy services were available seven days a week, although there were limited operating hours on a weekend. There were pharmacists on site Monday to Friday until 5pm. After 5pm there was an on call pharmacist and emergency drugs cupboard that staff could access.
- The pharmacy was open until 2pm on a Saturday and Sunday. There were other mechanisms in place to access medicines outside of the hours including an on call pharmacist.
- X-rays and blood transfusion services were available 24hours every day. There was also 24hour access to CT scanning through agreement with the senior doctor.
- Phlebotomy services were available during the day and through until 1am as part of the hospital and night system.
- There were less staff available on a weekend if stroke patients required thrombolysis. Monday to Friday there were usually two junior doctors and a nurse practitioner available. However, on a weekend there was one nurse practitioner and a CT2 doctor who also covered wards 10, 12 and 11.

Access to information

- Staff reported prompt response to information and test results.
- Discharge letters were sent to GPs on discharge. The trust aims to send out all discharge summaries within 24 hours of discharge. In 2013/2014 the trust maintained 90% compliance with this standard for electronic discharge summaries
- Where fully implemented, the Patient Status at A Glance (PSAG) board on each ward provided key information about patient treatment and progress, using a combination of symbols to anonymise patient information from the understanding of visitors and passers-by. The board highlighted factors that might have been, or was, causing delay. Hold-up points were very clear to see, which allowed senior ward staff to take corrective action.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- Information regarding consent and mental capacity were available to staff on the trust intranet.
- Information showed that, some staff on all wards were expected to have completed training in the Mental Capacity Act 2005. Training was variable across the wards ranging from only 16% on ward 1 to 77% on ward 9.
- Staff demonstrated an understanding of the Mental Capacity Act 2005 and Deprivation of Liberty Safeguards (DOLS). A number of applications had been made to the authorities to deprive patients of their liberty. During our visit we saw three mental capacity forms and seven applications for DOLS. All had been completed correctly. For example we saw an MCA assessment for a person with learning difficulties who required a urinary catheter.

Are medical care services caring?

Good

Almost all patients and relatives told us that they or their relatives had been treated with compassion and that staff were polite and respectful.

The percentage of patients who would recommend the services was consistent with or higher than the national average in December 2014. The trust performed around the same as other trusts in relevant questions in the CQC inpatient survey.

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

Most patients said they felt supported by staff including clinical nurse specialists who worked at the hospital.

Medical care (including older people's care)

Compassionate care

- The results of the Friends and Family test for the trust was consistent with the England average. The Friends and Family Test requires all patients, after discharge from hospital, to be asked: How likely are you to recommend our ward to friends and family if they needed similar care or treatment? Of those that responded in December 2014 97% said they would be likely to recommend the hospitals compared with 95% nationally.
- The trust performed around the same as other trusts in the CQC inpatient survey for 2013.
- The cancer patient experience survey results for 2013/2014 for inpatient stays showed the trust was in the top 20% nationally for 18 out of 34 questions with only one question in bottom 20% which was whether a patient's health got better or remained about the same whilst waiting for treatment, which was 77% for this trust compared to 83% nationally.
- The Patient-led assessments of the Care Environment (PLACE) 2014 survey for James Cook University Hospital indicated that the trust (87%) was similar to the national average (87%) for privacy, dignity and wellbeing.
- Throughout the inspection, we observed patients were treated with compassion and respect and their dignity was preserved.
- We spoke with 34 patients and relatives throughout the inspection. Almost all patients and relatives told us that they or their relatives had been treated with compassion and that staff were polite and respectful. Where this was not the case, staff responded appropriately to concerns raised.
- Comments included, "The staff respect you", "The food is good", "The care is excellent and staff have a personal touch" and, "You sometimes have to wait because of staffing levels".

Understanding and involvement of patients and those close to them

- On the whole, patients felt that they were listened to by staff.
- Patients were aware of what treatment they were having and understood the reasons for this and, in some cases, had been involved in the decisions.
- Ward 28 had a password protected system set up so relatives, who lived at a distance from the hospital or were unable to visit routinely, could ring up and staff could share information with the permission of the patient.

Emotional support

- Almost all patients said they felt supported by staff.
- There was a range of clinical nurse specialists at the trust. Patients and staff spoke positively about their input, for example, the diabetes nurse specialist and the cardiac nurses and the support they were able to offer. There were three WTE diabetic nurses with a business plan in the final stages to recruit a further full time post.
- The trust had service level agreements in place to provide support for people with mental health needs.
- There were a number of therapeutic volunteers who provided support to patients, especially those living with dementia.

Are medical care services responsive?

Good

There were processes in place to ensure most patients were cared for in the right place at the right time. Reconfiguration of the services was underway to further develop these pathways. The trust was proactive in planning discharge dates, there were s delays in discharging people who were medically fit to leave the hospital but required a transfer to other packages of care.

Staff worked to meet the needs of individual patients. The trust had prioritised and developed a number of initiatives to improve the care of people living with dementia.

Service planning and delivery to meet the needs of local people

- Deprivation in South Tees is higher than average, with some areas of considerable deprivation on a par with the most deprived areas of the country.
- The services at the hospital were predominantly commissioned by NHS South Tees Commissioning Group (CCG) to meet the needs of the local people.
- Based on engagement with patients, the public, staff and key stakeholders the trust had identified clinical priorities for 2014/15, which included improving the

recognition and treatment of the deteriorating patient, improving nutrition for patients living with dementia, and ensuring the right numbers of staff with the right skills to meet patients' needs.
- A transformation and reconfiguration plan was in place for acute and community provision to better meet the needs of the local population.
- Generally, staff we spoke with agreed there were a sufficient number of hospital beds available for the population, but there was an issue with delayed discharges which meant that there were shortages of beds.

Access and flow

- Patients were predominantly admitted from the emergency department (ED) to either of the acute admissions units or the short stay ward. This was based on established criteria. Patients requiring longer than 24 - 72 hours in hospital were then transferred to another ward following the period of assessment.
- There was also an ambulatory care service which saw patients with suspected DVTs (Deep Vein Thrombosis) or PEs (Pulmonary Embolism), some GP referrals and a limited number of other pathways.
- Most wards we visited held board rounds late morning to review the patients and update on any care or treatment needs. They were attended by nurses, doctors and allied health professionals. Some also included other professionals such as social care and liaison psychiatry.
- We saw that estimated dates of discharge were planned for most patients. The use of the planned discharge date had increased from 85% in March 2013 to 98% in March 2014.
- Trust-wide delayed transfers of care (32%) were significantly worse than the England average (19%). Delayed discharge rates as a percentage of occupied beds had reduced to 3.48% which was below the 4% threshold. The trust was working with partners to deliver sustained improvement; however there were a number of delayed discharges within the medical wards. The delayed transfers of care were predominantly attributed to waiting for the completion of assessments.
- The trust had done a bed utilisation review using an IT system to identify which patients were delayed discharges.
- There were discharge teams at the hospital that supported patients and staff with complex discharges. Case managers have been appointed to help secure more timely discharges for patients.
- Each day the case management team produced a "Ready for discharge" list, which was widely circulated. Most patients with delayed discharges were waiting for a DST (Decision Support tool) meeting, which were led by the CCGs. The DSTs followed after a nursing assessment had been completed and were held to decide on the most suitable placement and funding for each person. DST meetings were booked in advance with a set number of slots, usually ten, allocated per week. There were not enough slots for the number of patients requiring them. Staff told us that there were approximately 15 nursing assessments completed each week, which then required a DST slot.
- We were told that on the 7 December 2014 there had been 68 patients across the trust with delayed discharges.
- On the 9 December 2014 on the ready for discharge list there were 32 medical patients across the trust with delayed discharges; 11 of which were waiting for a DST, six were related to family choice of care and eight were waiting for a bed in a community hospital.
- On the 10 December 2014 there were between 40-44 patients with delayed discharges: 16 – 18 patients were waiting for a DST, 2-4 were waiting for a nursing assessment; eight were post DST but awaiting family choice of a care facility and 12 were awaiting community rehabilitation beds.
- There were community matrons in post to provide an in-reach service to the acute wards with the intention of ensuring support packages were in place in community services. This service operated Monday – Friday at the time of the inspection, but plans had been agreed to expand the service in January 2015 to 8am – 11pm seven days a week. This included liaison work with GP practices.
- There were community services which the trust could access seven days a week to enable discharge, for example, access to "Rapid social", "Rapid health" and "Rapid therapies". Responses were usually within two hours and care packages for a week to ten days were provided.
- The trust's referral to treatment time (percentage of people treated within 18 weeks) was above the national

standard but below the England average. Some specialities, for example general medicine, gastroenterology, geriatric medicine and neurology were achieving 100% for patients who were admitted.

- The trust's emergency medical admissions were higher than the national average.
- On the 9 December 2014 there were 33 medical outliers: patients with medical conditions who were cared for on a different ward to their required medical specialism. Patients who were "outliers" were reviewed by their own speciality medical team within routine working hours 9am -5pm. A junior doctor was allocated to patients who were outliers to help ensure the patients were seen every day.
- Regular bed meetings were held each day to support the management of acute admissions and patient flow through the hospitals. This included reviewing individual patient or staff moves that were needed to accommodate changing needs of patients.

Meeting people's individual needs

- Translation services were available and staff knew how to access these.
- We noted that information leaflets were available for patients, but these were not always readily available in languages other than English.
- The trust had developed clinical guidance to help support patients who required enhanced observation, for example supporting someone with confusion or dementia related problems. There were levels 0-3 of enhanced observation with a level 3 patient requiring one to one support. This was factored into daily staffing figures and was also used at the daily bed meetings to help prioritise staffing levels. We saw examples of additional staff and therapeutic volunteers being employed to provide the individual enhanced care for patients.
- Intentional rounding, to maintain patient safety, was in place and we saw completed documentation to say it had been recorded. This included checking to see if a call bell was within reach, ensuring the patient was comfortable and whether they required drinks, snacks or the toilet.
- There was a trust-wide team of staff to support people with learning disabilities. Staff on the wards we visited were aware of the team and also the use of patient passports. These provided information to health professionals about the likes, dislikes, and communication and support needs of people with learning disabilities.
- Staff also commented that they built up a relationship with and gained an understanding of patients with learning disabilities who regularly attended the hospital.
- There was a small team of dementia educators within the trust. A new dedicated dementia educator funded by Hambleton, Richmondshire and Whitby CCG started in December 2014 to support staff in developing an understanding of dementia and how to provide appropriate care.
- To help support people living with dementia the trust operated a "Forget me not" scheme. This included a leaflet completed with the patient and/or their family which was kept near the patient for staff to use. It included information staff needed to know to care for patients such as food likes and dislikes, usual sleep routine and how to identify when someone was in pain.
- There was also a service level agreement with a local mental trust to provide more specialised dementia care as required.

Learning from complaints and concerns

- The trust had acknowledged that the timeliness of responses to concerns had been an issue. The trust told us they had involved Healthwatch, the Council of Governors and the Patients Association in a review of the Complaints policy.
- The corporate Complaints team held the action plans from Complaints centrally and worked with the clinical centre leadership to ensure the actions were completed.
- Levels of activity for complaints overall have increased steadily since 2010/11. The trust advised us that if taken as a percentage of activity, complaints remained approximately 0.2% of all spells.
- Learning from complaints and concerns was not consistent across the medical wards. Staff were aware of the complaints process and some areas could provide examples of improvements to practice as the result of complaints and how this information was shared.

Medical care (including older people's care)

Are medical care services well-led?

Good

There had been very recent changes to the leadership of the integrated medical care centre as part of a wider trust restructure. Staff were generally positive about the leadership and the recent appointments. Most staff were clear about the vision and strategy for the service.

Clinical governance meetings were held at speciality, group and clinical centre levels. There was generally good clinical engagement and attendance. The clinical centre risks register included most but not all the issues identified as risks during the inspection.

The trust was average for staff engagement when compared with trusts of a similar type. However, the data for medicine showed that staff responded more positively when compared to the trust average.

There were examples of innovation and improvement.

Vision and strategy for this service

- The trust had a mission, vision and strategy which most staff we spoke with were aware of.
- The medical services were provided through three clinical centres: the integrated medical care centre, the speciality medicine centre and the tertiary services centre. Each of the centres had a managing director, medical and nursing leadership. The Integrated Medical Care Centre had various service groups within it, which had been in place since April 2014.The leadership of the centres had been fully in place since September 2014.
- The trust had a clear strategic aim to become a dementia friendly organisation - "with environments and processes that cause no avoidable harm to patients with dementia". The trust had done a self-assessment, based on the markers of best practice from the National Dementia Audit-Royal College of Psychiatrists, of the environment. An action plan was in place.
- There was a strategy to further develop early supported discharge of stroke patients into community services, which was planned to be implemented by April 2015.
- There was significant ongoing work, both strategically and locally on wards to improve the discharge of patients.

Governance, risk management and quality measurement

- There were monthly governance meetings held for each of the three clinical centres. The service groups, within the integrated medical care centre, each have a clinical governance section on their management agenda and they report to the Integrated Medical Care Centre Governance Board.
- There were risk registers in place for each of the medical clinical centres which were routinely updated and assessed. The clinical centre risk registers included most but not all the issues identified as risks during the inspection. We were told that the risk registers were not readily accessible for ward managers. The head of nursing in the integrated medical care centre was aware of the risks within the service groups and what actions were being taken.
- Nurses on the wards told us of incidents where they raised staffing as an issue and this was recorded on the risk register.
- We saw that concerns arising from monitoring of the safety thermometer, complaints and serious incidents were discussed at the care centres' clinical governance meetings. For example, lessons learnt included that the initial falls assessment did not identify all the relevant actions following identification of the risk factors; there was no record of any discussions within patient notes regarding appropriate footwear and; no recording on admission of the impact of ulcers on morbidity. For lessons learnt from pressure ulcers and complaints there was an action log which required evidence of actions being completed before they were signed off. We were told that the head of nursing for the integrated medical care team then met with ward mangers to check if actions had been completed.
- There was an action log for lessons learnt from pressure ulcers and complaints. We were told this was to be developed to include falls and medication incidents.
- There was no local ownership or leadership on ward 28 to ensure that the safety thermometer information was up to date. We were told this was due to sickness.
- There was a delayed discharge group which had agreed a number of actions to manage and reduce the number of delayed discharges across the trust. This included an audit of the Patient Status at A Glance (PSAG) boards on each ward to ensure the boards were used properly to aid planning.

Medical care (including older people's care)

Leadership of service

- Staff were generally positive about the leadership. The senior management team provided visible leadership of the clinical centres.
- The senior management team worked closely together. This ensured shared knowledge, robust planning and a cohesive framework for strategic change.
- Staff knew who they could contact and were generally confident to approach trust directors or senior managers in the hospital if they had concerns or lack of response from middle managers.
- Staff reported that the senior management team and the Trust Board were visible. Directors had made regular visits to clinical areas.
- Healthcare assistant staff felt well supported and comfortable in their role. They felt well trained and able to ask for help if needed.
- At ward level there was clear leadership of the services. There has been a very positive turnaround of ward 9 after concerns had been raised and an action plan in place by the trust. The leadership of the respiratory ward was very good.

Culture within the service

- Staff were very positive about the clinical centres and the service they provided for patients. We observed a supportive rapport between all staff. Different disciplines worked well together and considered each other's needs. Staff appeared to be well motivated.
- Individual complaints were discussed at clinical governance meetings so that learning was shared. Complaints were also reviewed to identify key themes.
- The overall satisfaction of doctors in training was similar to the England average according to the General Medical Council – National Training Scheme Survey.

Public and staff engagement

- The department sought views from the public through the NHS Friends and Family Test, the response rate was similar to the England average.
- The NHS staff survey 2013 indicted that only three areas out of 29 scored worse than the national average. These were the percentage of staff receiving health and safety training in last 12 months; the percentage of staff feeling pressure in last 3 months to attend work when feeling unwell and; the staff motivation at work score. The overall staff engagement score, 3.74, was similar to other trusts nationally 3.73. Staff at the trust were slightly more likely to recommend the trust as a place to work or receive treatment, when compared with other NHS organisations nationally.
- In the NHS staff survey the staff in the medicine speciality (73%) and acute medicine staff (69%) said they would recommend the organisation as a place to work which was higher than the trust-wide response of 64%.
- In the NHS staff survey the staff in the medicine speciality (83%) and acute medicine staff (74%) said that if a friend or relative needed treatment they would be happy with the standard of care provided by this organisation compared to the trust average of 75%.
- Each month 20% of the patients who had attended the hospital and were diagnosed as living with dementia or their relatives were contacted and asked to complete a survey about the care they had received. A recent Trust Board report indicated that that there had been an increase from a base of 52% to 77% for above average or excellent care of the person living with dementia.
- On some wards, for example ward 3, there were public display boards that included feedback to patients and the public "You said, we did" from previous questionnaires or surveys.

Innovation, improvement and sustainability

- Staff were aware of the financial challenges that the trust had of the local cost improvement programmes, to ensure sustainability, that were required to achieve these.
- A team of therapeutic volunteers had been created which was led by a therapeutic nursing sister who had been in place for 18 months. The volunteers had mandatory and dementia training and were in operation 24 hours a day. The role of the volunteers was to support patients who may be living with dementia or other illnesses which affected their behaviour and level of supervision required. This included engaging with patients, such as playing board games or other interests patients may have. They also supported patients who required help with eating or wanted to explore their environment. This included supporting them overnight if they were disorientated. The volunteers predominantly worked on wards 10, 12 and 26. The team had been regionally recognised for its work.

Surgery

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

Information about the service

James Cook University Hospital provided a range of surgical services for the population of Teesside and the immediate surrounding area and was also serving the population of the North East of England.

The hospital provided elective and non-elective treatments for neurosurgery, cardiothoracic surgery, ear, nose and throat (ENT), ophthalmology, colorectal surgery, trauma and orthopaedics, nephrology, urology and vascular surgery.

During this inspection we visited the following surgical wards: Ward 5 (urology), Ward 6 (vascular surgery), Ward 7 (upper gastrointestinal and colorectal surgery), Ward 19 (gynaecology), Ward 24 (neurosurgery), Wards 31, 32 (cardiothoracic surgery), Ward 34 (trauma and orthopaedics), Ward 35 (ENT, plastic surgery and oral maxillofacial surgery), Ward 36 (trauma and orthopaedics) as well as the surgical assessment unit (SAU) and the post operation surgical day unit (POSDU). We visited all theatres and recovery areas on site and observed care being given and surgical procedures being undertaken.

We spoke with 74 patients and relatives and 34 members of staff. We observed care and treatment and looked at care records for 28 people.

Summary of findings

There were effective arrangements for reporting patient and staff incidents and allegations of abuse. Staff were encouraged to report incidents and most received feedback on what had happened as a result. Staffing establishments and skills mix had been reviewed for the number and acuity of patients. There were arrangements for the effective prevention and control of infection and the management of medicines. Equipment was routinely examined, including daily checks for anaesthetic equipment. However, resuscitation equipment had not been routinely checked on some wards and signatures were missing from documentation. Care records were completed accurately and clearly.

Surgical services participated in national clinical audits and reviews to improve patient outcomes. Mortality indicators were within expected ranges.

There were processes to identify staff's learning needs and opportunities for professional development. There was effective communication and collaboration between multidisciplinary teams who met regularly.

We observed positive, kind and caring interactions on the wards and between staff and patients. Patients spoke positively about the standard of care they had received. Most patients we spoke with felt they

understood their care options and were given enough information about their condition. There were services to ensure that patients received appropriate emotional support.

Services were available to support patients, particularly those living with dementia, a learning disability or physical disability or those whose first language was not English. There were also systems to record concerns and complaints raised within the division, review these and take action to improve patients' experience.

The trust's vision, values and strategy had been disseminated to wards and departments and staff had a clear understanding of what these involved. Staff were aware of their roles and responsibilities and there was good ward leadership. Staff felt supported and had seen positive changes to improve patient care.

The service recognised the importance of patient and public views and had mechanisms to hear and act on patients' feedback. Staff were encouraged and knew how to identify risks and make suggestions for improvements.

Are surgery services safe?

Good

Staffing establishments and skills mix had been reviewed to maintain optimum staffing levels during shifts.

Effective handovers took place between staff shifts and included daily safety briefings to ensure continuity and safety of care.

There were arrangements for the effective prevention and control of infection and the management of medicines. Equipment was routinely examined, including daily checks for anaesthetic equipment. However, resuscitation equipment had not been routinely checked on some wards and signatures were missing from documentation.

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

Care records were completed accurately and clearly.

Incidents

- Staff were familiar with the process for reporting incidents, near misses and accidents using the trust's electronic systems, and they were encouraged to do so. They were also aware of the new statutory duty of Duty of Candour regulations that came into effect on 27 November 2014.
- Staff said they were encouraged to report incidents and knew how to do this. Feedback was given to ward managers who confirmed that themes from incidents were discussed at staff meetings and displayed in staff rooms.
- There had been two Never Events relating to surgery (serious, largely preventable patient safety incidents that should not occur if proper preventative measures are taken) reported at this hospital between April 2013 and July 2014. We saw that these had been fully investigated, identifying the root causes of the errors, contributory factors, lessons learned, arrangements for sharing learning and actions needed to stop recurrence.

Surgery

- Within surgery, 33 serious incidents had been reported in the last 12 months. The level of reporting of serious incidents was in line with that expected for the size of the hospital. Fifteen of these incidents related to grade 3 pressure ulcers.
- Incidents were discussed at ward and clinic manager meetings from across the trust to promote shared learning.
- Mortality and morbidity meetings were held monthly in all relevant specialties. All relevant staff participated in mortality case note reviews and reflective practice.

Safety thermometer

- The NHS Safety Thermometer is an improvement tool for measuring, monitoring and analysing patient harms and harm-free care. Information was clearly displayed on boards on all wards and theatre areas we visited.
- Safety Thermometer information included information about all new harms, falls with harm, and new pressure ulcers. The hospital was performing within expected levels for patient harm measures – the numbers of falls, pressure ulcers and urinary tract infections across the centre had all decreased in the latest available information (July 2014). This was reflected in information displayed within ward areas.
- Risk assessments for patient harm measures were being appropriately completed on admission.

Cleanliness, infection control and hygiene

- All wards and patient areas were clean and we saw that staff washed their hands and used hand gel between treating patients. The 'bare below the elbow' policy was observed to be adhered to in line with national best hygiene practice.
- Infection control information was visible in all ward and patient areas.
- All elective patients undergoing surgery were screened for Methicillin-Resistant Staphylococcus Aureus (MRSA) and there were policies to isolate patients, when appropriate, in accordance with infection control policies.
- Trust wide data showed there were three of incident of MRSA and some clusters of C.difficle involving small numbers of patients throughout 2014.
- Clinical waste bins were covered and had foot-opening controls. The appropriate signage was used for the disposal of clinical waste.
- We saw that separate hand-washing basins, hand wash and sanitises were available on the wards, theatre and patient areas.
- Records of recent environmental audits showed that the service was 100% compliant with infection control procedures.
- Nursing staff had received training in aseptic non-touch techniques. This included the necessary control measures to prevent infections being introduced to susceptible surgical wounds.
- The centre participated in the ongoing surgical site infection audits run by Public Health England. Each case was identified, discussed at formal meetings and actions identified to avoid a repetition.
- Infection control audits were completed every month and monitored compliance with key trust policies such as hand hygiene. These showed high levels of compliance.
- Local audits relating to use of personal protective clothing in theatres and recovery showed full compliance.
- Swab, pack surgical instrument and sharp count audits were completed and areas of non-compliance, with appropriate actions, identified. These were discussed at surgical services centre meetings.
- We saw extensive contact between the primary nurses and consultants during surgery.
- Pre-assessment of patients was in accordance with British Association of Day Surgery guidelines.

Environment and equipment

- We observed checks for emergency equipment, including equipment used for resuscitation. Resuscitation equipment in most areas had been checked daily but this was not universal practice. On some wards, equipment had not been routinely checked; there were signatures missing from documentation.
- We brought this to the attention of department managers who took immediate action to make sure the equipment was checked.
- Records showed that equipment was serviced by the trust's maintenance team under a planned preventive maintenance schedule.
- All freestanding equipment in theatres was covered and had been dated when cleaned. Equipment was appropriately checked and cleaned regularly. There was adequate equipment in the wards to ensure safe care.

Surgery

Medicines

- Medicines were stored correctly, including in locked cupboards or fridges where necessary. Fridge temperatures were checked.
- We saw that the preparation and administration of controlled drugs was subject to a second, independent check. After administration, the stock balance of an individual preparation was confirmed to be correct and the balance recorded.

Records

- Care pathways were in use, including enhanced recovery – for example, for fractured neck of femur.
- All wards completed appropriate risk assessments, including for falls, pressure ulcers and malnutrition. All records we looked at were completed accurately.
- There was a comprehensive preoperative health screening questionnaire and assessment pathway.
- Clinical notes were stored securely in line with Data Protection Act 1998 principles to ensure that patient confidentiality was maintained.
- Children's records reviewed included pre-assessment, medical notes, consent forms (written in detail and signed/dated), preoperative checklist completed, anaesthetic record detailed, medication administration record chart, discharge checklist and discharge letter and prescription.

Safeguarding

- Staff were aware of the safeguarding policies and procedures and had received training in this area. They were also aware of the trust's whistleblowing procedures and the action to take if needed.
- Information provided by the trust (September 2014) showed that 78% of staff requiring level 1 safeguarding for children had completed the training and 60% of staff had completed level 2; 78% had completed initial level 3 training and 83% had completed level 3 plus training.
- Staff we spoke with were able to describe the action they would take if they had any safeguarding concerns for either children or adults.
- Staff were aware that the trust had safeguarding policies and a safeguarding team they could contact for advice and support if they had any concerns.

Mandatory training

- Performance reports within the surgical services centre showed that staff were up to date with their mandatory training. For example: 89% had attended information governance training; 88% had attended infection prevention and control level 1; and 87% had attended infection prevention and control level 2 training.
- Staff confirmed that they were up to date with mandatory training, including annual cardiac and pulmonary resuscitation.

Assessing and responding to patient risk

- All wards used the National Early Warning Score (NEWS) system, a recognised early warning tool for the management of deteriorating patients.
- There were clear directions on the observation charts for escalating patients of concern and staff were aware of the appropriate action to take if patients scored higher than expected using the NEWS system.
- We looked at completed charts and saw that staff had escalated correctly, and repeated observations were taken within the necessary timeframes.
- Theatre lists were updated in 'real time' to reflect changing priorities and timescales.
- We observed that theatre staff used the World Health Organization (WHO) surgical safety checklist. Audits across all specialties showed 100% compliance in October 2014.

Nursing staffing

- Staffing levels for wards were calculated using a recognised tool. Work had been done recently by the trust to reassess the staffing levels on wards to ensure that the staffing establishment reflected the acuity of patients.
- Figures provided by the trust showed variations of the 'at work hours' of staff against the established levels of qualified and non-qualified numbers of staff. These showed that at band 5 there were 1.56% less hours worked than the calculated establishment. Similarly for band 6 staff, 3.65 % less hours were worked and at band 7, 3.08% less hours were worked than the calculated establishment.
- We reviewed the nurse staffing levels on all the wards we visited and in theatres and found that levels were not always compliant with the required establishment and skills mix. On surgical wards, the average 'fill rate' varied

from 84% to 102.6% during the day and 77.1% to 106.6% at night. The 'fill rate' for unregistered staff varied from 70.8% to 146.9% during the day and 93.4% to 173.2% at night.

- There was a safe staffing and escalation protocol to follow should the staffing level per shift fall below the agreed roster and acuity needs of patients. Staffing numbers on surgical wards had been adjusted flexibly between registered and unregistered staff to meet the needs of patients and in line with the protocol.
- We were given details of one serious incident on Ward 31 involving a medication error that staff believed had been caused by staff shortages. This had been appropriately reported and was being investigated.
- Bank or agency staff were not used and staff told us they were asked to cover staff shortages. The trust's use of bank and agency staff was 0% during 2014 against an England average of 6.1%. The trust had a policy on overtime and agency usage which was implemented.

Surgical staffing

- Surgical consultants from all specialties were on call for a 24-hour period and arrangements were in place for effective handovers.
- Patients who required unscheduled inpatient surgical care were placed under the direct daily supervision of a consultant and the hospital published a rota for general surgical emergency provision.
- The general surgical on-call team comprised the general consultant and a consultant vascular surgeon.
- Consultants were available on call out of hours and attended when required at weekends. Medical staffing within the division was made up of 42% at consultant level (England average 40%), 39% registrar level (England average 37%), middle career 7% (England average 11%), and 11% junior doctors (England average 13%).

Major incident awareness and training

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

Are surgery services effective?

Good

We saw processes for implementing and monitoring the use of evidence-based guidelines and standards to meet patients' care needs. Surgical services participated in national clinical audits and reviews to improve patient outcomes. Mortality indicators were within expected ranges.

A specialised 'one-stop' clinic, caring specifically for haematuria patients, had been introduced and a discharge lounge developed to speed up patient discharge.

There were processes to identify staff's learning needs and opportunities for professional development. There was effective communication and collaboration between multidisciplinary teams who met regularly to identify patients requiring visits or to discuss any changes to patients' care.

Evidence-based care and treatment

- Patients were treated based on national guidance from the National Institute for Health and Care Excellence (NICE), the Association of Anaesthetists of Great Britain and Ireland and the Royal College of Surgeons of England.
- Enhanced recovery pathways were used for patients.
- Local policies were written in line with national guidelines and updated every two years or if national guidance changed. For example, there were local guidelines for preoperative assessments and these were in line with best practice.
- The surgery departments took part in all the national clinical audits that they were eligible for. The division had a formal clinical audit programme where national guidance was audited and local priorities for audit were identified.
- The urology directorate in conjunction with the SAU had introduced a specialised 'one-stop' clinic caring specifically for haematuria patients.

- Although there was a shortage of recovery beds (18) for the number of theatres (17), the SAU had introduced a discharge lounge that sped up patient discharge.

Pain relief

- Pre-planned pain relief was administered for patients on recovery pathways.
- Patients were regularly asked about pain, particularly immediately after surgery, and this was recorded on a pain scoring tool that was used to assess patients' pain levels.
- All patients we spoke with reported that their pain management needs had been met.

Nutrition and hydration

- Patients were screened using the malnutrition universal screening tool (MUST). Where necessary, patients at risk of malnutrition were referred to the dietician.
- Records showed that patients were advised as to what time they would need to fast from. (Fasting times varied depending on when the surgery was planned.)
- In 2014, patient-led assessments of the care environment (known as PLACE) scored the trust above the England average for food (91%, England average 90%).

Patient outcomes

- There were no current CQC mortality outliers (statistical anomalies outside the expected range) relevant to surgery at this trust. This indicated that there had been no more deaths than expected for patients undergoing surgery at this hospital.
- Patient Reported Outcome Measures (PROMs) for hip replacements, knee replacements, groin hernia and varicose veins showed improvements in patients receiving these procedures – which were better or similar to the England results.
- Standardised relative readmission rates for elective surgical patients ran higher than the England average (100) for general surgery (132), urology (160) and trauma and orthopaedics (138). For non-elective patients, standardised relative readmission rates ran higher than the England average (100) for general surgery (109) and urology (113) and better than the England average for trauma and orthopaedics (95).
- The trust contributed to all national surgical audits for which it was eligible.
- The National Bowel Cancer Audit (2013) showed better-than-the-England-average results for clinical nurse specialist involvement (99%; England average 87.7%), and scans (96.7%; England average 89.1%); and 66.7 % of patients undergoing major surgery stayed in the hospital for an average of more than five days (lower than the England average of 68.9%).
- Lung cancer audit results showed the percentage of patients receiving surgery was lower than the England average (15.5%) at 12.2%. The audit showed results better than the England average for multidisciplinary team discussion (100%; England average 95.6%) and scans before bronchoscopy (94%; England average 89.5%).
- The trust participated in the National Hip Fracture Audit. Findings from the 2013/14 report showed that the trust was better than the England average in areas such as: patients being admitted to orthopaedic care within four hours (83%; England average 51.6%); for patients receiving surgery within 48 hours (90.8% against the national target of 87%); falls assessment (86.9%; England average 96.5%); the mean length of acute stay (15.3 days) and post-acute stay (0.81 days); and the mean total length of stay (16.1 days; England average 19.2 days).
- The trust was worse than the England average for bone health medication assessment (79.9%; England average 84.9%), preoperative assessment by a geriatrician (48.9%; England average 53.8%) and patients developing pressure ulcers (5.6%; England average 3.5%).
- The centre had introduced initiatives to improve compliance with national targets. Business cases and focus on additional weekend working and the introduction of additional theatre sessions had been designed to reduce backlogs.

Competent staff

- Staff told us that appraisals were undertaken annually and records for 2014 showed that the majority of staff across all wards in surgery and theatres had received an appraisal or had an appraisal scheduled.
- Although nursing staff said they did not receive clinical supervision or formal one-to-one sessions, informal meetings did take place.
- Monthly staff meetings were taking place and minutes were available to staff.

- Junior doctors told us they attended teaching sessions and participated in clinical audits. They told us they had received ward-based teaching, were supported by the ward team and could approach senior staff if they had concerns.
- Revalidation of doctors' outcomes were assessed and monitored by the deanery.

Multidisciplinary working

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

Seven-day services

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

Access to information

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

Consent, Mental Capacity Act and deprivation of liberty safeguards

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

Are surgery services caring?

Good

We saw positive, kind and caring interactions on the wards and between staff and patients. Patients spoke positively about the standard of care they had received.

Most patients we spoke with felt they understood their care options and were given enough information about their condition. There were services to ensure that patients received appropriate emotional support.

Compassionate care

- We saw patients being treated with compassion, dignity and respect throughout our inspection at this hospital. We saw that patients were spoken with and listened to promptly. Patients told us staff were "…brilliant, can't do enough for you", "…they are great, very friendly" and "…I am very positive about care and staff". One person said there is "…a good sense of teamwork on the ward. The ward is busy but things get done. There is lots of cleaning going on".
- We saw that staff were attentive to the comfort needs of patients. Patients and relatives were positive about the care and treatment they had received.
- Patients commented positively on the dedication and professionalism of staff and the quality of care and treatment received. Patients were complimentary about the staff in the service, and felt informed and involved in their care and treatment. We observed patients being kept informed throughout their time in the anaesthetic room and theatres.
- We saw doctors introducing themselves appropriately and drawing curtains to maintain patients' dignity.
- The hospital's NHS Friends and Family Test response rate was higher (35%) than the England average (32%) between April 2013 and July 2014 achieving scores across all areas similar to the England average during that period.

Patient understanding and involvement

Surgery

- All patients said that they were made fully aware of the surgery they were going to have and it was explained to them. Patients and relatives said they felt involved in their care and that they had been given the opportunity to speak with the relevant consultant.
- We saw that ward managers and matrons were available on the wards for relatives and patients to speak with.
- Ward information boards identified who was in charge of wards for any given shift and who to contact if there were any problems.
- The CQC's Adult Inpatient Survey (2013) showed a slight decrease (7.6 from 7.7 in 2012) in patients' belief that they were involved as much as they wanted to be in decisions about their care and treatment.
- There was also a decrease in patients responding positively (6.2 from 6.4 the previous year) to say that they received answers they could understand when asking a nurse important questions about their care.

Emotional support

- Patients said they felt able to talk to ward staff about any concerns they had – either about their care, or in general. Patients did not raise any concerns during our inspection.
- The CQC's Adult Inpatient Survey (2013) showed an increase (7.7 from 7.5 in 2012) in patients believing they had received enough emotional support from hospital staff.
- There was information in care plans to highlight whether people had emotional or mental health problems and what support they required.
- Patients were able to access counselling services, psychologists and the mental health team.
- Assessments for anxiety and depression were done at the pre-assessment stage and extra emotional support was provided to patients by nursing staff pre- and postoperatively.

Are surgery services responsive?

Good

Systems were in place to plan and deliver services to meet the needs of local people. Staff were responsive to people's individual needs. Identified issues relating to waiting times were continuously monitored and waiting list initiatives were implemented to meet demand.

Services were available to support patients, particularly those living with dementia, a learning disability or physical disability or those whose first language was not English. There were also systems to record concerns and complaints raised within the division, review these and take action to improve patients' experience.

There was evidence that the service reviewed and acted on information about the quality of care that it received from complaints.

Service planning and delivery to meet the needs of local people

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

Access and flow

- A pre-assessment meeting was held with the patient before the surgery date and any issues concerning discharge planning or other patient needs were discussed at this stage. Patients requiring assistance from social services upon discharge were identified at pre-assessment and plans were continuously reviewed during the discharge planning process.
- The trust was meeting the referral-to-treatment time targets for 90% of patients admitted for treatment from a waiting list within 18 weeks of referral.
- The referral-to-treatment times for patients admitted from a waiting list within 18 weeks was not met within trauma and orthopaedics (73.6%), urology (88.4%), ophthalmology (88.4%), oral surgery (73.1%) and

cardiothoracic surgery (74.1%). The trust was meeting the RTTs for general surgery (92.3%), ENT (95.9%), plastic surgery (90.1%), neurosurgery (92.1%) and thoracic medicine (100%).

- The reasons for these shortfalls had been identified and additional recruitment to consultant posts undertaken and locum cover arranged to reduce the backlog of patients. The centre had also introduced 'three session' days in response to referral-to-treatment times.
- Delays to discharge within the trust were caused mainly by patient or family choice (14.8%), waiting for further NHS non-acute care (23.9%) or completion of assessment (32.2%). These are all above the England average (13.8%, 21.2% and 18.7% respectively).
- The average length of stay was below the England average (three days) for all surgical patients (two days) and for general surgery (two days).
- Sixteen patients had their operations cancelled and were not treated within 28 days during 2014; this is higher than the England average during this period and represents a monthly average of 0.53% of elective patients between April and October 2014.

Meeting people's individual needs

- The service was responsive to the needs of patients living with dementia and learning disabilities. All wards had dementia champions as well as a learning disability liaison nurse who could provide advice and support with caring for people with these needs.
- Suitable information leaflets were available in pictorial and easy-to-read formats, describing what to expect when undergoing surgery and postoperative care. We were told these were available in languages other than English but these were not displayed within ward or surgery areas.
- Wards had access to interpreters as required, and requests for interpreter services were identified at the pre-assessment meeting.
- The trust had a 'Mental Capacity Act (2005) and Deprivation of Liberty Safeguards Policy'. There was access to an independent mental capacity advocate for when best interest decision meetings were required.
- Compliance with Mental Capacity Act 2005 training varied throughout the centre and areas for focus had been identified, for example, theatres and anaesthetics (40.21% compliance).

Learning from complaints and concerns

- The centre had received 75 formal complaints since April 2014 and these had been handled in line with the trust's policy.
- Patients or relatives making an informal complaint were able to speak to individual members of staff or the ward manager.
- Staff were able to describe complaint-escalation procedures, the role of the Patient Advice and Liaison Service and the mechanisms for making a formal complaint. We saw leaflets available throughout the hospital informing patients and relatives about this process.
- Information was given to patients about how to make a comment, compliment or complaint. There were processes for dealing with complaints at ward level and through the trust's Patient Advice and Liaison Service.
- Complaints and concerns were discussed at monthly staff meetings where training needs and learning were identified.
- If patients or their relatives needed help or assistance with making a complaint, the Independent Complaints Advocacy Services (ICAS) contact details were visible in the ward and throughout the hospital.

Are surgery services well-led?

Good

The trust's vision, values and strategy had been disseminated to wards and departments and staff had a clear understanding of what these involved. Staff were aware of their roles and responsibilities and there was good ward leadership. Staff felt supported and had seen positive changes to improve patient care.

The service recognised the importance of patient and public views and had mechanisms to hear and act on patients' feedback. Staff were encouraged and knew how to identify risks and make suggestions for improvements.

Vision and strategy for this service

- The trust's vision and strategy was well-embedded with staff. Staff were able to articulate to us the trust's values and objectives which were also clearly displayed across the surgical ward areas.

- We met with senior managers who had a clear vision and strategy for the division and identified actions for addressing issues within the division. Staff were able to repeat this vision and discuss its meaning with us during individual interviews.

Governance, risk management and quality measurement

- Clinical governance meetings were held each month. Meeting minutes showed that complaints, incidents, audits and quality improvement projects were discussed and action taken where required.
- Reports presented to the Trust Board identified risks throughout the trust, actions taken to address risks and changes made to improve performance. These reports monitored (among other indicators) MRSA and C.difficile rates, referral-to-treatment times, pressure ulcer prevalence, complaints, Never Events and mortality ratios.
- We saw that action plans for Never Events were monitored across the centre. Sub-groups were tasked with implementing elements of action plans where appropriate.

Leadership of service

- Staff said divisional managers were available, visible within the centre and approachable. Leadership of the service was good. Staff morale was good and teams felt supported at ward level.
- Staff spoke positively about the service they provided for patients and emphasised quality and patient experience as a priority and "everyone's responsibility".
- Nursing staff stated that they were well-supported by their managers, although we were told that one-to-one meetings were informal.
- Medical staff stated that they were supported by their consultants and confirmed they received feedback from governance and action planning meetings.

Culture within the service

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

Public and staff engagement

- The hospital's NHS Friends and Family Test response rate (35%) was higher than the England average (32%) between April 2013 and July 2014 and scores were similar across all areas with the England average during that period.
- The response rates for wards within the surgery centre varied between 22% and 89%. NHS staff survey data (2013) showed that the trust scored as expected in 22 out of 30 areas and better than expected in five areas. There were three negative findings – for example: the percentage of staff receiving health and safety training in the last 12 months; percentage of staff feeling pressure in the last three months to attend work when feeling unwell; and staff motivation at work.

Innovation, improvement and sustainability

- There were systems to enable learning and improve performance, including the collection of national data, audit and learning from incidents, complaints and accidents.
- Evidence showed that staff were encouraged to focus on improvement and learning. We saw examples of innovation, such as the development of the discharge lounge within the SAU and the dedicated 'one-stop clinic for haematuria patients.

Critical care

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

Information about the service

The James Cook University Hospital had a general intensive care unit (ICU), a cardiothoracic intensive care unit (CICU), a general high dependency unit (HDU), a cardiothoracic high dependency unit as well as spinal and neurological high dependency units. The general ICU and a general HDU fall within the integrated medical care centre within South Tees Hospitals NHS Foundation Trust. The cardiothoracic intensive care unit (CICU), a cardiothoracic high dependency unit and neurological high dependency units fall within the Tertiary Services Centre and the Spinal High Dependency Unit falls within the Trauma and Theatres Centre. These units covered a catchment population of around 678,800.

South Tees Hospitals NHS Foundation Trust had 66 ICU and HDU beds at James Cook University Hospital. The general ICU had 16 level 3 beds and the cardiothoracic ICU had 12 level 3 beds which reduced to nine or 10 on weekends and bank holidays. The general HDU had 16 level 2 beds, the spinal HDU had 4 level 2 beds, and the neurological HDU had eight level 2 beds. The units took patients who have had major trauma or surgical and orthopaedic elective procedures that require level 2 or 3 care, and acutely ill medical patients.

We visited the critical care units, both general and cardiothoracic, as well as the general, cardiothoracic, spinal and neurology HDUs. We spoke with 25 staff, including consultants, senior managers, nursing staff and allied healthcare professionals, as well as six patients and two relatives. We also observed care and reviewed documentation, including patient records.

Summary of findings

We rated critical care services as good. Effective arrangements were in place for reporting patient and staff incidents and allegations of abuse, which was in line with national guidance. Nurse staffing levels were determined using an acuity tool and national guidelines were followed. Although an additional coordinator was factored into staffing rotas in line with the Core Standards for Intensive Care Units 2013, this did not always happen due to staff sickness. However, patients' safety was not compromised as a result of this. The complement of medical staff and the skills mix of the medical team were suitable and in line with national guidance. There were arrangements for the effective prevention and control of infection and the management of medicines. Checks were carried out on equipment, and care records were completed accurately and clearly.

There were processes for implementing and monitoring the use of evidence-based guidelines and standards to meet patients' care needs. The unit performed well in comparison to similar units in terms of patient outcomes, and there were no concerning patient outcome figures.

Processes were in place to identify staff's learning needs and opportunities for professional development. There was effective communication and collaboration between multidisciplinary teams who met regularly to identify patients requiring visits or to discuss any changes to patients' care.

Critical care

All the critical care units were caring. We saw people and their relatives being treated with understanding, compassion, dignity and respect. Patients spoke positively about the care that they received. Patients and their relatives felt they understood their care options and were given enough information about their conditions. Services were provided to ensure that patients received appropriate emotional support.

The staff groups were responsive to patients' changing needs and worked effectively to manage the workload. Quality indicators, including early readmissions, late readmissions and post-unit hospital deaths were within acceptable limits on all units. Average length of stay for all admissions and for unit survivors were also within acceptable limits.

The units had a very low number of complaints. The vast majority of concerns and complaints were managed at a local level without the need for issues to be formally escalated. Any learning from complaints was disseminated to staff through staff meetings and directorate updates.

The trust's values and objectives had been communicated to all staff who had a clear understanding of what this involved. Governance processes were embedded and there were appropriate processes for managing risk. The leadership teams were approachable and open and viewed positively by staff. The management teams had a number of effective ways of engaging with staff, and patient engagement and feedback was actively sought on the unit.

Are critical care services safe?

Good

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

Nurse staffing levels were determined using an acuity tool and national guidelines were followed. Although an additional coordinator was factored into staffing rotas in line with the Core Standards for Intensive Care Units 2013, this did not always happen due to staff sickness. However, patients' safety was not compromised as a result of this. The complement of medical staff and the skills mix of the medical team were suitable and in line with national guidance.

There were arrangements for the effective prevention and control of infection and the management of medicines. Checks were carried out on equipment and care records were completed accurately and clearly. The units appropriately assessed and responded to patient risk.

Incidents

- Between November 2013 and October 2014 critical care services did not record any Never Events (serious, largely preventable patient safety incidents that should not occur if proper preventative measures are taken).
- Prior to these dates there had been one Never Event in July 2013 in critical care at this hospital. We saw that this had been fully investigated, identifying the root causes of the errors, contributory factors, lessons learned, arrangements for sharing learning and actions needed to stop recurrence.
- There were 584 incidents reported between November 2013 and October 2014 at this hospital. One of these incidents was reported on the Strategic Executive Information System (STEIS) as a serious incident in March 2014. A root cause analysis had been completed for this incident. The other incidents were graded as 'no actual harm' (358), 'minor' (216), eight as 'moderate' and one as 'severe'.

Critical care

- Nursing and medical staff in critical care described how they would report incidents and were clear about their responsibilities and who to escalate concerns to. Staff accurately stated that they would report incidents using an electronic incident reporting system.
- Staff also described how they received feedback about incidents that had been reported. This was mainly through staff meetings. We observed minutes of these meetings which confirmed that incident feedback was given.
- Staff were aware of the new Duty of Candour regulations that came into effect on 27 November 2014. Managers, medical and nursing staff stated this was already intrinsic to their practice. Training and awareness of the regulations were to be incorporated into the staff induction programme.
- Mortality and morbidity meetings were held weekly on a Wednesday. These meetings were open to all staff, but the majority of attendees were medical staff.
- The critical care team also participated in multi-specialty mortality and morbidity meetings, for example, with surgery, as well as meetings with the ICU at the Friarage Hospital, to promote shared learning.
- The mortality and morbidity meetings were used to provide staff with the opportunity to discuss errors and adverse incidents in an open manner. The meetings enabled staff to review care standards and make changes if required.

Safety thermometer

- The NHS Safety Thermometer information was displayed in all intensive care and high dependency units within this hospital. The NHS Safety Thermometer is a local improvement tool for measuring, monitoring and analysing patient harms and harm-free care. Some staff we spoke with were not aware of this information.
- Safety Thermometer information included information about all new harms, new pressure ulcers, Methicillin-Resistant Staphylococcus Aureus (MRSA) and Clostridium difficile (C.difficile) infection rates.
- Between November 2013 and October 2014 all units had between 91% and 98% harm-free care for three consecutive months. Pressure ulcer rates were inconsistent throughout this period, with some months reporting three grade 1 or 2 pressure ulcers, while other months reported none.
- Senior managers were aware of this and had commenced a programme of increasing staff awareness and had introduced and promoted the use of protectors for nasal cannulas. This had resulted in a decrease in grade 2 pressure ulcers.

Cleanliness, infection control and hygiene

- The general environment and equipment in all units were visibly clean.
- There was suitable provision of, and access to, hand-wash basins and hand gel.
- We observed all staff cleaning their hands when required, using both soap and water or hand gel; this was usually before and after contact with a patient and/or the patient's immediate environment.
- All staff followed the trust's uniform policy in clinical areas and was observed to adhere to the 'bare below elbows' principle in line with recommended hygiene best practice.
- We saw staff, including nurses and designated cleaning staff, cleaning areas of the ICUs and HDUs. Cleaning schedules were adhered to.
- Clinical waste bins were covered, with foot-operated opening controls. Appropriate signage was used for the disposal of clinical waste.
- Data on unit-acquired infection from the Intensive Care National Audit & Research Centre (ICNARC) for 2014 showed no concerning trends in terms of C.difficile or MRSA infections.
- Between November 2013 and October 2014, the general ICU had one reported case of unit-acquired MRSA, and no cases of Methicillin-Sensitive Staphylococcus Aureus (MSSA) or ventilator-induced pneumonia.
- Between November 2013 and October 2014, the general HDU had no reported cases of unit-acquired MRSA, and no cases of MSSA or ventilator-induced pneumonia.
- Infection control audits were completed every month and monitored compliance with key trust policies such as hand hygiene. The units achieved between 93% and 97% compliance with hand hygiene.
- Records of recent environmental audits showed that the units achieved between 94% and 100% compliance with infection control procedures.

Environment and equipment

- The environment and equipment were in a good state. There was adequate equipment to ensure safe care.

- Records showed that equipment was serviced by the trust's maintenance team under a planned preventative maintenance programme. This included syringe drivers and ventilators.
- Resuscitation equipment was easily accessible within all units. We observed that checks for emergency equipment, including resuscitation equipment, were carried out on a daily basis.

Medicines

- Pharmacists and pharmacy technicians provided medicines management support to all clinical areas, with the pharmacist reviewing all prescribing daily, Monday to Friday.
- Pharmacists completed monthly audits of antibiotic use on each ward and shared the results with ward teams. Audits demonstrated good compliance with trust policy for the use of antibiotics, a key factor in reducing the incidence of C.difficile and MRSA.
- The annual medicines storage and security audit of all clinical areas in the trust had been completed in March 2014 and showed good compliance with trust standards. On ITU3 we found that records for the monitoring of the medicines fridge were poor and recorded high temperatures had not been investigated in line with the trust's policy.
- The pharmacist told us that they reported all medicine incidents identified on the Datix patient safety incidents healthcare software system.
- A full audit of the management of controlled drugs in critical care had been completed in September 2014, with the results followed up by the clinical pharmacist.
- We reviewed six patient records, including drug prescription charts; there were no errors noted.
- We observed medications being administered appropriately.

Records

- The records on the unit were paper-based healthcare records.
- We reviewed six sets of patient records; these were correctly and adequately completed, including core care plans and risk assessments including venous thromboembolism (VTE or blood clots), moving and handling, pressure area care and nutrition.
- The bedside observation charts on the unit were completed accurately. We noted that staff visiting the unit also completed their sections on the chart as required.

Safeguarding

- Staff on the units were aware of the trust's safeguarding policies and procedures and could accurately describe the process for reporting concerns about safeguarding.
- On the ICUs, compliance with adults safeguarding level 1 training was 50%. Compliance with children's safeguarding level 1 training was 50% and children's safeguarding level 2 was 22%.
- On the HDUs, compliance with adults safeguarding level 1 training was 48%. Compliance with children's safeguarding level 1 training was 100% and children's safeguarding level 2 was 23%.
- The units had an action plan to ensure that all staff received the required safeguarding training by the end of March 2015.

Mandatory training

- For medical staff, compliance with mandatory training ranged between 20% and 85%. The highest training compliance figures for medical staff included information governance (85%) and equality and diversity (80%). The lowest compliance figures related to basic life support (20%) and fire safety (50%).
- For nursing staff on the ICUs, compliance with mandatory training ranged between 50% and 100%. The highest compliance figures for nursing staff included information governance (100%), equality and diversity (83%), and infection prevention and control (67%). The lowest compliance figures related to fire safety (50%).
- For nursing staff on the HDUs, compliance with mandatory training ranged between 21% and 100%. The highest compliance figures for this range of staff included children's level 1 safeguarding training (100%) and information governance (87%). The lowest compliance figures related to basic life support (21%).
- Both the ICUs and HDUs had action plans to ensure that all staff received the required mandatory training by the end of March 2015.

Assessing and responding to patient risk

Critical care

- The trust used the National Early Warning Score (NEWS) system for acutely ill patients, which supported the process for early recognition of those patients who were deteriorating and who required prompt medical assessment and intervention.
- All patients on the ICUs and HDUs were monitored closely and no concerns were raised in terms of the responsiveness of staff in reacting to the deteriorating patient. This included gaining prompt access to medical intervention.
- The hospital provided a critical care outreach team which worked collaboratively with patients' multidisciplinary teams to offer expert advice in relation to acutely ill or deteriorating patients who were cared for in ward environments.
- This service was available 24 hours a day, seven days a week. The outreach team responded to patients across the hospital who had high NEWS scores and supported ward staff in the management of such patients.
- The outreach team also reviewed, at least once, all patients who were discharged from critical care services back on to the ward.
- The outreach team was seen very positively by ward and unit staff throughout the hospital. Between January and July 2014, the team had received around 500 inpatient ward referrals.

Nursing staffing

- Nurse staffing levels were determined using a trust-wide staffing acuity tool. The Core Standards for Intensive Care Units 2013 were followed to determine the number of nursing staff needed for each patient; this included the requirement to have two-to-one care for level 2 patients and one-to-one care for level 3 patients.
- Staff shared their time between working on the ICUs and HDUs and there was some flexibility depending on patients' needs. There was no formal rotation of staff between these critical care units and the unit at the Friarage, although staff did move between the two sites to cover staff shortages.
- Nursing shift patterns were mixed, including 12-hour and 7.5 to 8-hour shifts.
- The trained nursing establishment for the units was 164.52 whole time equivalent (WTE). This included 14.22 WTE band 7 nurses, 36.57 WTE band 6 nurses and 113.78 WTE band 5 nurses.
- The units were under the ideal staffing complement for band 7, 6 and 5 nurses. These posts were being actively recruited to at the time of the inspection.
- The units had 7.5 WTE band 3 healthcare assistants and 16.42 WTE band 2 healthcare assistants. This was just under the ideal staffing complement and these posts were being actively recruited to at the time of the inspection.
- Any shortfalls in nurse staffing levels were addressed by existing staff working additional hours as overtime or flexible working.
- Bank and agency staff were not used on the unit.
- We were informed that, although an additional coordinator was factored in to staffing rotas in line with the Core Standards for Intensive Care Units 2013, this did not always happen due to staff sickness. However, patient safety did not seem compromised as a result.
- Two nurse handovers took place each day. The handover included patients' basic clinical information and allocating patients to incoming staff prior to their shift commencing.

Medical staffing

- The complement of medical staff and the team's skills mix were suitable and in line with national guidance.
- The critical care unit consultant staffing at this hospital consisted of 16 NHS and three (part-time) military consultants.
- All those appointed over the past five years had advanced ITU training or its equivalent. Most were anaesthetists.
- Other permanent medical staff included an associate specialist in critical care medicine and a staff grade in air medical services, trauma anaesthesia and critical care.
- The trainee rotas consisted of nine doctors at middle-grade level and 19 at resident level.
- The number of junior doctors varied; junior doctors we talked to spoke positively of their learning and development on the unit.
- Medical handovers, including those led by a consultant, were reported to be sufficiently detailed and comprehensive.
- Consultants did not work in five-day blocks; this was not in line with Core Standards for Intensive Care Units 2013. Instead, consultants covered for three-day blocks throughout the week. Nursing and medical staff stated that there were no problems with continuity of care due to this arrangement.

- Patients were reviewed by a consultant within 12 hours of admission to the unit, including at weekends. Patients were then medically reviewed by a consultant at appropriate intervals, again also at weekends.
- The non-consultant-grade doctors and the nurses we spoke with felt that the cover arrangements and working patterns of the medical team were suitable; this included access to a consultant out of hours, including at weekends.
- The consultant-to-patient ratio was in line with that recommended in national guidance. The unit did not use any locum doctors.

Major incident awareness and training

- The unit had a major incident policy and business continuity plans. These were accessible to staff.
- Staff we spoke with were aware of these policies and plans and how to escalate issues during emergency situations.
- The units had taken part in telephone and scenarios training exercises as part of major incident planning.

Are critical care services effective?

Good

There were processes for implementing and monitoring the use of evidence-based guidelines and standards to meet patients' care needs. The units performed well in comparison with similar units for patient outcomes, and there were no concerning patient outcome figures.

Processes were in place to identify staff's learning needs and opportunities for professional development. There was effective communication and collaboration between multidisciplinary teams, who met regularly to identify patients requiring visits or to discuss any changes to patients' care.

Evidence-based care and treatment

- A range of local policies and procedures existed and were easily accessible to staff. These were based on up-to-date evidence, including guidance from the National Institute for Health and Care Excellence (NICE), relevant royal colleges and core standards for ICUs
- There were a number of examples where practice was supported by evidence-based guidance. Examples included: how patients were rehabilitated (which was in line with NICE guideline 83, Rehabilitation after critical illness); the use of care bundles in ventilation; and neurological care.
- We saw evidence of regular local audits in areas of care such as ventilator-associated pneumonia, antibiotic use and central lines.
- On the patient charts and care plans we reviewed, there was evidence of decisions being made in line with national standards, for example, nutrition, pain, nasogastric tube placement and fluid management and hydration.

Pain relief

- There was an acute pain team that worked across the trust, including on the ICUs and HDUs.
- We reviewed six patient charts and noted that pain scores were appropriately recorded.
- We also observed pain scores being discussed during ward rounds.
- Patients we spoke with confirmed that their pain management needs had been met.

Nutrition and hydration

- All patients had a malnutrition universal screening tool (MUST) assessment on admission to the ICU/HDU. The MUST is a five-step screening tool to identify adults who are malnourished, at risk of malnutrition, or obese.
- Nutritional risk scores were updated and recorded appropriately.
- The JCUH unit had a dietetic service of 0.3wte (over 5 days). The Core Standards for Intensive Care Units (2013) recommend that there should be 0.05 – 0.1wte per bed. According to these guidelines the unit should have a staffing level of 0.8 – 1.6 WTE for ITU alone. A recent capacity and demand study had highlighted this shortfall and as a result of this it was agreed that the Dietician with the ICU service would set clear criteria on which patients they would treat and ITU staff would be led by protocol and guidelines for the dietetic management of the majority of patients on ITU.

Patient outcomes

- We reviewed the data from ICNARC for the ITU and HDU between 1 January 2014 and 31 March 2014. We also reviewed ICNARC data for the cardiothoracic intensive care unit (CICU); this data was not as detailed and we could only review data from early 2013–2014.

- Mortality rates for the ITU and HDU were not an area of concern and were in keeping with the averages for other similar units. Mortality risk predictive data for the CICU was better than the average for other similar units.
- For the ITU and HDU, for numerous outcome measures (including ventilated admissions, admissions with severe sepsis, pneumonia, elective surgical and emergency surgical admissions) there were no areas of concern and figures were within expected ranges.
- There were no concerns, from the data, in relation to MRSA and C. difficile infections for the ITU and HDU.

Competent staff

- All critical care consultants had an up-to-date appraisal and all had, or were undergoing, revalidation.
- Newly appointed consultants would not be part of the medical on-call rota for their first month, and all would be required to complete the trust's induction programme.
- New consultants would not be required to work autonomously for their first month.
- Any trainee doctors would be training specifically in anaesthesia and intensive critical care medicine.
- 42% of nurses had received an appraisal. The service had an action plan to ensure that all staff received an appraisal by the end of March 2015.
- Staff described opportunities for clinical supervision which included reflecting on practice and discussing issues at staff meetings.
- The units had a clinical nurse educator who was responsible for staff completing any required competencies such as the National Competency Framework for Adult Critical Care Nurses.
- All qualified nurses new to the units completed an eight-week supernumerary induction and were assessed using the National Competency Framework for Adult Critical Care Nurses.
- All healthcare assistants new to the units completed a four-week supernumerary induction and were then assessed using a relevant competency package.
- 50% of nurses on the unit had a post-registration qualification in critical care. This was in line with Core Standards for Intensive Care Units (2013).

Multidisciplinary working

- We observed good multidisciplinary team working; the units had positive input from a range of healthcare professionals, including doctors, nurses, physiotherapists, dieticians, pain nurses, speech and language therapists and a microbiologist.
- Most of these healthcare professionals were present during ward rounds, which meant that there was a holistic approach to patient care.
- All patients discharged from the units to the wards had at least one follow-up visit from the critical care outreach team.
- The critical care outreach team was accessible 24 hours a day, seven days a week.

Seven-day services

- The amount of consultant presence on the units in daytime met the recommended levels of intensive care medicine programmed activities.
- Both daytime and out-of-hours junior doctor cover was at safe levels. The skills mix was suitable to cover emergencies, including airway emergencies.
- Out-of-hours cover during the week was provided by a consultant with sufficient intensive care medicine experience, as per core skills requirements.
- Staff, including nurses and trainee-grade doctors, said that on-call consultants were approachable and would come in from home if necessary.
- Access to x-ray facilities was available 24 hours a day, seven days a week.
- Physiotherapy services were provided daily, including the weekend. Physiotherapy had an on-call service for urgent matters. There was a seven-day respiratory management service.
- Pharmacy services provided a daily service Monday to Friday. There was an on-call pharmacist available out of hours and at weekends.

Access to information

- Risk assessments, care plans and test results were completed at appropriate times during a patient's care and treatment and we saw that these were available to staff, enabling effective care and treatment.
- There were appropriate and effective systems to ensure that patient information was coordinated between systems and accessible to staff.

Consent and Mental Capacity Act and deprivation of liberty safeguards

Critical care

- Opportunities for gaining written and/or verbal consent from patients on the ICU and HDU were limited due to the severity of some patients' conditions and the fact that many patients were sedated or unconscious.
- Staff reported that much of the care provided to patients was in their best interests and how, for some medical interventions, the patient's family and/or friends would be consulted.
- We saw examples where specific consent had been gained from a person's family; this related to fitting a tracheostomy.
- In relation to the Mental Capacity Act 2005 and its related deprivation of liberty safeguards, nurses accurately explained to us the process for providing care where these issues needed to be considered.
- Staff had received Mental Capacity Act training: on the ICU, 75% of medical staff and 21% of nursing staff had completed this training; on the HDU, 30% of nursing staff had completed this training. There was an action plan to ensure that all staff received the required training by the end of March 2015.

Are critical care services caring?

Good

All the critical care units were caring. We saw people and their relatives being treated with understanding, compassion, dignity and respect. Patients spoke positively about the care they received.

Patients and their relatives felt they understood their care options and were given enough information about their conditions. Services were provided to ensure that patients received appropriate emotional support.

Compassionate care

- During our visit to the ICUs and HDUs, we observed a number of interactions between staff and patients and relatives. We observed that staff were always polite, respectful and professional in their approach.
- We spoke with six patients across the critical care services, four patients on the HDUs and two patients on the ICUs.
- The patients on the HDUs were positive about the care they received and they felt staff were caring and attentive.
- Patients on the ICUs were also complimentary about their care and found staff to be understanding and supportive.
- We also spoke with the relatives of patients on the critical care units. Relatives told us that they felt staff were compassionate and caring.
- We observed staff supporting patients with personal care; privacy and dignity was maintained by closing bedside curtains and speaking with patients (including unconscious or sedated people) in a respectful way.

Understanding and involvement of patients and those close to them

- The nursing staff described how they supported patients, where possible, to be involved in making decisions about their care, but this was often not possible with the majority of ICU patients.
- Family members and/or friends and relatives were more often included in making decisions about their relative's or friend's care.
- In some instances, patients were aware of their medical treatment and we observed staff explaining and supporting patients to understand their plan of care.
- The unit managers and nursing staff were available for relatives and patients to speak to..
- The general ICU and HDU both provided feedback questionnaires for patients and their relatives. In 2014: 'excellent' scores were given by relatives in areas such as the nursing care provided and staff communication for the ICU; 89% of responses were rated either 'very good' or 'excellent' for overall satisfaction with the HDU and staff communication.

Emotional support

- There was access to counselling services.
- The trust arranged an annual event for patients discharged from critical care services at both this hospital and the Friarage Hospital which gave patients an opportunity to discuss their experiences of the unit.
- Multi faith services were available.
- All patients in the ITU had a delirium (confusion assessment) score and were placed on a specific delirium pathway if required.

Are critical care services responsive?

Critical care

Good

Critical care services were responsive. The staff groups were also responsive to the changing needs of patients and worked effectively to manage the workload.

Quality indicators, including early readmissions, late readmissions and post-unit hospital deaths were within acceptable limits on all units. Average length of stay for all admissions and for unit survivors were also within acceptable limits.

The units had a very low number of complaints. The vast majority of concerns and complaints were managed at a local level without the need for issues to be formally escalated. Any learning from complaints was disseminated to staff through staff meetings and directorate updates.

Service planning and delivery to meet the needs of local people

- The hospital had an escalation and surge policy and procedure to deal with busy times.
- The unit worked closely with the critical care unit at the Friarage Hospital in terms of staff cover and escalation procedures for bed capacity issues.
- The introduction of the critical care outreach team in 2013 was seen by staff as a significant improvement for service delivery and patient outcomes. Staff throughout the hospital commented on the positive impact this team had in the management of acutely ill patients and their outcomes.

Meeting people's individual needs

- The ICUs and HDUs were responsive to patients with complex needs, including people living with dementia and specific learning needs.
- Nurses commented that they had experience supporting patients with complex needs, and how they liaised closely with patients' relatives or carers in such cases.
- The care and support offered by patients' relatives or carers was valued and was a key part of providing suitable care.
- The nurses described how the unit was flexible with visiting times, especially in cases where a patient needed a significant amount of extra support.
- Translation services were available and staff could describe the process for accessing these services.

Access and flow

- We reviewed the data from ICNARC for the ITU and HDU between 1 January 2014 and 31 March 2014. We also reviewed ICNARC data for the CICU; this data was not as detailed and we could only review data from early 2013/14.
- The CICU had a comparatively high number of elective surgical admissions and a low number of emergency surgical admissions; this was not a concern.
- In relation to quality indicators for the ITU, early discharge rates had previously been consistently above that of other similar units but, from the end of 2013, those numbers had dropped back within the expected range.
- Out-of-hours discharge (out of hospital) rates, for the majority of the time, between 2009 to early 2014 was above that of other similar units. This issue was recognised and efforts were being made to continually improve in this area. Out-of-hours discharges (to the ward) were within range.
- Delayed discharges (four-hour delay) had been steadily increasing since 2009 but figures followed the national average; this was also true for the HDU.
- For the quality indicators, early readmissions, late readmissions, post-unit hospital deaths, transfers out and non-clinical transfers out, there were no areas of concern for the ITU or HDU.
- For average length of stay for the ITU, the figures had been slightly above the average for other similar units since 2011 but this was not significant.
- In relation to the HDU, there was a significant rise in the number of admissions for early 2012 but the average length of stay remained consistent and was not a concern. Average length of stay for HDU had steadily declined since mid-2011.
- Between October 2013 and October 2014, 64 operations were cancelled due to no available critical care/high dependency beds at this hospital.
- Staff described an increase in occupancy on ICU since the hospital became a major trauma centre.
- Between November 2013 and November 2014 the average occupancy on the ICU was 91%. Occupancy was lowest in January 2014 at 82% and highest in August 2014 at 96%.

Critical care

- Between November 2013 and November 2014 the average occupancy on the HDU was 86%. Occupancy was lowest in August 2014 at 75% and highest in November 2013 at 92%.
- Between January and July 2014, the number of critical care discharges readmitted to the critical care service within 48 hours of discharge to wards was between 0% and 4.1%.

Learning from complaints and concerns

- All units had a very low number of complaints. The vast majority of concerns and complaints were managed at a local level without the need for issues to be formally escalated.
- Complaints were reported at the directorate monthly clinical governance meetings.
- Learning from complaints was disseminated to staff through staff meetings and directorate updates.

Are critical care services well-led?

Good

Critical care services were well-led at this hospital. The trust's values and objectives had been communicated to all staff who had a clear understanding of what this involved. Governance processes were embedded and there were appropriate processes for managing risk.

The leadership teams were approachable and open, and viewed positively by staff. The management teams had a number of effective ways of engaging with staff, and patient engagement and feedback was actively sought on the units.

Vision and strategy for this service

- The trust had a vision and strategy for the organisation, with clear aims and objectives. The trust's values and objectives had been disseminated across the unit and were visible in staff areas.
- Staff had a clear understanding of what the vision involved and most were able to discuss it during individual conversations.
- The senior management team had a vision and strategy for the direction of critical care services in the hospital.

Governance, risk management and quality measurement

- The units participated in monthly clinical governance meetings. Complaints, incidents, audits and quality improvement were discussed.
- Feedback from these meetings was given at staff meetings.
- There was a risk register for the ICUs, including controls and assurances to mitigate risk.
- The senior management teams had a good understanding of the risks to the service and could effectively articulate the controls and assurances in place to mitigate these risks.

Leadership of service

- From our observations, and from speaking with frontline staff, it was evident that the critical care teams worked well together and there was a good sense of collaborative working and team effort. Staff worked flexibly between the ICUs and HDUs.
- Our review of the systems and processes on the units showed that the leadership was effective and seen positively by staff.
- Senior nurses, consultants and managers had good visibility on the units and were well-known to staff.
- The leadership team was approachable and open.

Culture within the service

- The culture within the service was positive and there was a strong sense of teamwork, openness and focus on patient safety and good patient outcomes.
- Staff were well-engaged with the rest of the hospital and reported an open and transparent culture on the units. They reported good engagement at unit level and felt that they were able to raise concerns and that these would be acted upon.
- Staff spoke positively about the service provided for patients. High-quality, safe care was seen as a priority.

Public and staff engagement

- Patient and relative engagement was actively sought on all units. This was completed both informally and formally through questionnaires, and results were disseminated to staff. Feedback from patients and relatives was very positive, particularly in relation to care and communication.
- The management teams had a number of effective ways of engaging with staff, including formal staff meetings, informal discussions at handover, and by having a strong presence on the unit.

- Information about the units, including details of incidents and minutes of meetings, were all accessible to staff. Information was openly shared and discussed between all levels of staff.

Innovation, improvement and sustainability

- Managers and staff told us they were supported to try new ways of working to improve the effectiveness and efficiency of the unit.

Maternity and gynaecology

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

Information about the service

The trust offered a full range of maternity services for women and families based in this hospital and the community setting – ranging from specialist care for women who needed closer monitoring, to a home-birth service for women with low-risk pregnancies. There were teams of community midwives who delivered antenatal and postnatal care in women's homes, clinics, children's centres and GP locations across the South Tees region. A women's health unit incorporating a pregnancy advisory service also provided a range of treatments for gynaecological problems.

In October 2014, following a reconfiguration of maternity services, all consultant-led intrapartum care was transferred to James Cook University Hospital, with a midwifery-led care model provided at the Friarage Hospital in Northallerton.

The maternity service at South Tees NHS Foundation Trust delivered 5,247 babies per annum.

We visited the antenatal clinics, labour ward, obstetric theatres, midwifery-led unit, pregnancy advisory service, early pregnancy assessment unit, high dependency unit (HDU), and induction of labour suite, latent phase room and postnatal wards. We spoke with 10 women and 30 staff, including midwives, midwifery support workers, doctors, consultants and senior managers. We observed care and treatment and looked at 14 care records. We also reviewed the trust's performance data.

Summary of findings

Overall, maternity services were good in all areas inspected, with the leadership ('Are maternity and gynaecology services well-led?') being rated as 'outstanding'. We observed areas of exemplary practice in the care and treatment of women.

The service provided safe and effective care in accordance with recommended practices. Outcomes for women using the service were continuously monitored and, where improvements were required, action was taken.

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

Women's individual needs were taken into account in planning the level of support throughout their pregnancy. Women were treated with kindness, dignity and respect. The service took account of complaints and concerns and implemented action to improve the quality of care.

The maternity and gynaecology services were led by a highly committed, enthusiastic team, each sharing a passion and responsibility for delivering a high-quality service. Governance arrangements were embedded at all levels and enabled the effective identification and monitoring of risks, and the review of progress on action plans. Engagement with patients and staff was strong. There was evidence of innovation and a proactive approach to performance improvement.

Maternity and gynaecology

Are maternity and gynaecology services safe?

Good

There were effective systems for reporting, investigating and acting on adverse events. Information was routinely collected and reviewed around standards of safety and then shared with staff.

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

Care and treatment was planned and delivered in a way to ensure women's safety and welfare. Staff followed safety guidance for infection prevention and control. Medicines were managed safely. Records relating to women's care were detailed enough to identify individual needs and to inform staff of any risk and how these were to be managed.

Incidents

- Trust policies for reporting incidents, near misses and adverse events were embedded in maternity services. All staff we spoke with said they were encouraged to report incidents and were aware of the process to do so. Incidents were reported on the trust's electronic incident-reporting system. Staff told us they always received feedback about incidents they had reported, with details of the outcomes of any investigations. Junior doctors said incidents and case reviews were discussed with them as part of ward-based teaching.
- There were 425 incidents reported for maternity and gynaecology for the period January to September 2014. Two incidents were classified as 'severe risk' and one as a 'moderate risk'. Change action reports had been completed following a review of each incident, and learning was shared with staff, including any changes to guidelines. Other improvements included: clocks being moved in delivery rooms to enable midwives to note times more easily; assistance or attendance of senior staff sought early if a clinical situation worsened; and enlisting a scribe to also act as timekeeper in all emergency situations.
- There were a number of internal communication methods used to inform staff of learning and changes to practice. This included a monthly obstetric risk management newsletter, Risky Business, emails, staff supervision and a daily multidisciplinary meeting where incidents or interesting cases from the previous 24-hour admissions were discussed.
- There were no Never Events reported for maternity in 2013/14. Never Events are serious, largely preventable patient safety incidents that should not occur if proper preventative measures are taken.
- One serious incident of a maternal death was reported in 2013/14. The incident was thoroughly investigated using root cause analysis, including an external expert review. We saw that a comprehensive action plan was implemented to minimise future risk.
- Perinatal mortality and morbidity cases were discussed at audit and monthly multidisciplinary meetings which were attended by obstetric and neonatal staff. Risk management reports for April to September 2014 showed that, from the cases reviewed, recommendations had been made to revise clinical guidelines and changes clinical practice accordingly.

Safety thermometer

- The NHS Safety Thermometer (a local improvement tool for measuring, monitoring and analysing patient harms and harm-free care) was in use at the unit and the information was displayed in some clinical areas for patients and relatives to view. There had been no patient harms in the previous 12 months.
- The women and children's quality performance report showed that, between April and September 2014, 94.5%–96% of patients had received a venous thromboembolism (VTE or blood clot) assessment, against a trust target of 95%. The sample of records we looked at showed risk assessments for VTE had been completed correctly.

Cleanliness, infection control and hygiene

- There were no cases of hospital-acquired Methicillin-Resistant Staphylococcus Aureus (MRSA) or Clostridium difficile (C. difficile) in 2013/14.
- All areas we visited had antibacterial gel dispensers at the entrances. Appropriate signage was on display regarding hand washing for staff and visitors.

- There were facilities for isolating patients with an infectious disease.
- Women were screened for MRSA before undergoing elective caesarean sections.
- Failsafe systems were in place to identify women for Hepatitis B and HIV at booking to ensure that relevant patients were managed on the correct care pathways.
- Cleaning services were commissioned with external contractors. Cleaning schedules showed that staff followed required cleaning practices and the appropriate frequency of cleaning.
- The CQC Survey of Women's Experience of Maternity Care (2013) showed that the service scored 'about the same' as other trusts for cleanliness, infection control and hygiene.
- Observations during the inspection confirmed that all staff wore appropriate personal protective equipment when required, and they adhered to 'bare below the elbow' guidance, in line with national good hygiene practice.
- A trust-wide environmental audit (October 2014) showed that the service was compliant with trust targets.

Environment and equipment

- There was adequate equipment on the wards to ensure safe care – specifically, cardiotocography (CTG) and resuscitation equipment. Staff confirmed that they had sufficient equipment to meet patients' needs.
- The service used a CTG training tool to assess staff competence and awareness of the functionality of the equipment. For example, checks were performed to ensure that the date and time on the CTG was accurately set and that all necessary equipment was available to monitor the foetal heart rate.
- Maintenance of equipment was regularly checked by the trust's medical engineering department and records showed that staff carried out equipment checks each day.
- There was no birthing pool in the unit; however, all bathrooms had appropriately shaped baths to enable women to use them during labour where suitable. Trust data showed that there was an 8% water-birth rate in 2013/14.
- All delivery rooms had piped ENTONOX® (gas and oxygen) and other gases. A foetal blood analyser was situated in the central delivery suite.
- The design of the unit helped to ensure that women and babies were kept safe and could be transferred quickly in an emergency. The unit had its own separate entrance to enable 24-hour access and security control. There was easy access from the birthing rooms to two dedicated obstetric theatres. Theatres were in close proximity to the neonatal unit to ease transfer of babies. There was also provision for partners to stay overnight.
- The service had made appropriate adjustments to ensure that women with a disability had access to suitable facilities. This included adapted bathroom and toilet areas. Specialist equipment for women with a high body mass index (BMI) could be obtained when required.

Medicines

- Medicines were stored in locked cupboards and trolleys in all of the units.
- Medicines that required storage at a low temperature were stored in a specific medicines fridge. All of the fridge temperatures were checked and recorded daily. There were no gaps in recording.
- Midwives told us that they received support from the on-site pharmacist, when required.
- Records showed the administration of controlled drugs were subject to a second, independent check. After administration, the stock balance of an individual preparation was confirmed to be correct and the balance recorded.

Records

- Clinical records were completed to a high standard. Each record we looked at contained a clear pathway of care which described what women should expect at each stage of their labour. When not in use, records were kept safe in line with the data protection policy.
- Risk assessments were completed at booking and repeated at every antenatal visit.
- Women carried their own records throughout their pregnancy and postnatal period of care. The child health 'red book' – showing records of routine tests and vaccinations – was given to women prior to the new-born examination and was completed correctly.
- The maternity service used approved documentation for the process of ensuring that all appropriate maternal screening tests were offered, undertaken and reported on during the antenatal period.

- Standard operating procedures and care pathways were included in care records for women with diabetes, epilepsy, hypertension or a high BMI in pregnancy.
- Monthly audits of six sets of records were carried out across the service. Results for 2014/15 showed that the service achieved 100% in most of the 49 areas audited across each stage of pregnancy.

Safeguarding

- There were effective processes for safeguarding mothers and babies. The service had a dedicated, full-time midwife responsible for safeguarding vulnerable adults who liaised with multi-agency safeguarding teams across the catchment areas.
- Risk assessments and clear care pathways were in place to identify women and children at risk. Electronic reminders alerted staff to check for any previous history such as parenting capacity, health needs and family and environment. The service had developed a joint antenatal pathway with health visitors where any vulnerability or safeguarding concern was highlighted at an early stage. An in-depth, joint midwife/health visitor appointment was arranged where needed.
- Staff demonstrated they had a good understanding of the need to ensure that vulnerable people were safeguarded. Staff understood their responsibilities in identifying and reporting any concerns. The safeguarding lead told us that all midwives received annual safeguarding training and community midwives also attended a 1.5-hour refresher course every 12 weeks. Records for the women's services showed that 100% of staff had completed level 1 children's safeguarding training. All midwives we spoke with told us they had also completed levels 2 and 3 safeguarding training.
- Appropriate security measures were used. Security was discussed with women antenatally, during their stay in hospital and recorded in the medical notes. A child abduction critical response plan set out actions to be taken by staff if needed.
- Private rooms were available on the pregnancy advisory unit to counsel young women. Staff were trained to ask girls aged 13 to16 about their sexual activity and refer to appropriate agencies were required. Girls under 13 years of age who saw the advisory unit were automatically referred to the safeguarding team.
- Staff were aware of the possibility of female genital mutilation and were working within the Department of Health multi-agency guidelines and the best practice to follow in all cases.

Mandatory training

- Midwifery and medical staff attended a three-day obstetric mandatory programme which included emergency drills, adult and neonatal resuscitation, infant feeding, record-keeping and risk management awareness. Emergency drill training was also facilitated on an annual, one-day obstetric mandatory training day for maternity support workers. In addition, structured bi-monthly emergency drill programmes were facilitated on both sites.
- All attendance at training provided by the maternity service (including CTG training) was monitored by the clinical training and education midwife who maintained a database of attendance. Any staff member who failed to attend three months after the due date, despite reminder letters, was referred to their line manager or educational supervisor.
- A quarterly training report was produced by the clinical training and education midwife and presented to the risk management group for monitoring of compliance. Data showed 100% compliance for CTG training and between 96% and 98% (April to September 2014) for obstetric emergency training which was better than the trust's target of 80%.

Assessing and responding to patient risk

- Midwifery staff used an early warning assessment tool known as the Maternal Early Warning System (MEWS) to assess the health and wellbeing of women who were identified as being at risk. This assessment tool enabled staff to identify and respond with additional medical support if required. The records we reviewed contained completed MEWS tools for women who had been identified as at risk. An audit for October 2014 showed that 100% of MEWS charts had been completed correctly.
- There were arrangements to ensure that checks were made prior to, during and after surgical procedures in accordance with best practice principles. This included completion in obstetric theatres of the Patient Safety First's Five Steps to Safer Surgery – an adaptation of the World Health Organization (WHO) surgical safety checklist. We observed the theatre team for a caesarean

section list undertaking the five steps. All stages – from the sign-in before induction of anaesthesia to the sign-out when patients left theatre – were completed correctly.

- An obstetric audit of the WHO checklist for the period 1 October to 30 November 2014 (sample size 67 records) showed 84% 'sign-in' documented, 92% 'time out' and 78% 'sign-out'. A presentation of the lessons learned and actions for improvement was scheduled for 20 January 2015. For the period 1 April to 31 October 2014, data for gynaecology theatre lists showed that 100% of the WHO checklist had been completed.
- There were clear processes in the event of maternal transfer by ambulance, transfer from homebirth to hospital and transfers postnatally to another unit.
- High dependency care for women was provided in a dedicated HDU on the labour ward. Eleven midwives had received specialised critical care training which included an academic module at Teesside University and a period of six to eight weeks working in a variety of intensive care settings (critical care, renal unit and theatres) to provide staff with further specialist experience.
- There was one trained HDU midwife available on each shift. At-risk women could be cared for on the unit and only required transfer to intensive care for ventilator support. This ensured there was limited separation of mother and baby.
- A database was maintained of all women admitted to the HDU and each woman received a follow-up telephone call six weeks after discharge. The critical care midwives met every six weeks to discuss high dependency care and each meeting involved a case presentation.
- The unit used the 'fresh eyes' approach – a system which required two members of staff to review foetal heart tracings. Staff had also developed a 'fresh ears' approach for two-hourly foetal auscultation (second listener to listen to fetal heart to ensure correct recording and early detection of concerns), which indicated a proactive approach in the management of obstetric risks.

Midwifery staffing

- The service met the national benchmark for midwifery staffing set out in the Royal College of Obstetricians and Gynaecologists guidance (Safer Childbirth: Minimum Standards for the Organisation and Delivery of Care in Labour) with a ratio of 1:27 against the recommended 1:28.
- The service used an acuity tool to assess workload. Staffing levels and skills mix were reviewed each month by the head of midwifery and managers. There was a safe staffing and escalation protocol to follow should staffing levels per shift fall below the agreed roster. The service was innovative in managing workloads and could utilise staff flexibly – for example, using non-clinical midwives where required. The head of midwifery told us of their intentions to benchmark staffing establishments against the new National Institute for Health and Care Excellence (NICE) guidelines Safe Midwife Staffing in Maternity Services due to be published in February 2015.
- Women told us they had received continuity of care and one-to-one support from a midwife during labour. The trust reported that the percentage of women given one-to-one support from a midwife was good.
- The service had piloted a formal patient handover tool (SBAR); however, personnel found this had not worked effectively in the unit. Briefing boards were used and verbal handovers occurred between midwives at patients' bedsides. The risk management midwife reviewed handover procedures such as the use of intentional rounding (also known as comfort rounds or round-the-clock care) as an alternative.

Medical staffing

- A consultant obstetrician was present on the labour ward/maternity floor every day between 8am and 10pm (without any other clinical commitments) providing 98-hour cover for the labour ward each week. Outside of these hours, a consultant obstetrician was available on an on-call basis from home and could be present on the labour ward within 30 minutes. There was also an on-call facility for those doctors to be resident if required. This was in line with the Royal College of Obstetricians and Gynaecologists recommended standards for a service delivering 5,000 to 6,000 births per year.
- Trust data showed the percentage of consultant attendance at complicated deliveries between January and September 2014 ranged between 93% and 97% which was better than the trust's target of 90%.

Maternity and gynaecology

- The consultant obstetricians provided acute day time obstetric care on the labour ward and participated in out-of-hours' work when they were on call for the obstetric unit only. The gynaecology out-of-hours cover was provided by consultants who solely practiced in gynaecology.
- Multidisciplinary ward/board rounds were conducted at 8am, 1pm, 5pm and 10pm for all women and review of critical care women as their condition dictated.
- There were effective arrangements for cover and consultants were expected to arrange cover when they were on annual or study leave. In the event of short-term sickness, the lead consultant arranged the appropriate cover through the use of supporting professional activity sessions for day-time cover and by discussion for out-of-hours cover.
- Locum agency staff were rarely used. The service used existing staff or ex-trainees to cover any gaps in the rota.
- There was anaesthetic cover for the central delivery suite seven days a week, 24 hours a day.
- There were adequate numbers of junior doctors on the wards and any gaps in the rota were filled by internal medical cover.
- The General Medical Council National Training Scheme Survey 2013 showed that the workload for junior doctors was 'better than expected' for this trust.

Major incident awareness and training

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

Are maternity and gynaecology services effective?

Good

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

Staff had the correct skills, knowledge and experience to do their job. Medical and midwifery staff received training to deliver their roles effectively, had been supervised and supported to maintain their competencies and professional development.

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

Evidence-based care and treatment

- There was evidence to demonstrate that women using maternity services were receiving care in line with NICE quality standards 22 (which related to routine antenatal care), 32 (caesarean section) and guidance 37 (for postnatal care).
- Staff were consulted on guidelines and procedures which were regularly reviewed and amended to reflect changes in practice. Policies and procedures were available on the trust's intranet and were ratified by the obstetric risk management group. The policies we reviewed (postpartum haemorrhage, multiple births, pre-eclampsia and raised blood pressure) were all in-date and in line with best practice. The clinical audit lead told us that all guidelines were audited three months after being introduced and action plans were implemented and monitored where required.
- The service had a dedicated cross-specialty research team which included a research midwife. The team received additional training in good clinical research practice to ensure that research studies were run ethically, safely and effectively.

- The labour ward lead reviewed all instrumental and caesarean sections and produced an annual report. This was disseminated to all staff and formed part of the audit meeting. Individual complication rates were reported back to trainees and consultants.
- Staff we spoke with at all levels told us there was a robust audit cycle. There were ongoing audits for rates of third-degree tears, post-partum haemorrhage, infection control, transfers from the midwifery-led unit to consultant care, breastfeeding initiation and many more areas.
- Change action reports were completed which identified recommendations for improvement and included regular review of pathways and proformas and key individuals were identified to perform live audits within clinical areas and feedback compliance to individuals and team. Lessons learned were circulated to all managers and clinical directors to enable them to brief their teams. Lessons were also displayed on information boards and discussed at staff supervisions or appraisals.
- We saw from audit reports and presentations that a wide range of improvements and changes had been made to enable best practice. Examples included: launch of a health and wellbeing website, tools to support discussions about diet and exercise postnatally, changes to clinical practice and guidelines.

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Pain relief

- Detailed information was given to women to make them aware of the pain relief options available.
- There was access to various types of pain relief during birth, including drug-free methods and complementary therapies. For example, the service had a hypnobirthing midwife who provided a birth education programme, teaching women simple self-hypnosis, relaxation and breathing techniques for a better birth. There was also access to aromatherapy during pregnancy and birth.
- Clinical records showed that pain assessment charts were completed at least four-hourly or following any pain-related intervention.
- The service provided a 24-hour anaesthetic and epidural service. An audit of women requesting epidurals showed the time of request to insertion was within the median of 30 minutes, in line with obstetric anaesthetic guidelines.

Nutrition and hydration

- There was a specialist midwife for infant feeding with a lead role in supporting and improving infant feeding and nutrition across the service. The service also had 30 maternity care assistants and 20 voluntary peer supporters working at the hospital and in the community who advised and supported breastfeeding women.
- Breastfeeding initiation rates for deliveries that took place in the hospital for April 2013 to September 2014 were reported as 60%. The service had introduced five days of contact postnatally to encourage and support women to continue breastfeeding. This had reduced readmission rates of babies with weight loss and had improved the percentage of women continuing to breastfeed.
- The service was participating in the biological nurturing, laid-back breastfeeding philosophy which adopted approaches to enable a baby's natural response to breastfeed in a number of positions or behavioural states.
- The trust had achieved level 3 United Nations Children's Fund (UNICEF) Baby Friendly Initiative.
- Women told us they had a choice of meals and these took account of their individual preferences, including religious and cultural requirements. Women we spoke with said the quality of food was good.
- As part of the enhanced recovery programme, women were offered food following caesarean section.

Patient outcomes

- There were no risks identified in maternal readmissions, emergency caesarean section rates, elective caesarean sections, neonatal readmissions or puerperal sepsis and other puerperal infections (Source: HES 2013/14; Intelligence Monitoring Report July 2014).
- Emergency caesarean section rates were 12.3% which was better than the national average of 15%. For elective sections, the service achieved 11.2% which was slightly higher than the national average of 10.8%
- The service achieved a normal vaginal delivery rate of 62.2% which was better than the national average of 60.4%.
- Trust data showed that the antepartum stillbirth rate over 24 weeks was better than the trust's target.
- There were four women admitted to the intensive care/ HDU between April and September 2014.
- The number of women readmitted with wound infections was no worse than the trust's target.

- There were 51 unplanned admissions to the neonatal intensive care unit (April to September 2014).
- The trust was better than the national average of 5% for third and fourth degree tears. A case review was performed for any fourth degree tears and a case file compiled. Following an audit of non-attendance at follow-up clinics for women who had sustained either a third or fourth degree tear at delivery, a telephone follow-up was routinely given to ensure that women were not suffering from any morbidity associated with repair of third/fourth degree perineal trauma.
- A midwifery-led vaginal birth after caesarean section (VBAC) clinic was held. Trust data for January to August 2014 showed a 49.5% success rate of VBAC and 51.4% attempted VABC. (Median average of 40% Promoting Normal Birth, 2010, Department of Health). Further work was being planned to ask women what factors influenced their decisions and what, if anything, staff could change to increase the take-up of VBAC.

Competent staff

- We found that staff had the correct skills, knowledge and experience to do their jobs.
- The maternity service training strategy ensured timely provision and monitoring of specialist training for all staff in line with national guidance. (Centre for Maternal and Child Enquiries (2011). Saving Mothers Lives. Reviewing maternal deaths to make Motherhood Safer. 2006-2008 and NICE).
- All midwives had a named supervisor of midwives. The team of supervisors were experienced midwives from a variety of clinical and managerial backgrounds. They were clearly committed, innovative and hard-working.
- Supervisors were available seven days a week and were on call out of hours. Supervisors were clearly visible and had caseloads of 1:15 which was in line with the local supervising authority recommendations. Midwives said they had received a supervisory review and knew how to contact their supervisor if required.
- As part of the supervisory review, all midwives provided a written piece of reflective practice which included areas for personal development to discuss with their supervisor.
- All third-year student midwives met with their named supervisor to discuss the supervisory annual review, which was good practice.
- A comprehensive 18-to-14-month preceptorship practical experience and training programme was undertaken by newly registered midwives. Following successful completion of goals and competencies, midwives gained automatic progression to a high banding.
- Junior doctors attended protected weekly teaching sessions and participated in clinical audits. They told us they had good ward-based teaching and were well-supported by the ward team and could approach their seniors if they had concerns.
- The results of the General Medical Council National Training Scheme Survey 2013 showed educational and clinical supervision, induction and adequate experience for junior doctors was within expectations for this trust.
- At the time of our inspection, a group of staff were attending the launch of Mothers and Babies: Reducing Risk through Audits and Confidential Enquiries in the UK (MBRRACE-UK). Midwives told us an action plan was already implemented to give an update to all staff on the findings at the next mandatory training day in January 2015.
- There was a designated lead for antenatal screening. Screening tests followed the guidance of the UK National Screening Committee. The service submitted quarterly key performance indicators (KPI) to the national screening programme. Data showed improved compliance with KPI standards. For example, rates for repeat newborn blood spot tests had reduced from 5% to 2%.

Multidisciplinary working

- There was good multidisciplinary working. All necessary staff, including those in different teams and services, were involved in assessing, planning and delivery of women's care and treatment. The service participated in regional and local multidisciplinary team networks in areas such as foetal medicine.
- There was access to medical care for women who had other conditions – for example, clinics were held for diabetes, cardiology and mental health.
- Women had access to interventional radiology for cases of postpartum haemorrhages. The service was available 24 hours and coordinated with the radiology team.
- Midwives at the hospital and in the community worked closely with GPs and social care services while dealing with safeguarding concerns or child protection risks.
- The service was developing a formal transitional care facility on the postnatal ward for babies requiring extra care and support immediately following birth. At

present midwives were trained to administer intravenous antibiotics to babies from 35 weeks and 1.8kg upwards. Staff told us that advanced neonatal nurse practitioners and neonatal doctors worked closely with midwives and visited the ward each day. Support and advice was provided by the consultant neonatologist when requested.

Seven-day services

- There was an obstetric theatre team that was staffed and available at all times. A team was also on call out of hours. One consultant anaesthetist was present on the labour ward for 10 sessions per week (Monday to Friday 8am to 6pm). In addition, a duty anaesthetist was available for maternity services 24 hours per day. The anaesthetist was supported by an appropriately trained anaesthetic assistant, also present on the labour ward 24 hours a day.
- There was medical staff presence on the labour ward 24 hours a day.
- The maternity assessment unit was open 24 hours, seven days a week and triaged all emergency admissions as well as assessment and management of early pregnancy problems.
- Access was available to pharmacy and diagnostic services. The service acknowledged its risk of non-compliance with NICE guidance to provide a seven-day early pregnancy ultrasound service. Action had been taken with the appointment of additional sonographers who were in the process of completing a year's training.
- There was a designated physiotherapist for women's health who was present on the unit and provided advice and exercise programmes for women with pelvic pain during pregnancy.

Access to information

- Failsafe systems were in place to ensure that appropriate tests were taken when women booked late. For example, reminders were sent at 28 weeks to women who declined HIV testing. There was a process for the review of results and the reporting of these to women and other relevant healthcare professionals.
- During patient transfers there were processes to ensure that all appropriate documentation and case notes travelled with the woman, including the results of any investigations.

Consent, Mental Capacity Act and deprivation of liberty safeguards

- Women confirmed they had been given sufficient information to help in making decisions and choices about their care and the delivery of their babies.
- Consent forms for women who had undergone caesarean sections detailed the risk and benefits of the procedure and were completed in line with Department of Health consent to treatment guidelines. This was followed up with written information.
- There was a system to ensure consent for the termination of pregnancy was carried out within the legal requirements of the Abortion Act 1967. We looked at the completion of seven certificates and found that these were correct, with two practitioners certifying their opinion in line with legislation. Consent forms included the risks and benefits of the procedure and were signed by the woman. Regular audits of 10 sets of records were undertaken which showed the service was working within legal requirements.
- Staff had a good understanding of mental capacity and described the process to care for women with special needs, the community midwife made arrangements via the needs coordinator and care plans were arranged accordingly.

Are maternity and gynaecology services caring?

Good

Staff provided compassionate care and emotional support to women and their partners. Women felt involved in their care; they understood choices open to them and were given options of where to have their babies. Women were treated with dignity and respect.

Compassionate care

- Results from the CQC Maternity Service Survey 2013, showed that the service scored better than other hospitals in six of the 11 questions relating to antenatal care, labour, birth and postnatal care, with the other areas scoring about the same as other hospitals.
- Women spoke positively about their treatment by clinical staff and the standard of care they had received. Women told us they had a named midwife. They felt

well-supported and cared for by staff, and their care was delivered in a professional way. Comments included, "brilliant birth experience", '"staff sensitive, happy with every stage of the procedure", and, "had every confidence in the staff".

- Results of the NHS Friends and Family Test showed that most respondents were 'extremely likely' or 'likely' to recommend the service to friends and family. The antenatal response rates for the trust were below the England average for antenatal, postnatal and birth scores. The matron was proactively promoting patient experience projects, including the NHS Friends and Family Test, which included a feedback card and envelope system to improve the response rate.
- We observed staff interacting with women and their relatives in a polite, friendly and respectful manner. There were arrangements to ensure privacy and dignity in all clinical areas.
- Maternity services scored about the same as the England average for the time taken for staff to respond to call bells.
- Company representatives visited the postnatal area daily. They liaised with ward staff to check if it was appropriate for women to be visited.

Understanding and involvement of patients and those close to them

- Women were involved in their choice of birth, at booking and throughout the antenatal period. Women we spoke with said they had felt involved in their care; they understood the choices open to them and were given options of where to have their baby.
- Women were encouraged to visit the maternity unit in person or use the website for a virtual tour to familiarise themselves with the facilities and to help them decide where they wanted to give birth.
- We noted that the rate of home births was low (1%). Records showed that staff discussed birth options at booking and during the antenatal period. Supervisors of midwives were also involved in agreeing plans of care for women making choices outside of trust guidance, focusing on supporting women's choices of birth while ensuring they were making fully informed decisions.
- There were a range of information leaflets in clinical areas, including about tests and screening, breastfeeding and where to find other sources of support. The leaflets were available in different languages if required.

Emotional support

- Bereavement policies and procedures were in place to support parents in cases of stillbirth or neonatal death; this was facilitated by a senior midwife with a special interest in the care of the bereaved and a bereavement support worker who worked closely with the chaplaincy service.
- There were effective and confidential processes for women attending the pregnancy advisory service. Standard operating procedures were in place for the sensitive disposal of foetal/placental tissue.
- Women using the maternity services could access clinical nurse specialists for the following aspects of care: antenatal screening; diabetes; substance misuse; and infant feeding.
- There were effective processes to support women with mental health concerns. A comprehensive, evidence-based maternal mental health referral algorithm was used for antenatal and postnatal care. (NICE CG45, Department of Health maternal mental health pathway 3). The assessments were carried out at booking and, following birth, before hospital discharge. Referrals could be made to the consultant or CPN in perinatal psychiatry.

Are maternity and gynaecology services responsive?

Good

The service was aware of its risks and the need to ensure that services were planned and delivered to meet increasing demands. There were a few occasions where capacity in clinics meant women experienced longer waiting times, however, the service was responding to this and had introduced a number of measures to improve patient flow.

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

Maternity and gynaecology

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

Service planning and delivery to meet the needs of local people

- The service was aware of its risks and the need to ensure that services were planned and delivered to meet the increasing demands of the local and wider community. For example, women from the local population could elect for delivery at home, in the obstetric-led unit at James Cook University Hospital or in the midwifery-led unit at James Cook University Hospital or Friarage Hospital.
- The services worked closely with local commissioners of services, the local authority, other providers, GPs and patients to coordinate and integrate pathways of care that met the needs of the local population. We observed a collaborative approach to planning and delivering care and treatment with examples of well-developed sub-specialty clinics in maternal and foetal medicine, nurse-led colposcopy and hysteroscopy clinics and gynaecological oncology.
- Services were planned and delivered to enable women to have the flexibility, choice and continuity of care wherever possible. A postnatal debrief service was available for all women following instrumental birth, third/fourth degree perineal trauma and emergency caesarean sections prior to discharge. Any woman anxious post delivery could request an appointment.
- The service worked closely with the maternity services liaison committee (local equivalent family and birth forum) to design services that meet the needs of women and their families. For example, the forum was actively involved in the design of the induction of labour suite.

Access and flow

- Bed occupancy for maternity services for the first quarter of 2014/15 was 40.5%. This was lower than the England national average of 58.6%.
- Between March 2013 and August 2014, the trust temporarily closed its maternity unit at the James Cook site on seven occasions. We discussed this with the head of midwifery who told us that this was due to increased peaks of activity during certain times of the day.
- Women received an assessment of their needs at their first appointment with the midwife. The midwifery package included all antenatal appointments with midwives, ultrasound scans and all routine blood tests as required. The midwives were available on call 24 hours a day for advice. Community midwives were integrated within the service.
- The maternity assessment unit was open 24 hours a day, seven days a week and incorporated day assessment and triage. Women were referred by their GP, through A&E or self-referral. Staff told us that, occasionally, there were problems transferring women from the maternity assessment unit to the central delivery unit, particularly during times of high activity. We saw a comprehensive escalation plan was used at times of increased capacity and action was taken to prioritise care and treatment for women with the most urgent need.
- Admission processes for women requesting medical terminations were flexible and included direct referrals from GPs or the community sexual health service. All women choosing to proceed with a termination of pregnancy were offered an appointment for the procedure within five working days after decision to proceed.
- There were a few occasions where capacity in clinics interrupted the provision of services in antenatal care, which meant that women experienced longer waiting times. One woman told us she had waited for two hours for a scan; another woman said she had been waiting 45 minutes. We observed staff regularly giving women information and apologising about the delays. We discussed clinic waiting times with the antenatal manager and head of midwifery who told us the delays were mainly due to a lack of sonographers. The service had invested in training for first trimester scanning and two midwives were currently completing the programme – this would help to improve patient flow. The service was working hard to improve waiting times, including process mapping, enhancing the patient experience, review of staffing skills mix and changes to consultant job plans.
- Women had access to a seven-bed midwifery-led unit. The unit could accommodate uncomplicated ventouse assisted births. This showed a proactive approach which reduced the incidence of women being transferred to the consultant-led delivery suite at a vulnerable point in their labour. About 35% of all women attending James

Cook gave birth in the unit. There was sufficient flexibility to transfer women from midwifery-led care for low-risk births to consultant-led care for high-risk pregnancies if required.

- An anaesthetic clinic was introduced to reduce risk in line with the Centre for Maternal and Child Enquiries. The clinic ran fortnightly for all women with BMI greater than 40 or any other issue that could cause an anaesthetic problem which required review.
- Communication was sent to the GP, community midwife and health visitor electronically on discharge from the department. The electronic record detailed the reason for admission and any investigation results and treatment undertaken. The discharge summary was checked first with the woman, who signed-off to say they were happy with the content.
- The service did not collect data relating to the percentage of women seen by a midwife within 30 minutes and a consultant within 60 minutes during labour. However, staff told us that all women were seen immediately on transfer to the central delivery suite.
- The percentage of pregnant women accessing antenatal care who were seen in under 12 weeks was 73.47%, compared with 4.83% seen after 20 weeks.

Meeting people's individual needs

- Antenatal women who had concerns about their impending labour and delivery could be referred to the Talking about Birth midwifery-led clinic. The aims of the clinic were to: reduce reduce patient anxiety levels and also to reduce elective caesarean rates (where not clinically indicated); discuss any issues outstanding from a previous birth which were impacting on the current pregnancy; and discuss and formulate birth plans when women were expressing a choice which fell outside the criteria for their individual risk (NSF, Standard 11, 2004).
- Following an audit of non-attendance at follow-up clinics for women who had sustained either a third/ fourth degree tear at delivery, a telephone follow-up was routinely given through the Talking About Birth clinic to ensure that women were not suffering from any morbidity associated with repair of third /fourth degree perineal trauma.
- Women were referred to services which the midwife and woman felt were appropriate; these included: talking therapies; aromatherapy; natal-hypnotherapy; consultant clinic; counselling via the GP; reflexology; and parent craft.
- A midwife for newborn hearing screener was available on the postnatal ward. Midwives were trained in carry out newborn physical examinations and paediatric staff routinely attended to review babies prior to discharge. The ward ensured that there were always two midwives trained in these examinations on duty at weekends to avoid any delays in discharge. The trust was achieving the national standard of newborn physical examinations within 72 hours. Woman received an extended clinic follow up appointment up to 28 days post discharge.
- Postnatal women had the opportunity to discuss any outstanding issues with their community midwife on the first postnatal community visit. The woman was also given a contact number to call if they had any outstanding issues which could not be resolved by the community midwife. The clinical matron was dealing with these enquiries via the telephone or, if required, at a meeting. As a result of this process, three women and their partners attended for a debrief meeting with the clinical matron and a consultant obstetrician. All women gave positive feedback and reported reduced anxiety. One of the patient experience stories was recorded and shared with teams for learning, which staff reported as being a very powerful and effective medium.
- All women with a BMI equal to or greater than 30 were placed on a care pathway. The service worked in partnership with local authority commissioners to provide services for women with a BMI of 30 to 39.9 in community weight management programmes. Specialist midwifery-led services, such as a healthy lifestyle clinic, were in place for the care of women with a BMI greater than 40.
- Women who were in early labour had access to a latent phase room which provided a homely atmosphere and was situated away from the labour ward. Evidence-based guidance showed that women who were reviewed in a designated area away from the delivery suite experienced shorter labour and less medical interventions (Evidence Based Guidelines for Midwifery-Led Care in Labour Latent Phase, Royal College of Midwives, 2010).

- Staff could access interpreter services and were piloting the use of a system which enabled two-way telephone conversations to be translated into the required language.
- A 'baby buddy' mobile phone app was being piloted by the community midwives to inform women of pregnancy, common ailments and reasons to seek advice.
- Women using the pregnancy advisory service were provided with sexual health and family planning information prior to discharge. The service was finalising processes for nurses to provide Depo-Provera contraceptives to patients on discharge with a 12-week follow-up review with the sexual health service.
- Following a review of readmissions of infection rates for women with a high BMI, the service introduced caesarean section care pathways for women with a BMI over 40. Women received an extended clinic follow-up appointment up to 28 days post discharge and the service had introduced different wound dressings. This had led to a reduction in infection rates.
- There was a dedicated bereavement room situated on the central delivery suite. The head of midwifery told us that plans were being developed as part of the refurbishment of the unit to move the room to a more private area.

Learning from complaints and concerns

- Complaints and concerns were included on a performance dashboard and regularly monitored at governance meetings.
- When complaints were received, staff offered to meet the complainant, and any meeting was followed up in writing, detailing the outcome. We reviewed the management of a complex complaint which confirmed that a debrief meeting was held with the parents to share the findings of the investigation report and lessons learned and to answer their questions. The family had requested for their case to be used to help prevent a similar incident. In its response, the service had introduced a rule called 'low threshold for scan' which reflected this and was included in the revised 2015 breach guidelines.
- The service produced an annual complaints report which went to the Trust Board. The report for 2013/14 showed that the main themes for complaints in obstetrics related to communication, staff attitude and labour debrief. A number of actions had been taken to address these areas, including discussions with all postnatal women regarding issues of concern, the introduction of weekly patient experience rounds and changes to practice guidelines.

Are maternity and gynaecology services well-led?

Outstanding ☆

Leadership in maternity and gynaecology services was outstanding. The service was managed by a strong, cohesive leadership team who understood the challenges of providing good quality care and had identified effective strategies and actions needed to address these. This was particularly evident with the reconfiguration of services which were well-developed and understood throughout the department.

Staff were encouraged, able to input ideas and were empowered to develop and implement solutions to provide a high-quality service.

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

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

Vision and strategy for this service

- The service could demonstrate a clear short-term and long-term strategy for maternity and gynaecology services. The strategy included a programme to ensure that services and patient activities were physically organised in a way to optimise operational efficiency

and a better patient experience. A reconfiguration of maternity services was completed in October 2014 providing a midwifery-led unit at the Friarage Hospital with consultant-led care being transferred to James Cook University Hospital.

- Frontline staff felt they had been fully consulted about the changes caused by the maternity services reconfiguration and saw this as a positive opportunity to shape future service provision and improve patient care. The leadership team told us that staff had been "brilliant in adapting to new roles and ward areas".

Governance, risk management and quality measurement

- There was a well-defined governance and risk management structure. The maternity risk management strategy set out clear guidance for the reporting and monitoring of risk. It detailed the roles and responsibilities of staff at all levels to ensure that poor-quality care was reported and improved.
- Comprehensive quarterly and annual risk management reports were produced. The service used a tracking and trending system which detailed the key themes and trends from incidents, complaints and claims.
- The service demonstrated a dedicated focus on understanding and addressing the risks to patient care. Two dedicated, part time (48 hours per week) risk management midwives and a clinical governance lead held regular clinical incident panel meetings and reviewed all adverse outcome incidents. The midwives worked proactively with wards, audit leads and supervisors of midwives and fed into the governance processes to recognise and raise concerns and ensure safe practice.
- Staff at all levels were required to attend at least one risk and audit meeting per year and senior midwives (band 7) had to attend at least two meetings per year. Attendance was monitored and reviewed as part of the staff appraisal process.
- Performance and outcome data was reported and monitored through the service performance dashboard. Any outliers (services lying outside the expected range of performance) were reviewed and timely action taken. For example. South Tees had been identified by the local supervising authority to be above the national average for stillbirths, with 5.3 in 1,000 births (the national average was 4.8). A robust action plan was developed to reduce all avoidable stillbirths, to three per 1,000 births, a reduction of about a third. Changes made included implementation of customised growth charts, information about reduced foetal movement provided to women at 20 weeks (including information about going to sleep on the left side) and competency assessments for all midwives and medical staff on fundal (uterus) height measurements. Trust data showed that antepartum stillbirth rates over a 24-week period had improved and were better than the trust's target.
- Local risk registers assisted the corporate governance group to identify and understand the risks. There were seven risks identified for maternity and gynaecology: none were classified as 'very high'; six were identified as 'moderate risk'; and one was classified as a 'low risk'. We reviewed information which indicated the description of the risk and subsequent action taken, plus the outcome where known. For example, midwives were being trained to be able to carry out ultrasound scans to enable the service to comply with NICE guidance. We found there was clear alignment of what staff had on their 'worry list' with what was on the risk register.
- The Trust Board had a responsibility to review performance against the quality indicators on a monthly basis. Monitoring was carried out through the quality performance dashboard and the board received progress updates against any improvement projects. Regular meetings and ongoing communication was evident between the head of midwifery and chief nurse.
- Governance documents clearly identified the roles of the supervisor of midwives and the local supervising authority. Supervisors of midwives told us they attended in this capacity and not in a dual role. This was in line with recommendations by the Nursing and Midwifery Council.
- Most staff we spoke with had an awareness of the new Duty of Candour regulations that came into effect on 27 November 2014and said information had been communicated in the staff bulletin. Policies on being open were already in use and an open culture was observed for reporting and responding to incidents and complaints. The service was in the process of carrying out a gap analysis and action plan to deliver the Duty of Candour requirements.

- Completion of HSA1 (grounds for carrying out an abortion) and HSA4 (abortion notification) forms were completed by two doctors who followed guidance and submitted the forms to the Department of Health as required.

Leadership of service

- The directorate of maternity and gynaecology formed part of the women and children's centre. There was a clear managerial structure which included strong clinical engagement. We found the consultant body to be cohesive and proactive in decision-making, with innovative approaches to areas such as sub-specialisms and job planning. The senior management team told us they took 'intelligent risks' by evaluating and monitoring changes and how these impacted on service provision.
- Leadership was encouraged at all levels within maternity services. All ward managers were supported to complete the NHS leadership programme.
- We saw examples where staff had input ideas to develop and implement solutions to provide a high-quality service – for example, the development of the 'fresh ears' approach and the Talking About Birth clinic.
- We observed a strong, cohesive leadership team who understood the challenges for providing good quality care and identified strategies and actions to address these. This was evident in the management of the reconfiguration of services. Action plans showed close collaborative working with commissioners and rigorous assessments of the impact of any changes, including overall risk, travel, ambulance services, and impact on neighbouring trusts, the local economy and equality.
- The head of midwifery and matron were seen in clinical areas and had a good awareness of activity within the service during the inspection. Staff were clear about who their manager was and who members of the senior team were.

Culture within the service

- An open, transparent culture was evident where the emphasis was on the quality of care delivered to women. The service encouraged a 'no blame' culture where staff were able to report when errors or omissions of care had occurred and use these to learn and improve practice. For example, patient stories and postnatal debriefs were actively used for learning during study days. This included the introduction of a new rule, 'Low Threshold for Scan,' which reflected the learning from a complex complaint and was included in the trust's revised 2015 breach guidelines.
- We observed strong team working, with medical staff and midwives working cooperatively and with respect for each other's roles. All staff spoke positively and were proud of the quality of care they delivered. A number of junior doctors commented that it was a "fantastic unit" to work in.
- Staff told us about the 'open door' policy at department and board level. This meant they could raise a concern or make comments directly with senior management which demonstrated an open culture within the organisation.
- Staff experience walkabouts were being piloted in maternity services. These were used to identify and deal with any issues at an early stage and generate conversations in clinical areas with managers and staff. Managers examined staff experience within a clinical area they did not manage. Themes and actions were collated and presented with the quarterly patient experience summary.
- We spoke with the college tutor about the processes to deal with staff bullying. They told us the post-graduate department sent emails with an anonymous link for staff to report any concerns, and there was also information about raising concerns in the trust's and the maternity services' induction programmes. Consultant medical staff held meetings to discuss trainee concerns and addressed these with the educational supervisor.
- We saw examples of letters sent to staff involved in difficult and complex clinical interventions in recognition of their prompt and swift actions.

Public and staff engagement

- There was evidence that the trust had engaged extensively with patients, public and staff over the reconfiguration of local services. Information was widely shared about the changes to maternity care, including a mail drop to all homes and businesses in the Hambleton and Richmondshire area and the wider area covered by the Friarage Hospital.
- The service actively promoted patient experience projects, including weekly patient experience walkabouts and the 15 Steps Challenge – a series of toolkits used as part of the productive care work stream. The toolkits helped to look at care in a variety of settings

through the eyes of patients and service users, to help determine what good quality care looks, sounds and feels like. The 15 Steps Challenge was carried out in different maternity clinical areas bi - monthly.

- The service actively sought the views of women and their families. The Families and Birth Forum was a highly functional multidisciplinary group where comments and experiences from women were used to improve standards of maternity care. The forum had increased the number of lay representatives due to the proactive approach of the across site chair and promoting the forum in clinical areas, through the trust's website, posters and local events. The forum had been actively involved in the design of the induction of labour suite and were championing the take-up of breastfeeding rates through the use of peer supporters and improving information to raise awareness and promote the service to women when they had left the hospital.
- Minutes of the September 2014 forum meeting showed that priorities for 2015/16 included work around the latent phase room, education and information for women, additional telephone advice lines and the development of a clinical pathway based on the All Wales Clinical Pathway for Normal Labour. The clinical pathway for normal labour provided support for midwives who wished to practice evidence-based clinical care of the highest standard with minimal unnecessary intervention.
- Evidence showed that lay representatives were actively involved in the patient experience rounds and 15 Steps Challenge. A multidisciplinary team (GP, university representative, lay representative, and directorate staff) visited identified areas every two months. The area was not informed prior to the assessment, but the team did report back their findings immediately afterwards. This was documented and displayed on the 'Knowing how we are doing' board. Changes included improvements to décor such as curtains, pictures and bed covers.

Innovation, improvement and sustainability

- All staff spoke passionately about the services they offered and the creative ways they worked to ensure they met the needs of women using the services**.** They explained how their systems and processes were always developing in line with latest research and guidance. We saw a number of areas of exemplary and innovative practice. The management of obstetric risks demonstrated a proactive approach to providing high-quality care such as the 'fresh ears' approach for foetal auscultation. Staff told us that, following a period of audit and evaluation, this development was being submitted for publication in professional journals to promote best practice to other hospitals.
- We observed staff continuously striving to improve the quality of care for women. Areas for improvement were identified by both the leadership and staff within the service. For example, the promotion of the birth normality agenda was evident throughout the service with the development of a latent phase room, Talking About Birth clinic and comprehensive pathways of care for women with mental health concerns.
- There were effective processes to ensure efficiency and sustainability of services was achieved without impacting on the quality of patient care. The service had also consistently achieved its annual cost improvement targets.
- Multidisciplinary working parties of the most appropriate staff were set up to develop, discuss and test the resulting new ideas and guidance. Changes to services were implemented in a controlled way and audited appropriately. This was particularly evident during the reconfiguration of services across sites.
- Change action reports were completed to identify recommendations for improvements and included regular review of pathways and proformas. Key individuals were identified to perform live audits in clinical areas and to report back on compliance to individuals and teams. Lessons learned were circulated to all managers and clinical directors for them to brief teams, display results on information boards and discuss at staff supervisions or appraisals.
- In January 2014 the trust achieved level 3 (highest level) accreditation against national maternity clinical risk management standards. This showed a track record of delivery of care to a high standard and in line with evidence-based practice.

Services for children and young people

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

Information about the service

The directorate of paediatrics and neonatology was responsible for services for babies, children and young people at James Cook University Hospital. Services at the hospital included three children's wards: Ward 21, a 30-bed ward for paediatric medicine which included an 11-bed young people's unit; Ward 22, a 17-bed ward for paediatric trauma and surgery; and the paediatric day unit (PDU), a seven-bed assessment area which accepted children from the emergency department and general practice. The service included the children's outpatient department and the neonatal unit, which had 10 intensive/high dependency cots and 20 special care baby cots. The directorate was also responsible for the paediatric intensive care unit (PICU) which included four critical care beds and three high dependency beds. There was also a nine-bed/chair-based paediatric surgery day unit managed by the anaesthetic/theatre directorate. The directorate also provided community paediatric services.

Based on statistics provided by the trust, it served a population of 62,389 children in the NHS South Tees area and 30,468 children in the NHS Hambleton, Richmondshire and Whitby area. The service included paediatric critical care beds and neonatal intensive cots serving children from outside its usual catchment areas.

During the period April 2013 to October 2014 the hospital had 24,022 ordinary admissions and 4,216 day case admissions. In the same period, the trust reported 129,362 outpatient attendances and 2,495 ward attendees. To provide more meaningful context, within the last 12 months, Ward 21 admitted the following children: 2,642 (age 0-1 years), 347 (age 2 years) 1,832 (age 3-11 years), 1,524 (age 12+ years) giving a grand total of 6,345 admissions on the 30-bed paediatric medicine ward.

During our inspection, we visited all clinical areas where children were either admitted or attended on an outpatient basis, including the neonatal unit, wards 21, 22, the PDU, PICU, children's outpatient department and paediatric surgery day unit. We talked with eight medical staff and 20 nursing and allied healthcare professionals, and examined 14 medical/nursing records. We spoke with 18 parents and seven children/young people.

Services for children and young people

Summary of findings

We rated services for children and young people as good, although safety required improvement. The level of nursing staff did not meet nationally recognised guidelines within the children's clinical areas, although we did not identify evidence showing that this impacted negatively on patient care. The PICU staffing numbers were not always sufficient to meet the dependency needs of children. The children's services actively monitored safety, risk and cleanliness.

Children's services had made improvements to care and treatment where the need had been identified using assessment programmes, or in response to national guidelines. The medical staff had a proactive clinical audit programme.

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

We found that a recent service reconfiguration was being closely monitored and managed in partnership with commissioners and other healthcare providers. We found that access and flow was good in the children's inpatient areas, facilitated by regular medical handovers and reviews. However, patient flow on the PDU was impeded at times due to the environment.

The service had a clear vision and strategy based on the National Service Framework for Children. The service was led by a positive management team who worked well together. The service regularly introduced innovative improvements with the aim of constantly improving the delivery of care for children and families. We found several areas of outstanding, innovative practice in the care and involvement of young people.

Are services for children and young people safe?

Requires improvement

The level of nursing staff fell below nationally recognised guidelines on the children's wards and neonatal unit. The seven-bed PICU/HDU was only commissioned and staffed for the four critical care beds. Medical staffing had some gaps but these were being managed and addressed. Members of staff of all grades confirmed that they received a range of mandatory training, although training records did not always accurately reflect training take-up.

Staff demonstrated awareness of how to report incidents using the trust's reporting mechanisms and we saw that these were reviewed and acted on by the management team. Risks were regularly assessed and monitored, and control measures implemented. All children's clinical areas were kept clean and were regularly monitored for standards of cleanliness. Medicines were stored and administered correctly. Medical records were handled safely and protected.

Incidents

- Staff demonstrated an awareness of how to report incidents using the trust's reporting mechanisms. The management team and ward managers in all clinical areas felt that their staff were good at reporting incidents. Most staff told us that they were able to receive feedback about incidents they had reported.
- Minutes of meetings of the children's services directorate meetings and the children's services risk meeting held during 2014 showed that incidents were routinely discussed. The directorate also routinely collated quarterly risk management reports which showed the top 10 incidents during the period, followed by a summary of action taken where appropriate. For example, eight medication-related incidents had been reported in quarter two and the narrative explained how staff involved had completed a reflection exercise and adherence to the trust's '10 steps to safer medication' (a process setting out a clear process for staff to follow from prescription through to administration of medicines) had been reinforced.
- We reviewed incident data for the period April 2013 to March 2014. A total of 235 incidents had been reported,

with two classified as 'moderate to severe'. Quarterly submissions by staff during each period were reasonably consistent with an average of 61 – 67 incident reports submitted for three of the four quarters. This showed that staff were consistent at submitting incident reports.

- The neonatal unit monitored incidents separately from the acute children's services areas. The neonatal quarterly risk management reports for the period April 2013 to March 2014 showed that a total of 154 incidents had been reported, with one classified as 'moderate to severe'. Quarterly submissions by staff during each period were reasonably consistent with an average of 32 to 43 incident reports submitted.
- The ward managers for each clinical area in the directorate reviewed all their incidents submitted each month and completed a tracking and trending report. This review aimed to identify any trends or themes that emerged in the clinical area. For example, during quarter two (July to September 2014) of the 2014/15 data period, 41 incidents had been reported. The most common incidents reported during this time were medication related (eight) followed by information governance (six), although there were no particular themes identified within these areas.
- There was a nominated clinical lead for risks or incidents who was a consultant paediatrician. The paediatrician sent out a weekly email which we were told contained a "short and snappy" message regarding a lesson of the week which had been identified from incidents, risks or complaints. The aim of the email was to ensure that learning could be promptly shared with all members of staff.
- Children's and neonatal services incidents were also reported within the women and children's centre's quarterly patient safety governance report. These reports grouped incident numbers with other directorates in the centre but included a narrative summary of incidents reported in the paediatric and neonatal directorates.
- The matron and head of nursing for paediatrics gave examples of how learning had taken place following incident investigations utilising a root cause analysis approach. For example, one review during 2014 resulted in the improvement of patient access and flow for babies with a specific clinical presentation.

Cleanliness, infection control and hygiene

- We found the children's wards (wards 21and 22), the PDU, PICU, children's outpatient department and the neonatal unit were kept very clean and tidy. Various infection-prevention measures were in place, such as multiple wall-mounted hand gel dispensers and hand-wash sinks.
- During our inspection of all clinical areas, members of medical, nursing and other staff were regularly performing hand hygiene measures such as hand washing.
- Regular hand-hygiene audits and infection-control audits were undertaken in the clinical areas. For example, the environment audits for November 2014 showed an overall compliance rate of 84% for Ward 21 and 88% for Ward 22. Areas for improvement included issues such as cleaning dust more effectively and avoiding members of staff wearing jewellery that could compromise hygiene. Other audits we reviewed included the external infection prevention quality improvement tools for care settings. Overall compliance with this assessment tool included 85% for the neonatal unit (September 2014) and 98% for the PICU (April 2014).
- The matron explained that they completed a monthly walk-around with the external domestic provider along with additional ad-hoc walk-around checks. In addition, weekly compliance checks were completed by the ward managers. We were told that the children's directorate felt well-supported by the trust-wide infection prevention and control team.
- We saw that meeting minutes included regular feedback about infection control and prevention.
- Each area in the service had nominated members of nursing staff who acted as infection control link nurses. These nurses shared information at staff meetings and ensured that staff maintained correct infection control procedures.
- We were told that incidents reported relating to infection control were very low. The management team talked through, and we saw evidence of, how robust measures had been implemented and investigations had taken place following a recent Pseudomonas (a strain of bacteria) outbreak on the neonatal unit and the PICU.
- The ward performance dashboard for wards 21 and 22, and the PICU showed there had been no reported

incidents of Methicillin-Resistant Staphylococcus Aureus (MRSA) or hospital-acquired Clostridium difficile (C.difficile) during the report period of November 2013 to October 2014.

- The matron explained the 'bare below the elbows' initiative. This involved young people who were patients acting as inspectors to check that members of staff adhered to the 'bare below the elbows' guidance for hygiene best practice. This included the young inspectors issuing a 'certificate of achievement' to members of staff if they were compliant. We were told that this exercise was completed every six months. This was good practice because it actively involved young people with the engagement and maintenance of good practice among members of staff.

Environment and equipment

- We saw, and staff told us, that all clinical areas had a wide range of clinical and other equipment to assist them in providing care for children and young people. Records showed that the trust regularly tested and serviced equipment.
- All the children's clinical areas we visited had suitable resuscitation equipment available, which had been checked regularly by members of staff.
- We saw that the environment for children varied depending on the clinical area visited. Ward 22 and the neonatal unit were spacious, well-lit and reasonably uncluttered. The neonatal unit lacked storage space but this was, in part, due to the recent closure of the special care baby unit at Friarage Hospital. A range of equipment, such as incubators and infusion devices, had been brought over from the other hospital and this was being stored in an unused bay area until it was sorted out.
- Additional facilities had been developed to meet the individual needs of children, for example, there was a dedicated young people's unit within the clinical area of Ward 21.
- The outpatient department was a dedicated children's area but we saw that the waiting area appeared small for the volume of families attending clinic sessions.
- We found that Ward 22, a 30-bed medical children's ward which had overflow bed capacity, had tired décor and was cluttered in places. This area, along with some other areas such as the children's outpatient department, had unusual split doors which partially folded inward when opened in some door spaces such as toilets. This presented a wide open gap, posing a potential risk for toddlers and younger children who may trap their small hands or fingers. We were not told if this was currently managed as a potential risk by the management team. The senior nursing team did refer this to the estates department during the inspection.
- Ward 21 had some basic facilities for parents, such as a small kitchen and seated area for parents. Parents were able to sleep in camp beds next to their children and there were other parent facilities available, such as separate rooms. There was a lack of disabled facilities on Ward 21 which may carry risk regarding moving and handling. There was only one hoist available and we were told this was shared with other wards and clinical areas within children's services. The ward had no dedicated, adjustable assisted bath (there was one on Ward 22) and no rooms with a roof-mounted hoist. We were told by the management team and some staff that this made caring for children with complex physical needs difficult at times.
- The seven-bed PDU was located along one corridor adjacent to Ward 21. We were told that the PDU environment did not always fully meet the needs of children and families due to capacity issues, which carried some risk. The PDU waiting area for families was very small. This sometimes meant families were left in the corridor for periods of time waiting for a bed space to become available. The waiting overspill area in the corridor partially closed a door leading to a link corridor. The waiting area was not clearly observable by the PDU staff which meant a waiting child may become poorly without staff being immediately aware. During our inspection we observed parents waiting in the corridor on more than one occasion, making it difficult to access the link corridor to other parts of the children's area.
- The head of nursing and the matron explained that the children's directorate was aware of the issues surrounding the PDU. We were told that a feasibility study was in the process of being completed which, if approved, would improve the layout, access and flow within the PDU. It was hoped that a spacious, rarely used playroom could become a waiting area and there were two parent bedrooms which could become consultation rooms. The parents rooms would be re provided outside of the ward area.

Medicines

- We reviewed a sample of paper-based treatment records on the children's wards and neonatal unit and observed the administration of medications. We found that medicines had been appropriately stored, checked and administered in the clinical areas where children received inpatient care.
- The management team explained that children's services had a named pharmacist who attended the children's clinical areas most days. They said the directorate felt well-supported by their pharmacist who also attended the children's directorate meetings. Meeting minutes confirmed that the pharmacist attended these meetings and provided detailed feedback on a range of areas such as specific drugs and take-home medications.
- Pharmacists completed monthly audits of antibiotic use on each ward and shared the results with ward teams. Audits demonstrated good compliance with trust's policy for the use of antibiotics, a key factor in reducing the incidence of infections such as MRSA.
- Children's services risk meeting and directorate meeting minutes showed that medicines management incidents were monitored, investigated and discussed.
- The management team explained documents which showed how the numbers of medication incidents in 2009/10 led to the review of all medication incidents during that period. This resulted in a review of practice and the development of a systematic approach from policy known as the '10 steps to safer medication'. This process set out a clear process for staff to follow from prescription through to administration. Documentation showed that the new process led to a 46% reduction in medication incident reports for April 2010 to March 2011. Staff received ongoing information via DVD and workshop training and risk meeting minutes showed continued review of medications incidents and practice. This was good practice which demonstrated how medications management had improved following formalised changes to practice.

Records

- Records were managed and handled safely. For example, we did not identify any unattended medical notes during our inspection.
- The paediatric quarter two 2014/15 risk management report noted six incidents reported relating to information governance. These were predominantly related to requests from Caldicott Guardians (a senior person responsible for protecting patient confidentiality) for removal of information from the system.
- We reviewed 14 medical notes throughout the children's services. The respective paediatricians and surgeons had appropriately completed paper-based medical records.
- Nursing and medical staff completed joint multidisciplinary documentation on admission which recorded a range of jointly assessed information such as social history, medications, observations, allergies, nursing assessment and clinical notes. This meant the joint assessment entries were written at the same time, alongside each other, so that it was clear what treatment and care the child required.
- Nursing documentation was paper-based and included an assessment of the child's or young person's activities of daily living, which had been individualised where needed to reflect the child's and family's needs.
- Nurses maintained detailed evaluation records for each span of duty which were kept in a folder at the bottom of each bed space, along with various risk assessments and observation charts.
- The head of nursing and the matron explained that the current joint multidisciplinary documentation record had recently been reviewed and a newer version was at the printers. It was hoped that the new document would streamline the risk assessment process.

Safeguarding

- Managers and members of staff within children's services demonstrated a clear awareness of the referral processes they must follow if a safeguarding concern arose.
- Records showed that 100% of children's directorate staff had received level 1 safeguarding training. The head of nursing told us that clinical staff who worked with children should be trained to the level 3 safeguarding children standard. The full level 3 training was delivered once to each staff member followed by level 3 update training yearly, delivered via a rolling programme.
- Ward managers kept their own training records and they told us the trust's system did not accurately reflect training completed. For example, of 85 staff employed on the neonatal unit, the local record showed that most staff were up to date with safeguarding training.

- A document titled Paediatric directorate mandatory training requirements 2014 – 2015 showed an improving compliance with level 3 safeguarding training, from 51% in 2013 to 75% in 2014.
- The trust had the necessary statutory staff in post, including the named nurse and named doctor. The director of nursing was the nominated executive lead for safeguarding.
- The matron explained that the directorate was well-supported by the trust-wide safeguarding team. The hospital did not have a dedicated child protection facility, although there were processes for children needing a child protection review to be seen privately within the children's outpatient department.
- Documents showed that safeguarding adults training e-learning had only recently become a requirement for the paediatric directorate staff. Records demonstrated that staff were accessing this training now it had become a requirement. For example, compliance had increased from quarter one at 8% (12 staff) to 31% (45 staff) in quarter two.

Mandatory training

- Members of staff we talked with, including staff from wards 21, 22, the PDU, PICU, children's outpatients and the neonatal unit, confirmed they received mandatory training. This covered subjects such as fire, information governance, infection prevention and control, moving and handling, safeguarding, blood transfusion and resuscitation.
- On the neonatal unit, the ward manager explained that there was good mandatory training compliance in certain subject areas such as safeguarding children and neonatal life support. A locally held training record showed training take-up had been low for some subject areas such as manual handling and blood transfusions. Precise statistics for the neonatal unit were not available. It was explained by the head of nursing and the matron that staffing shortages on the neonatal unit earlier in the year may have affected training attendance in this clinical area.
- The management team provided the Paediatric directorate mandatory training requirements 2014 – 2015 which recorded training completed up to the end of September 2014 for children's areas other than neonatology. This record showed a mixed picture of the take-up of training, although the majority of training was delivered via an ongoing rolling programme. Good completion of mandatory training was noted in areas such as paediatric basic life support at 89% (33 out of 37 healthcare assistants and support staff), paediatric immediate life support 78% (104 out of 134 registered nurses) and information governance 87% (151 out of 174 staff).
- Compliance was low in some subject areas which were labelled as "once only" mandatory training. For example, Mental Capacity Act 2005 awareness training attendance was 16% (23 out of 144 staff) and conflict resolution update 24% (37 out of 150 staff).

Assessing and responding to patient risk

- We reviewed 14 care records which showed that individualised clinical risk assessments were completed on admission and reviewed regularly. These risk assessments included areas such as a children's pressure sore risk tool and a nutritional screening tool. A broader safety checklist was also completed and maintained, covering a range of individual safety checks.
- The children's clinical areas used an early warning assessment tool based on a standard type Paediatric Early Warning Score (PEWS) tool. The tool included a clinical observation chart, along with an assessment table to assist clinical staff in determining the action that should be taken. It was explained that the chart helped with determining whether a child required transfer to either the hospital's own PICU/HDU or a tertiary critical care centre for children, such as those at Newcastle or Leeds.

Nursing staffing

- The head of nursing and the matron explained that recruitment and retention were good in the children's clinical areas, so vacancy rates were low. Children's services directorate meeting minutes included a section titled "organisational capability" which discussed staffing matters.
- We found that staffing levels varied across the range of children's services provided at James Cook University Hospital. The inspection focused on the staffing of three clinical areas: Ward 21, the PICU and the neonatal unit. Staff we spoke with in these areas did not always feel there was enough staff available. On Ward 21 (which was very busy during our inspection) several parents also told us how busy the nurses were on the ward.

- We did not observe any evidence during our inspection to suggest that the level of nursing staff was not adequate to meet children's and families' needs on any of the clinical areas we visited.
- We reviewed staffing on Ward 21 which was a 30-bed medical ward that included an 11-bed young people's unit and had extra overflow beds available as needed and subject to staffing. The head of nursing, the matron and ward manager all explained that expected minimum staffing was currently five registered nurses plus one healthcare assistant on both day and night duty. Using the same number of registered nurses on both spans of duty reflects good staffing guidance for children's wards and should be considered positive practice.
- The ward manager explained that registered nurse staffing more often fell below the expected number to four nurses. They explained that, on these occasions, they were allowed to reduce the available number of beds from 30 to 24 beds.
- The current staffing establishment for each of the children's wards fell below the recommended minimum staffing level for children's wards set out by the Royal College of Nursing (RCN) staffing guidance. The ward manager explained that the staffing numbers roughly equated to one registered nurse to seven children. Ratios set out by the RCN recommend one registered nurse to four children (over two years of age).
- Basic staffing ratios do not take account of the dependency of each child and family. The head of nursing, the matron and ward manager explained that they had introduced a validated acuity tool from Scotland known as SCAMPS (Scottish Children's Acuity Measurement in Paediatric Settings). Wards 21 and 22 were completing the tool twice-daily at 7am and 7pm and auditing the dependency level.
- The SCAMPS tool had informed the children's management team of the dependency workload on Ward 21. We were told this ongoing work had yet to be used to accurately determine suitable staffing levels to meet the dependency needs of the child and family. Using an evidence-based acuity tool was an example of good practice.
- Staffing on the neonatal unit had historically fallen below nationally recognised standards set out by the British Association of Perinatal Medicine (BAPM). These standards set out minimum staffing for the three levels of dependency used to describe neonatal care – including level 3 (intensive care), which required registered nurses/midwives who had undertaken a specialist neonatal course. This was a recorded risk on the risk register.
- Statistics collated by the Northern neonatal network for quarter two (July to September 2014) showed that staffing (a comparison of staffing in relation to bed occupancy and level of care required) met BAPM standards on only 9.8% of days. This equated to the following days met/not met: in July 2014, BAPM standards were met on nine days, but not the remaining 22 days; in August 2014, BAPM standards were not met for the full 31 days; and similarly, in September 2014, BAPM standards were not met for the whole month.
- The neonatal unit had changed from October 2014 because an additional 10 cots had opened to accommodate the closure of the special care baby unit at Friarage Hospital. This had also led to an increase in staffing establishment, with a number of neonatal nursing staff who had moved to James Cook University Hospital. The ward manager on the neonatal unit explained that these additional staff, along with trust investment for an additional 5.5 neonatal qualified nurses, were already having a significant, positive impact on the staffing of the neonatal unit.
- Staffing on the PICU/HDU was complex and historical in nature. The four intensive care beds were funded via a subcontract arrangement from Newcastle and formed part of the regional paediatric critical care network. The three HDU beds had been developed and opened locally by the trust. The leadership team explained that the PICU nurse staffing was funded for four beds and not the seven beds available. At no time was the PICU expected to staff 7 beds.
- We reviewed the staffing level on the PICU between 17 November and 7 December against the dependency needs of the children and found that there may not always be a sufficient number of staff on duty. National guidance sets out staffing ratios of 0.5:1 nurse/patient ratio level 1 and 1:1 nurse/patient ratio level 2 and 1.5:1 nurse/patient ration level 3. For example, during the period 1–7 December, we identified a number of shifts where staffing fell below national guidance. On 2–4 December there were five level 2 patients (which would require a minimum of five registered nurses) but the

duty rota showed there were four registered nurses on duty with only three on one night duty. The weekend of 6–7 December had four level 2 patients with three registered nurses on duty for each span of duty.

- Duty rotas showed that the service regularly used staff from the ward areas to support the PICU. In addition, the unit's band 7 clinical educator (normally supernumerary) was regularly used to staff some of the shifts, including on 17, 24, and 26 November and 2 December.
- The nurse in charge on the PICU (usually a band 6 sister) cared for a child as well as coordinating the shift. This was in addition to carrying the emergency crash pager which would require them to leave the unit to attend a sick child in other parts of the hospital.
- During the period 17 November to 7 December, at least one level 3 child was refused admission from another hospital because there were not enough staff on duty. There were also other events during the period that would have impacted on the nurse staffing on duty, such as withdrawal of care. The nurse management team told us that the commissioner of the services was currently reviewing how the service was funded.

Medical staffing

- Medical staffing was reasonably covered in paediatrics and neonatology. We talked with eight doctors of all grades, including the clinical director for paediatrics, three consultant paediatricians, two trainee doctors and two neonatologists.
- We were told that tier 1 medical staffing in paediatrics contained no gaps and was adequately covered. We were informed that there were occasional gaps in the on-call rota for tier 2 (middle grade) doctors. These gaps were covered by regular locum doctors or a consultant paediatrician. The clinical director explained that there were currently four out of 17 gaps within the consultant rota, which was, in part, due to long-term sickness. These gaps were also covered by the use of regular locum consultants or existing consultants conducting extra duties.
- The neonatal unit was staffed independently of the paediatric areas. Tier 1 cover was achieved via a combination of trainee doctors and six advanced neonatal nurse practitioners trained to tier 1 level. There were seven tier 2 specialty trainee doctors and one research fellow. This left two gaps which were currently covered by use of regular locum doctors. Two of the advanced neonatal nurse practitioners had recently undergone tier 2 training and would cover these roles shortly. There were five consultant neonatologists.
- We attended a paediatric medical handover on Ward 21. Attendance included 11 doctors and the ward manager. Handover included discussion of the child's medical plan and was followed by a ward round, split into four teams to facilitate discharge within the PDU, wards 21 and 22 and the PICU. Two other medical handovers were held each day and we found that they were well-organised.

Major incident awareness and training

- The trust had a major incident plan, setting out actions to be taken for major incidents and other similar events. The head of nursing and the matron we talked with demonstrated awareness of the plan and their respective roles, although they did not recall when the children's service had been involved in any such exercise for the last few years. The head of nursing told us there was an exercise planned soon. None of the training records we reviewed showed that there had been any specific training in the use of the major incident plan.

Are services for children and young people effective?

Good

The trust had systems and processes to review and implement National Institute for Health and Care Excellence (NICE) guidance and other evidenced-based best practice guidance. We reviewed information that demonstrated that children's services participated in national audits that monitored patient outcomes when these were applicable. Medical staff had a proactive programme of clinical audit which looked at outcomes for children and young people.

Children and young people had access to a range of pain relief if needed and used an evidence-based pain-scoring tool to assess the impact of pain. The nutritional needs of children were addressed. Consent forms were completed

to an adequate standard and staff showed awareness of Gillick competencies guidelines for deciding whether a child is mature enough to make decisions and give consent.

Staff had received an annual appraisal and received support and personal development. Members of staff gave positive feedback about the individual support they received regarding their personal development. There was clear evidence of positive multidisciplinary working across various disciplines and specialties.

Evidence-based care and treatment

- The trust had systems and processes to review and implement NICE guidance and other evidenced-based best practice guidance. The clinical director acted as the service lead for the review of guidance and supported its incorporation into protocols where required.
- The trust submitted a spreadsheet prior to our inspection, setting out which child/neonate specific guidance the service was compliant with and which guidance was being acted on to change policies and process. For example, the spreadsheet noted that the service was compliant with several guidance documents such as those for cystic fibrosis and asthma. The sheet noted that the neonatal service was partially compliant with guidance for 'antibiotics for early onset neonatal infection' but comments noted that a new policy was being prepared for ratification. This example demonstrated that the service reviewed national guidance and changed policy and practice as a result.
- Discussion with clinical staff, and the review of a number of submitted documents, demonstrated that the service participated in national audit such as diabetes, epilepsy and asthma. Evidence was submitted including action plans which showed the service had reviewed the audit results of these national surveys and set actions to identify improvement. For example, the asthma audit plan included actions such as improving the recording of information and the development of a study to investigate higher readmission rates.
- The directorate of paediatric and neonatology conducted a range of clinical audits which was well organised. The directorate set out its yearly audit within the Clinical audit forward plan 2014/2015. This plan set out 'must do' investigations such as national audits, along with five specific audits regarding the implementation of NICE guidelines, for example, sedation in children and young people. Several other clinical audits were planned during the period such as audits of diabetes surgical guidelines and extubation (safe removal of ventilator) for patients on the PICU. The forward plan included reaudit activity. The neonatal unit also had its own audit forward plan detailing exercises such as 'audit of Resuscitaire heat level.'
- The trust also produced quarterly clinical audit activity reports for paediatrics. This document contained a large number of audits, either with a status update for audit in progress or a detailed summary of findings for completed audit. The various documents demonstrated the service's proactive approach toward audit activity which was largely focused on clinical outcomes for the child.
- The trust submitted a number of completed clinical audits, some of which demonstrated how they had audited adherence to national guidance. For example, an audit dated June 2014 reviewed practice relating to the current management of children admitted with alcohol infection or recreational drug use. This audit was presented to the paediatric audit meeting held in May 2014. The main action arising out of the audit was the development of a formal guideline for the management of alcohol and drug abuse for children and young people.

Pain relief

- Children and young people had access to a range of pain relief if needed, including oral analgesia and patient-controlled analgesics.
- The service used evidence-based pain scoring tools to assess the impact of pain. We reviewed a sample of pain score ratings, which showed that members of staff regularly assessed pain when required. Parents we talked with confirmed that their child had their pain assessed.
- We attended a medical handover during our inspection which demonstrated how pain was discussed and managed. The medical team discussed early referral of a child with recurrent abdominal pain to the chronic pain team for later follow-up and they discussed a pain management strategy for moving a child with hip pain to have an x-ray.

Nutrition and hydration

- Children's likes and dislikes regarding food were identified and recorded as part of the nursing

assessment of the child's daily activities. The nursing team used a nutritional assessment tool for children known as the 'Screening Tool for the Assessment of Malnutrition in Paediatrics' (STAMP). We reviewed a sample of nursing records which showed that these records had been appropriately completed.

- Children were able to choose their food from the daily menu with the support of parents and staff. Children could eat food from the adult menu or have a meal from the children's menu. Snacks and drinks were available in between meals.
- We were told that the children's clinical areas operated a protected mealtimes approach to help ensure meal times were not disturbed by procedures.
- The directorate held a nutritional steering group which met every two months and included a multidisciplinary membership of a dietician, paediatrician, acute and community nurses and the neonatal unit staff. The steering group had developed various clinical guidelines, for example, the Standard operating procedure, food and hydration – paediatrics and The preparation and administration of paediatric enteral feeds in the acute and community setting.

Patient outcomes

- We reviewed information demonstrating that children's services participated in national audits that monitored patient outcomes when applicable to the service. For example, we reviewed data and information relating to the National Neonatal Audit Programme (NNAP) along with national Commissioning for Quality and Innovation (CQUIN) data for neonatal outcomes. The neonatologist who led on the NNAP audit gave an example of how improvement work had been undertaken in relation to taking babies' temperature on admission as a result of the last audit results.
- The PICU participated in the Paediatric Intensive Care Audit Network (PICANet) audit programme. We reviewed the PICU specialised service quality dashboard summary prepared for NHS England covering the winter period for 2013/14 and this did not record any significant outlier for the criteria assessed. Some outcomes were better than expected, for example, rate of "accidental extubation of patients" was better than the national average.
- We reviewed evidence which demonstrated how the services participated in and responded to national clinical audits such as diabetes, epilepsy and asthma. For example, in the epilepsy audit report published in November 2014, the service was not an outlier in 11 of the 12 performance indicators and was a 'positive outlier' in relation to access to an epilepsy specialist nurse. The action plan for the last asthma audit (2013/14) stated six actions for improvement, including measures to investigate the higher readmission rate and look at history and/or follow-up arranged. Education on asthma management during admission and early review with a specialist nurse or respiratory team where repeated readmission is evident.
- Clinical areas in children's services also submitted ongoing data (where applicable to children) that contributed to the patient safety thermometer monitoring dashboard. Data showed that all participating children's clinical areas were scored as 100% harm-free.
- We were told that children's services do not participate in the NHS Friends and Family Test. The management team was aware of a paediatric version of this national test and planned to introduce it to the service during early 2015.
- An alternative system had been set up to gain the views of children, young people and families about their experiences within the children's service. On the ward areas a locally developed questionnaire was given to a sample of 15 parents and children each month. The questionnaire included a sheet for the child to draw a picture of what made them happy and unhappy while in hospital. Other methods of seeking the family's views of the service included comments cards. The results of any changes as a result of families' comments were highlighted on a 'You said, we did' information board.
- The neonatal unit provided a good practice example that helped contribute to ensuring positive patient outcomes. The unit utilised a simulation approach to test new equipment and clinical procedures that extended the testing of staff's neonatal life support skills. The neonatologists we talked with gave examples, including the testing of different neonatal resuscitation equipment.

Competent staff

- Formal processes were used to ensure that staff received training and an annual appraisal.
- We did not review any documents which recorded appraisal statistics, but the matron stated that appraisal completion was 80% for the children's clinical areas and

lower for neonatology. The ward manager for Ward 21 confirmed that 80% of the 55 staff employed on the ward had had an appraisal. The ward manager for the neonatal unit explained that around 70% of the 85 staff employed on the unit had received their appraisal. Members of staff we talked with confirmed they had received an appraisal.

- Members of staff in all clinical areas gave positive feedback about the individual support they received regarding their personal development.
- Trainee medical staff we spoke with were positive about the regular training and support they received to develop their clinical and educational knowledge and skills. They felt well-supported by consultant staff within paediatrics and neonatology.

Multidisciplinary working

- Medical and nursing staff within the paediatric and neonatal services gave positive examples of multidisciplinary working. We were told that the paediatricians and nursing teams worked closely together and also with other allied healthcare professionals such as dieticians, occupational therapists and physiotherapists.
- Staff told us that children's services worked closely with surgeons and doctors in specialties such as emergency medicine, ear, nose and throat surgery, orthopaedics, general surgery and anaesthetics. The clinical director explained how they had developed joint working with gynaecology consultants, including the development of a 'one-stop' joint paediatric/gynaecology clinic.
- The head of nursing and the matron provided an example of how the children's service had developed positive working relationships with the Child and Adolescent Mental Health Services (CAMHS). We were told that the multidisciplinary team, including paediatricians, emergency medicine, CAMHS, safeguarding, hospital inpatient liaison team (HILT) and other representatives met regularly to discuss processes and care for children with mental health issues such as self-harm. The clinical director highlighted the service's multidisciplinary approach alongside psychiatry for young people with eating disorders.
- Formal adolescent transition arrangements were in place for some sub-specialty medical conditions. For example, there were established transitional arrangements for adolescents transferring within the diabetes sub-specialty, including young person's clinics with the adult team. Other specialties, including epilepsy and cystic fibrosis, had some form of transitional arrangements being further developed.

Seven-day services

- The children's inpatient services accessed diagnostic services such as the x-ray department, pharmacy and laboratory during the weekend. Staff did not raise significant concerns over accessing these services.
- We were told there were sometimes delays when accessing some services at the weekend. For example, on Ward 22 there were delays in accessing a surgical team or, for all areas, there may be delays to a child's discharge due to waiting for take-home medications. Trainee doctors working out of hours and at weekends told us they felt well-supported by consultant staff, who were on call.

Access to information

- Staff we talked with told us they were readily able to access patient information and reports, including at weekends and out of hours. For example, trainee medical staff explained they were given their computer log-in passwords straight away which allowed them access to the system on their first day working at the hospital.

Consent

- The children's service included a dedicated surgical ward (Ward 22) for a range of specialties, including general surgery, dental, and ear, nose and throat, orthopaedics and spinal surgery.
- We reviewed a sample of six records where consent had been obtained for surgery, and found these had been appropriately completed, dated and signed by the doctor/surgeon and parent.
- Staff we talked with showed they understood the Gillick competency standard guidelines for deciding whether a child is mature enough to make decisions and give consent. Staff explained that the consent process completed by surgeons actively encouraged young people to be involved in decisions about their proposed treatment.

Are services for children and young people caring?

Services for children and young people

Good

Children, young people and parents told us they received compassionate care with good emotional support. They felt they were informed and involved in decisions relating to treatment and care. We spoke with 25 children and parents who provided examples of how they had been provided with supportive care centred on their personal needs. Staff were responsive to children's and parents' emotional needs.

Compassionate care

- Throughout our inspection, we observed members of medical and nursing staff who provided compassionate and sensitive care that met the needs of children, young people and parents.
- We observed members of staff who had a positive and friendly approach towards children and parents. Staff explained what they were doing and took the time to speak with children and parents, despite being very busy on some of the clinical areas such as Ward 21 and the PDU.
- We spoke with 18 parents and seven children across all children's inpatient and outpatient areas. The parents provided examples of how they had received supportive care. For example, several parents explained how they felt their child's pain had been promptly treated. A number of parents described staff as being "very caring", with some parents describing their overall experience as "brilliant".
- We were told that children's services did not participate in the NHS Friends and Family Test (which allows patients to give feedback on the quality of care and whether they would recommend the hospital's service to friends and family). On the ward areas, a locally developed questionnaire was given to a sample of 15 parents and children each month. The questionnaire included a sheet for the child to draw a picture of what made them happy and unhappy while they were in hospital.
- We reviewed a sample of 10 questionnaires completed during November 2014 and found all responses from parents were positive and the majority of children had drawn pictures of their experiences. In the five questionnaires from Ward 21: one parent stated that they had a "wonderful" stay; another stated "100% fantastic staff"; and two parents noted particular praise for the same children's nurse. Of the five questionnaires from Ward 22: one parent stated "the staff go above and beyond to make our stay here better". The children's responses revealed the nurses, toys and hospital food as positives, while negative feedback included injections, pain, medicine and sleep.
- The children's outpatient department routinely asked parents and children to submit questionnaires. We reviewed one report summarising findings of 80 questionnaires submitted for August and September 2014. Results from a number of questions asked were very positive. Positive comments included: "staff polite and professional", "staff speak directly to the child" and "friendly, quick and informative when children having blood [taken]". Negatives included: "long waiting times", "long walk to the x-ray department" and "smokers outside the south entrance overshadowed the excellent care given by staff".

Understanding and involvement of patients and those close to them

- Members of staff used age-appropriate language when talking with children and young people. This was supported by a children's outpatient questionnaire survey report for the period August/September 2014. Of 80 responses, 99% answered 'yes' to the question "The staff spoke to me in a way I/my child could understand".
- A number of children, young people and parents told us they had felt involved in the planning and decisions relating to the patient's care.
- One question in the local questionnaire asked parents "Have you been involved as much as you wanted to be in your care?" All 10 responses of the sample we reviewed indicated that they had felt involved.
- Parents and children talked positively about the information they had received – both in the children's areas and the neonatal unit. Families also explained how they had been given sufficient information to make an informed choice about their children's care.
- Some parents felt that communication updates about their child's care could be better; for example, one parent explained that communication was "good in PDU but not so good on the ward … not kept up to date".
- Information leaflets about various treatments and other care were available within the hospital. Leaflets at this trust were written in English. Members of staff explained that they could get leaflets translated when required.

Services for children and young people

Emotional support

- Parents and children told us they had been well-supported during their visits to the various children's areas.
- We observed members of staff who were responsive to and supportive of children's emotional needs. For example, we observed one nurse on Ward 22 who displayed courteous, kind and fun behaviour while attending to a child.
- Parents we talked with gave examples of how staff supported their children. For example, one parent outlined how supportive staff had been in the management of their baby's care on the neonatal unit.
- Parents made it clear when talking to us, and through the questionnaires, that they could talk to a member of staff when they felt concerned or anxious during their children's stay in hospital. Parents' comments were positive about the care and emotional support they had received in the children's clinical areas.

Are services for children and young people responsive?

Good

The children's service actively planned and delivered services to meet the needs of local families. A recent service reconfiguration was being closely monitored and managed in partnership with commissioners and other healthcare providers.

We found areas of outstanding practice regarding the meeting of young people's individual needs.

Access and flow was good within the children's inpatient areas, facilitated by regular medical handovers and reviews. However, patient flow on the PDU was impeded at times due to the environment.

Service planning and delivery to meet the needs of local people

- A range of evidence was available to demonstrate how the children's service engaged with the trust, commissioners, the local authority and other providers to address the needs of the local population.
- A commissioner-led service reconfiguration had recently been undertaken for the Frairage Hospital located at Northallerton. This had led to the closure of overnight inpatient beds for children and the children's ward had become a short-stay paediatric assessment unit, open from 10am to 10pm seven days per week. The special care baby unit had also closed at the Friarage Hospital; to replace them, 10 new cots had opened at the James Cook neonatal unit. The children's outpatient department remained open at the Friarage Hospital. These changes had occurred on 1 October 2014.
- We saw the trust and other partners had proactively planned these changes and completed a range of work to ensure the local population were aware of what to do now that the 24-hour inpatient ward had closed. Various posters and leaflets had been produced to inform people of the changes and what they should do if their child needed the hospital's services.
- The trust was closely monitoring the reconfiguration of services and the impact on services at the Friarage and James Cook hospitals. Currently every transfer from Friarage Hospital was being reviewed (and reported as an incident to facilitate close monitoring) and we were told an audit had just been completed immediately prior to our inspection. Statistics so far showed that the number of transfers to James Cook had been low – 32 transfers since 1 October up to the time of the inspection. Of these, few occurred after 6pm, for example, in the week 17–23 November, three children were transferred after 6pm.
- The head of nursing and the matron explained that there was a weekly telephone conference call between the clinical commissioning groups, emergency departments, ambulance service, children's services and maternity services to discuss the reconfigured services.

Access and flow

- Access and flow varied within the children's services provided throughout the trust. The emergency department facilities for children were limited and were part of the adult service. The children's directorate had no direct influence over the provision of emergency services in the emergency department, although the clinical director and paediatricians we talked with explained they worked well with the emergency medicine team.
- There was a PDU which operated as a short-stay assessment unit type. This was located adjacent to Ward 21 (paediatric medicine) and the other children's

wards, such as Ward 22 and the PICU. The children's management team explained there had been previous option outline appraisal to consider relocate the PDU alongside to a new dedicated children's emergency department but, for reasons not provided, this had not occurred.

- The PDU accepted direct referrals from the emergency department and GPs and also saw other ward attendees who required review or minor tests. The PDU had some local flow issues due to the environment which did not facilitate the prompt review of children attending the unit. The waiting area was small which meant families had to wait in the corridor during busy times. There were seven beds and one cubicle but there was limited space for medical or nursing staff to undertake prompt assessment because there were no consultation rooms. The management team had commissioned a feasibility study that would improve access and flow, if the resulting plan was approved.
- We found there was good access and flow between the other inpatient areas, including Ward 21 (medicine), Ward 22 (surgery) and the PICU. In addition, the theatre/anaesthetic directorate directly managed a nine-bed/chair paediatric surgery day unit located adjacent to the paediatric recovery area. This unit was open between 7am to 9pm and saw around 2,000 minor surgical day cases per year. This unit meant that Ward 22 was able to focus on more complex elective surgery and trauma. Although this unit was not managed by the children's directorate, we saw that it was able to work closely with other children's services within the hospital.
- To assist with the flow of patients, consultant paediatricians held three handovers/patient reviews each weekday. A review of care records showed that discharge planning began on admission.
- The children's service used an early warning clinical observation system known as the Paediatric Early Warning Score (PEWS) that helped staff to identify children who were becoming ill more promptly so that transfer arrangements could be made to the hospital's PICU/HDU or a tertiary regional centre, such as in Newcastle, when required.

Meeting people's individual needs

- Staff told us interpreting services were available when they needed them, and that they did not normally have any issues when accessing these services.
- The children's ward areas had facilities to promote family-centred care. For example, parents had access to a seated area and facilities to make hot drinks on Ward 21. Parents were able to sleep next to their child at night on camp beds. We were told that the camp beds had recently been replaced with new ones as a response to feedback from parents via comment cards.
- We found several areas of outstanding practice relating to the facilities, care and support provided to young people.
- We saw that the children's wards took account of adolescents' needs. Ward 21 had a dedicated 11-bed young people's unit which offered spaces for children and young people aged 11 to 16 years of age. The unit had wall art suitable for teenagers and the area included a "chill zone" which was a room were young people could relax, watch DVDs, play music and games together.
- The trust's children's service had proactively participated in the You're Welcome toolkit which was a quality criteria highlighted in the National Service Framework for Children. The toolkit sets out a number of principles to ensure that young people aged 11 to 19 (including vulnerable groups) were able to access services better suited to their needs. The toolkit covered 10 key areas assessed, including accessibility, publicity, confidentiality/consent, the environment, staff training, skills, attitudes and values.
- Evidence showed that Ward 21 with the young people's unit was the first inpatient unit to nationally achieve the You're Welcome award in 2010. Since then, accreditation has also been gained by Ward 22, the children's outpatient department and the paediatric surgery day unit.
- Other excellent young people's practice included the development of a young people's advisory group which provided a forum for young people to give feedback on hospital care and to share their ideas about how services should be delivered. The children's wards had also been periodically inspected by a group of young people who had reported positive comments and areas they would like to see develop. The matron, who inspired passion and drive for young people across the department, explained that the advisory group had suggested service developments that had been introduced, such as a pregnancy advisory service room.

- The clinical director explained how they involved and included young people on interview panels for people wanting to work within the children's services. We were told the last three consultant paediatrician appointments panels had included a young person.
- Formal adolescent transition arrangements were in place for some sub-specialty medical conditions. For example, there were established transitional arrangements for adolescents transferring within the diabetes sub-specialty. Other specialties, including epilepsy and neuro-disability conditions, had some form of transitional arrangements being further developed.
- The matron recognised that there was currently no overarching policy statement regarding the coordinated development of adolescent transitional services, though this would soon be developed. We found the leadership team and staff had a very positive approach and showed commitment to the continued development of adolescent transitional care to complement the range of adolescent services already offered for young people.

Learning from complaints and concerns

- The head of nursing and the matron explained that the number of formal complaints was low but could deal with complex issues within the children's service. It was explained that the service always tried to meet with the family to review the complaint and apologise. The ward-level performance dashboard for each of the clinical areas confirmed that complaints received and Patient Advice and Liaison Service enquiries were low. For example, the Ward 21 dashboard noted four Patient Advice and Liaison Service enquiries and one formal complaint in the period April to October 2014. The PICU and neonatal dashboards had no complaints lodged in the same period.
- The monthly children's services directorate meetings included a subheading for complaints under the 'quality of care and patient safety' standing agenda item, and minutes showed that these meetings reviewed and discussed complaints.
- The women and children's centre had produced an annual complaints and Patient Advice and Liaison Service report for April 2013 to March 2014. The report specific to paediatrics for this period had identified some themes such as "poor escalation processes to consultants" and "not listening to parents concerns". Lessons learned included various measures such as "children who are admitted and stay longer than 12 hours will be reviewed by a consultant".
- Lessons learned via complaints were shared via a weekly email which set out a lesson of the week which had been identified from incidents, risks or complaints. The aim of the email was to ensure that learning could be promptly shared with all members of staff.

Are services for children and young people well-led?

Good

The service was well-led. Governance and risk management arrangements were used. There was a clear vision and strategy for the service, based on best practice set out in the Department of Health's National Service Framework for Children. The service was led by a strong management team who worked well together. The service regularly implemented innovative improvements with the aim of constantly improving the delivery of care for children and families. Although there was an executive director for safeguarding children, the trust did not have a formally nominated board-level director who championed children's rights.

The service engaged with people who used the service through a range of methods. The service involved children and families in decisions regarding the service and facilitated a range of support groups. There were excellent areas of innovative practice in the care and involvement of young people.

We found a positive, open and friendly culture at the service. Staff placed the child and the family at the centre of care delivery, and this was seen as a priority and everyone's responsibility.

Vision and strategy for this service

- The trust had a children's specific strategy – the Children and Young People Strategy which was valid for the period 2012 to 2017. The strategy included an overall vision with five linked strategic vision statements. The overall vision stated: "To deliver services that meet the

health needs of children, young people, parents and carers and provide effective and safe care, through appropriately trained and skilled staff working in a suitable child friendly and safe environment".

- The strategy set out core values and strategic themes regarding quality of care and patient safety, business sustainability, organisational capability and partnerships and engagement. Strategic objectives were outlined for core children's services such as neonatal services, surgery, medicine, outpatients, inpatients, ambulatory care, child therapy services and community services.
- Part two of the strategy used the standards set out in the Department of Health's National Service Framework for Children, Young People and Maternity Services. The strategy mapped the strategic objectives identified for each core children's service against a target (National Service Framework for Children, Young People and Maternity Services standard) and the strategic vision.

Governance, risk management and quality measurement

- The children's services' risk register listed four risks. Three risks related to neonatology and included "risk of non-compliance with national staffing recommendations for NICU (BAPM standards)", "risk of compromised quality of care and service provision due to increased patient activity" and "risk of service disruption due to Pseudomonas outbreak on neonatal unit". The paediatric risk related to "risk of service disruption due to gaps in tier 1 and 2 medical staff rota". The risks identified had measures to manage them appropriately.
- Risks were regularly discussed within children's service directorate meetings. The directorate routinely collated quarterly risk management reports which set out a summary of quarterly patient safety incidents healthcare software report totals, the top 10 incidents during the period, followed by a summary of action taken where appropriate.
- The women and children's centre produced quarterly patient safety governance reports which included current risks. Risk meetings were held separately for paediatrics at James Cook and Friarage hospitals, neonatology and community children's services. The children's management team explained that, as many of the risks and incidents were similar, the four risk meetings would be merged into one monthly meeting.
- We found the leadership and clinical teams held a range of meetings which covered clinical governance matters regarding the children's service. There was a monthly children's service directorate meeting which included agenda items centred around the children's strategy themes. These meetings involved members of the children's leadership team at ward and unit level, along with the children's management team, the clinical director, head of nursing, and the matron and directorate manager.
- The clinical director for paediatrics explained that the directorate clinical audit and governance meetings discussed a range of matters, including child death review processes, actions from incidents and complaints, along with other matters such as the presentation of clinical audit. This was a consultant-led meeting but open to the multidisciplinary team to attend. This particular meeting did not currently record formal meeting minutes.
- The children's nursing leadership team also held regular meetings attended by the head of nursing, the matron and band 7 ward managers. Meeting minutes showed that these meetings held more detailed discussion about a range of areas such as infection control and training.
- The children's management team formed part of the monthly women and children's centre meetings. This meeting was more corporate and business focused and discussed matters such as finance. We reviewed a sample of meeting minutes which showed that quality issues where discussed and recent minutes included updates relating to the reconfiguration of Friarage Hospital services.
- The head of nursing, matron and directorate manager showed a clear awareness of the new Duty of Candour regulations that came into effect on 27 November 2014. Other staff we talked with showed some awareness, though a small number did not know what the duty meant.

Leadership of service

- The directorate of paediatrics and neonatology formed part of the women and children's centre. There was a centre chart which set out a multi-tiered structure within the directorate and centre.
- Within the directorate of paediatrics and neonatology there was a separate clinical director for paediatrics and neonatology and a manager for paediatrics. Nursing

leadership within the directorate included a head of nursing who was supported by a clinical matron. Each clinical area was led by a band 7 ward manager who was supported by band 6 sisters. The directorate had shared access to supporting services such as governance.

- The children's management team (clinical directors, head of nursing, directorate manager and matron) reported to the centre management team which included a managing director and a senior clinician who was appointed as the chief of service.
- We spoke with all band 7 ward managers during our inspection, with the exception of the PICU manager who was not working. All managers told us they felt well-supported by the head of nursing and the matron. The clinical director for paediatrics explained that the chief of service (an obstetrician) was very supportive toward children's services. During our interviews with the children's leadership team, we observed a team who understood their service and demonstrated how they worked positively together.
- We found that children did not have adequate representation at the Trust Board level, which a view was shared by some of the clinicians we talked with. There was an executive board lead for safeguarding children (the director of nursing). We could not identify that there was a formal board-level director to promote children's rights and views, as recommended by the National Service Framework for Children standard for hospital services.

Culture within the service

- We found a culture of openness and flexibility among all medical, nursing and allied healthcare professional staff we met within the children's service. Staff spoke positively about the care they provided for children, young people and parents. We saw how staff placed the child and the family at the centre of care delivery, and how this was seen as a priority and everyone's responsibility.
- Staff worked well together and there were positive working relationships between the multidisciplinary teams and other services involved in the delivery of care for children.
- The leadership team demonstrated how they took pride in their service and enthusiastically provided a number of examples of how the children's service had developed. For example, the matron demonstrated a passionate approach to the development of young people's services which had resulted in the ongoing You're welcome accreditation of various clinical areas.

Public and staff engagement

- We found that people's experiences of the service were regularly sought. On the ward areas, a locally developed questionnaire was given to a sample of 15 parents and children each month. The questionnaire included a sheet for the child to draw a picture of what made them happy and unhappy while in hospital. The children's outpatient department also asked parents and children to complete questionnaires and the results were collated into reports for them to view.
- The children's wards also had comments cards available. The matron provided examples of how these comments cards had led to improvements or changes to service provision. For example, new camp beds had been recently purchased, a direct result of parent feedback. Ward 21 had a "You said, we did" board to provide information to parents and children on how the service had responded to their feedback.
- Children and young people were encouraged to participate while on the ward. One example was the 'bare below elbows' initiative where children checked members of staff to see that they were adhering to trust policies for best hygiene practice. Young people had performed inspections of some clinical departments, such as the wards and outpatients, and advised where areas could change or improve. Young people were involved in the interview process for new consultant staff, which was excellent practice.
- The children's service either facilitated or was involved in various support groups that had been set up for parents and children. For example, there was a young people's advisory group which had already led to changes in service provision as a result of feedback. It was explained that parents attended various meetings, such as diabetes meetings, with members of staff.
- The matron provided an example of how the children's service involved parents in the reporting process following an incident and in the root cause analysis investigation. We were told that a parent had contributed to one investigation and the learning that resulted, and was shortly to attend a meeting prior to an incident report being submitted. This was positive practice.

- The neonatal unit gave various examples of how they had developed patient and public involvement. We were told there was an active Bliss (the organisation concerned with the care of premature and sick babies) family support group" in Middlesbrough which was well-attended by families. Parents had helped with medical paediatric examinations each year and had supported nurse training by returning to talk about their experiences.
- Staff we spoke with told us they had been engaged prior to and following the recent reconfiguration of services at the Friarage Hospital. We also heard individual examples of how members of staff had been engaged and supported by each other and members of the leadership teams at ward and directorate level. The management team explained they were developing a 'thank and praise' ethos to develop positive approaches and support for members of staff.

Innovation, improvement and sustainability

- The children's service, its consultant paediatricians and other staff had introduced innovative ideas to improve service provision and sustainability for children and families who used the service.
- A review of practice regarding medication administration led to the development of a systematic approach from policy known as the '10 steps to safer medication'. This process set out a clear process for staff to follow from prescription through to administration of medicines. Documentation showed that the new process led to a 46% reduction in medication incident reports for April 2010 to March 2011. Staff had received ongoing DVD information and workshop training and risk meeting minutes showed a continued review of medication incidents and management. This was good practice which demonstrated how medications management had been improved and sustained following formalised changes to practice.
- The children's service demonstrated how it reviewed the latest evidence-based tools and took action to introduce them. For example, the children's service had previously used the Braden Q scale (adult-adapted children's pressure sore risk calculator). A review of pressure incidents from the period April 2011 to April 2014 showed there had been 14 grade 2 pressure ulcers and four grade 3 ulcers. Of these, 61% had occurred in children with disabilities with 55% of ulcers were directly caused by pressure from equipment. The team conducted a literature review and identified a more recently developed tool known as the Glamorgan risk assessment scale which was found to be more accurate at identifying children with mobility issues at risk of pressure sores. The new scale had been recently introduced in the hospital.
- We found several areas of excellent practice relating to the care and involvement of children and young people. The trust's children's service had proactively participated in the You're Welcome toolkit which was a quality criteria for young people highlighted in the National Service Framework for Children. Ward 21, with the young people's unit, was the first inpatient unit to nationally achieve the You're Welcome award in 2010. Since then, accreditation had also been gained by Ward 22, the children's outpatient department and the paediatric surgery day unit. The service planned to extend accreditation to the community with the school nursing service.
- The service had developed a young people's advisory group which provided a forum for young people to give feedback on hospital care and to share their ideas about how services should be delivered. The matron, who we saw inspired the passion and drive for young people in the department, explained that the advisory group had suggested new service developments that had been introduced, such as a pregnancy advisory service room. The children's wards and children's outpatient department had also been periodically inspected by a group of young people who had reported back on positive issues and also areas they would like to see develop and improve.
- The clinical director explained how they involved and included young people on interview panels for people wanting to work within the children's services. We were told the last three consultant paediatrician appointments had included a young person sitting with the interview panels.
- Children and young people who were patients acted as inspectors to check members of staff adhered to 'bare below the elbows' hygiene guidance. This included the young inspectors issuing a 'certificate of achievement' to members of staff if they were compliant. We were told this exercise was completed every around six months. This was good practice because it actively involved young people with the engagement and maintenance of good practice among members of staff.

Services for children and young people

- The neonatal unit provided a good practice example that helped contribute to ensuring positive patient outcomes. The unit utilised a simulation approach to test new equipment and clinical procedures. The neonatologists we talked with gave examples, including the testing of new neonatal resuscitation equipment.
- In relation to innovation, the clinical director cited several examples of good clinical practice they were proud of, including the diabetes and epilepsy services, joint working with gynaecology consultants to provide a 'one-stop' paediatric/gynaecology clinic, and the service provided for children with eating disorders.

End of life care

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

Information about the service

The James Cook University Hospital formed part of South Tees Hospitals NHS Foundation Trust and provided end of life care services on-site and in partnership with the Friarage Hospital, community and hospice services. The hospital did not have any wards that specifically provided end of life care. Patients requiring end of life care were identified and cared for in ward areas throughout the hospital, with support from the specialist palliative care team (SPCT), comprising one full-time palliative care consultant and one half-time respiratory consultant with an interest in palliative care. There was an end of life lead nurse and three additional palliative care nurses. The team worked as part of a wider multidisciplinary palliative care team that provided specialist palliative care support to patients at this hospital, the Friarage Hospital and across two community regions. All patients requiring end of life care could have access to the SPCT. We saw that referrals to the service from 1 October 2013 to 31 March 2014 totalled 537.

During our inspection we spoke with members of the SPCT, the non-executive director lead for end of life care, members of the end of life steering group, bereavement support staff, mortuary staff, the chaplain, porters, medical staff, ward managers, nursing staff and allied healthcare professionals. In total we spoke with 25 staff. We visited a number of wards across the hospital, including general medicine wards, gastroenterology, respiratory medicine, geriatric medicine, medical oncology, neurosurgery, cardiology, stroke medicine, critical care and the A&E department. We reviewed the records of 13 patients at the end of life and reviewed 31 do not attempt cardio-pulmonary resuscitation (DNA CPR) orders. We spoke with two patients and three relatives and we reviewed audits, complaints, surveys and feedback reports specific to end of life care.

End of life care

Summary of findings

Overall, we rated end of life services as 'requiring improvement'. End of life services were caring, responsive and well-led but required improvement in order to be safe and effective. Do Not Attempt Cardio –pulmonary Resuscitation (DNACPR) forms were not always completed in line with national guidance and the trust's policy. Patients who were identified as lacking mental capacity were not always having their mental capacity assessments documented. Monitoring of the safe use of syringe drivers for end of life medication was not being recorded consistently.

Training and education for ward-based staff had been problematic due to issues with releasing staff from the wards to attend. The SPCT had approached this issue by delivering more informal, ward-based training, however, this hadn't been recorded so its effectiveness was difficult to evaluate. Education was one of the key themes identified as part of the end of life steering group work programme.

The trust had a care pathway in place which was being used during the transition from the phase out of the Liverpool Care Pathway and the introduction of a new regional pathway. We saw that the last days of life care pathway did not include specific prompts around nutrition and hydration assessments and that these were sometimes missing in the pathways we reviewed. However, this had been addressed to ensure specific prompts were incorporated into the new guidance.

The SPCT supported ward-based staff with care and they were committed to the development of end of life care skills to improve care for patients. We saw evidence of plans to address issues identified in internal and external audits. Service planning was in progress, centred around seven key themes identified by the end of life steering group.

There was evidence of innovation in the form of a bereavement service and a pilot to review patients at the end of life who were highlighted on admission. The focus of these innovations was to improve support to relatives and care to patients at the end of life. Staff were caring and compassionate and we saw that the service was responsive to patients' needs. There were prompt referral responses from the SPCT and rapid discharge for patients at the end of life wishing to be at home.

End of life care

Are end of life care services safe?

Requires Improvement

End of life services required improvement to be considered safe. DNA CPR forms were inconsistently completed. Of the 31 forms we viewed, nine had not been signed by a consultant, eight did not include details of discussions with the patient or relatives, one was a photocopy and 13 did not include a date for review. We saw one patient whose condition had improved, yet a review of the DNA CPR decision had not been carried out. This meant that resuscitation decisions were not consistently being recorded in line with national guidance and trust policy.

Syringe driver monitoring was inconsistent, with required four-hourly checks not always being carried out, meaning that safety checks were not always conducted in line with trust policy. We observed four patients who were receiving medication to reduce their symptoms via a syringe driver; in all four cases, syringe driver monitoring was inconsistently recorded.

We were told that porters had been using an old manual concealment trolley when transferring the deceased rather than the height-adjustable trolley that was available, therefore presenting a manual-handling risk that had not been assessed.

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

Incidents

- There had been no Never Events – serious, largely preventable patient safety incidents that should not occur if proper preventative measures are taken – or serious incidents reported for end of life care in the 12 months prior to our visit.
- Staff told us they knew how to report incidents through the use of Datix software (an electronic system for reporting incidents) although some felt they were not always given feedback.
- We saw evidence of learning from incidents. One example of this was a review of an electronic observation system following an incident of a patient with inadequate pain management. The review included involvement from the pain management team, an audit of pain management documentation and a management plan being put in place.

Environment and equipment

- We viewed mortuary protocols and spoke with mortuary and portering staff about the transfer of the deceased. We saw that a hydraulic concealment trolley was available for use but were told by porters and mortuary staff that porters generally preferred to use a smaller, manual concealment trolley as it was easier to manoeuvre. This presented a manual-handling risk that had not been added to the risk register and we saw no evidence of the risk having been assessed. It had been identified that a new trolley was required and this was in the process of being sourced.
- We observed the use of McKinley syringe drivers on the wards. Syringe driver safety monitoring was inconsistent in some areas.
- An audit of the use of McKinley syringe drivers dated June 2014, to ascertain compliance against the use of a safety checklist against trust protocol, showed that inappropriate infusion lines had been used and that the four-hourly checks had not been consistently carried out.
- As a result of the audit, the SPCT had re-informed all areas of risk alerts and information had been shared and disseminated through the matron's forum. We saw that this audit was part of an ongoing audit cycle; however, this continued to be an issue on the wards we visited.

Medicines

- The service had Palliative and end of life care guidelines for cancer and non-cancer patients which had been co-written by the palliative care consultant and had been distributed through the trust's intranet. The guidance included the use of medicines in the management of symptoms, including pain, nausea and vomiting, breathlessness and anxiety.
- Patients who required end of life care were prescribed anticipatory medicines (medication that they may need to make them more comfortable).
- There were clear guidelines for medical staff to follow when prescribing anticipatory medicines for patients who needed them. We reviewed 13 medication record

charts for patients who were considered to be in the last days of life and, in all cases, we saw that anticipatory medicines were prescribed appropriately and in line with the guidance.

- Medical staff told us they could access the guidance for prescribing anticipatory medicines using the hospital's intranet and that specialist advice was available to them at all times.
- We viewed the use of syringe driver monitoring charts on the wards. The charts included space for nursing staff to record the drug, dose, rate and volume of medication to be infused subcutaneously. We saw that four-hourly checks were incorporated as part of the monitoring; however, in four cases, we observed inconsistencies with how frequently this was being recorded. This meant that it was unclear if checks were being carried out regularly as required.
- On Ward 28 we saw that one patient had been prescribed medication for symptom management via a syringe driver. The person had been without the syringe driver for four hours due to the ward running out of the prescribed medication. Although the person had been given medication as a single dose at this time, they had not received continuous medication as prescribed. The person also had other medication prescribed that had not been administered (with no record of the reason for omission) and their medication administration chart had not been accurately completed. This meant that medication was not consistently being administered in line with safe administration guidance. This was discussed with the clinical matron who initiated an investigation in line with the trust's reporting procedures.
- We saw that incidents relating to medication were reported and investigated using a medication error decision tree. We were told by a clinical matron that clinical practice issues were escalated to the head of nursing and that practice competencies were assessed using the Witnessed, Assimilated, Supervised and Proficient (WASP) framework.
- The end of life lead nurse told showed us a specifically designed pharmacy request form for medication for rapid discharge. The process used ensured that medication requests in these circumstances were prioritised and would be made available immediately where possible.

Records

- Patients identified as being in the last days of life were commenced on the last days of life care pathway. While on many wards these were completed accurately and in full, we did view examples where the assessments were not always completed or signed by the assessing doctor and nurse. Of the 13 records we reviewed, we saw that eight included incomplete assessments.
- We viewed an audit of the last days of life care pathway that had been carried out by the SPCT from January to April 2014. This audit highlighted that the assessment of spirituality needs and recording of the preferred place of death were not always consistently completed. Actions to be addressed from this audit included the need to liaise with community colleagues about advanced care planning for patients approaching the end of life.
- DNA CPR forms were inconsistently completed. Of the 31 forms we viewed, nine had not been signed by a consultant, eight did not include details of discussions with the patient or relatives, one was a photocopy and 13 did not include a date for review.
- We did not see evidence of advanced care planning decisions in the patients' medical records we viewed.

Safeguarding

- The SPCT were able to explain what constituted a safeguarding concern and the steps required to report them.
- The trust had mandatory safeguarding training schedules as part of staff induction programmes.
- The SPCT had completed the required adult level 1 and children's level 1 safeguarding training.
- The patients and relatives we spoke with told us they felt safe being cared for in the hospital.

Mandatory training

- We were told by the SPCT that, while end of life care training was not mandatory for all staff, training for ward-based staff was considered to be significant role of the SPCT.
- Ward staff we spoke with reported varying attendance at end of life care training. The end of life lead nurse told us that there had been issues with ward staff attendance at end of life care training sessions tailing off, making it difficult for the team to justify running courses on a regular basis. However, we were given examples by some ward staff of training being delivered by a member of the SPCT, specifically around the use of new guidance and in response to specific ward needs.

End of life care

- We viewed an education action plan that included end of life care training being incorporated into a preceptorship training and experience programme for all new staff nurses within the trust. We also saw that the SPCT delivered training for foundation doctors on palliative care and communication at the end of life, including discussions around DNA CPR decisions and also hydration and nutrition.
- The SPCT had completing the required mandatory training which included basic life support and manual handling.

Assessing and responding to patient risk

- We observed the use of general risk assessments in patients who had been identified as being in the last days of life. This included the assessment of risk in relation to nutrition and hydration, falls and the potential for pressure area damage.
- Tools used for the management of deteriorating patients included the National Early Warning Score (NEWS) for acutely ill patients, and we observed the tool being used to identify when patients were deteriorating.
- We saw that recognition of the last days of life was generally consistently applied. The end of life lead nurse told us that patients who were recognised as dying could be commenced on the care pathway for the last days of life. We saw examples of the pathway in use and staff we spoke with told us it was a useful tool in providing a focus for responding to patient risk and need.
- The current and piloted guidance document for care in the last days of life included a section to record recognition that the patient was ill enough to die and we observed discussions in practice with patients and their relatives around care in the last days of life.

Nursing staffing

- There were four nursing staff within the SPCT for the hospital: three band 7 Macmillan specialist nurses (3.0WTE) and one Lead Nurse for End of Life Care and Bereavement (0.8WTE).
- We were told that a vacant band 6 Macmillan Support Sister post (1.0 WTE) was to be recruited to in the new year..
- Nursing staff we spoke with on the wards told us that they generally felt that the quality of care they were able to give people at the end of life was of a good standard. Some nurses cited staffing difficulties as impacting on general nursing activities but most felt they were able to prioritise their time based on patient need and, therefore, deliver care appropriately.
- Specialist palliative care nurses were available Monday to Friday during normal working hours at the time of our inspection. We were told that a new Macmillan-sponsored pilot was due to start in January 2015 where specialist nurses would be available for on-call advice from 4.30pm to 11pm Monday to Friday and from 8.30am to 4.30pm at weekends.

Medical staffing

- One full-time palliative care consultant was available across the JCUH site. A second respiratory physician with an interest in palliative care working was available as part of the SPCT on a half-time basis.
- Out-of-hours specialist medical advice was available through a regional consultant on-call rota that ensured there was a specialist palliative care consultant on call 24 hours a day, seven days a week.
- We observed records in patients' notes that reminded staff of the on-call rota and the fact that there was 24-hour specialist support should they require it.
- Junior medical staff we spoke with told us advice was readily available, including the use of published guidelines via the hospital's intranet.

Major incident awareness and training

- We viewed business continuity plans for the mortuary that would be triggered when a certain point in capacity was reached or should there be a situation where business continuity was affected.
- Business continuity was maintained through contingency planning with the coroner's office, transfer between hospital sites and the use of the trust's contracted funeral director.

Are end of life care services effective?

Requires Improvement

End of life services required improvement to be effective. The trust had a care pathway in place which was being used during the transition from the phase out of the Liverpool Care Pathway and the introduction of a new regional pathway. We saw that the assessment of nutrition

and hydration had been inconsistent for patients at the end of life, with documentation not always being adequately completed in its current format. Following the results of the National Care of the Dying Audit, nutrition and hydration had been addressed in the new guidance and plans were in place to develop training in this area.

DNA CPR forms were inconsistently completed and we viewed five records where the patients had been identified as not having mental capacity to make decisions, yet there had not been a mental capacity assessment carried out. This was not in line with national guidance or trust policy.

The trust had taken action to plan and develop services in line with national guidance, with action plans incorporating areas of identified development. We saw that members of the SPCT were appropriately qualified to give specialist advice and we saw evidence of good multidisciplinary team working as part of the approach to supporting ward-based staff and patients in delivering good quality end of life care.

Evidence-based care and treatment

- The SPCT based care and treatment on the National Institute for Health and Care Excellence (NICE) quality standard 13 which sets out what end of life care should look like for adults with life-limiting conditions.
- We viewed an end of life steering group work programme that incorporated guidance from a number of external sources including NICE, the General Medical Council and the National Care of the Dying Audit of Hospitals.
- The trust had local guidelines and policies that were up to date and based on the NICE guidance. We saw that up-to-date palliative and end of life care guidelines, co-authored by the palliative care consultant, were available and widely used across the hospital, available in hard copy and via the trust's intranet.
- A number of initiatives had been developed by the SPCT, including a pilot approach to proactively identify patients who were approaching the end of life earlier to improve their quality of care. Staff told us there were plans to develop this work more widely across the trust, along with more robust outcome measures.
- The trust had a care pathway in place which was being used during the transition from the phase out of the Liverpool Care Pathway and the introduction of a new regional pathway.Members of the SPCT told us they had taken the decision to extend the use of their existing pathway for the last days of life during the pilot phase for new guidance. They told us that the decision had been based on the need for patients to benefit from consistent standards of care during this time. We viewed clear guidance attached to the pathway that incorporated the need for care to be guided by the five priority areas highlighted by the Leadership Alliance for the Care of Dying People.

Pain relief

- The SPCT had drawn up prescribing guidance to ensure that anticipatory prescribing took place and pain relief was administered to patients in a timely manner.
- Patients at the end of life had their pain assessed, along with other symptoms to promote effective management.
- We saw that pain assessment charts were available on the wards we visited. Pain assessment charts were adapted based on a person's ability to express pain. This included the use of a sliding scale pain score, the assessment of a person's facial expression and the assessment of behaviour and activity.
- Pain assessment charts were in use on the wards and were mostly used consistently to assess pain and evaluate pain relief.
- Patients and relatives we spoke with told us that pain relief was given as needed. We did not see patients who were in pain during our inspection.

Nutrition and hydration

- A malnutrition universal screening tool (MUST) was used routinely on admission to the hospital to identify patients who were malnourished or at risk of malnutrition. We saw that these assessments had been used on most of the patients whose records we reviewed as a standard admission practice.
- Patients' fluid and nutrition needs were assessed and recorded as necessary. We saw a number of wards using fluid balance charts for patients as required and, in all cases, we saw that these were recorded appropriately.
- We viewed results of the 2014 National Care of the Dying Audit of Hospitals and saw that the trust performed below the England average in terms of the review of patients' nutritional and hydration requirements.
- We saw one patient receiving subcutaneous fluids and one example of a patient who was receiving enteral

feeds via a nasogastric tube. In both cases we saw that the use of fluid and feeds was regularly reviewed by medical staff and there were recorded discussions with family members.

- On Ward 28 we reviewed the records of one patient, including detailed discussions with family members who were concerned that their relative might be hungry. We saw that there was a plan to review the patient's nutritional needs on a daily basis and that, if the patient was alert enough, give them food (comfort tastes) to promote their comfort. Staff we spoke with were aware that the patient could be given food and oral fluids if they were awake. We saw evidence of input from the dietician recorded in the patient's note.
- As part of the last days of life care pathway the assessment of a patient's nutrition and hydration needs was incorporated into a section titled 'additional information'. There were inconsistencies in how nutrition and hydration were recorded in this section and it was not always completed or signed appropriately by medical and nursing staff. This meant that it was not always possible to identify if a patient had had their nutrition and hydration needs assessed in the last days of life, or to ascertain how consistently patients' needs were being met.
- We reviewed draft documentation that was due to be implemented in January 2015 to replace the last days of life care pathway and we saw a section dedicated to nutrition and hydration. This included clear guidance for staff to offer assistance to patients who wanted to eat or drink. The guidance stated that patients may still elect to eat and drink, despite the risk of aspiration, provided the patient was able to understand the risks. In the case of a patient who does not have mental capacity to be able to understand the risks, then eating and drinking should be based on a 'best interest' decision.

Patient outcomes

- The trust had participated in the National Care of the Dying Audit of Hospitals in 2013. The trust performed well in areas such as multidisciplinary recognition that the patient was dying and discussions with the patient and their relatives regarding their recognition of this. We saw that the trust had addressed areas highlighted, such as the assessment of nutrition and hydration, as part of their review and revision of end of life care guidance.
- We viewed a change action report as a result of the audit. Specific examples of areas where action had been taken included the provision of education around medication prescribed for the five common symptoms at the end of life and incorporating a more robust approach to nutrition and hydration requirements within the new end of life care guidance and documentation.

Competent staff

- There were four Macmillan specialist nurses within the SPCT for the hospital and a vacant band 6 Macmillan Support Sister post (1.0 WTE) was to be recruited to in the new year.
- One band 7 clinical nurse specialist had attained a master's degree in cancer care and another nurse was undertaking a master's degree. The end of life lead nurse told us that nurses within the team were encouraged to achieve academically and received regular appraisals and supervision.
- The SPCT had received, or were scheduled to receive, an appraisal before 31 March 2015.
- Some ward-based nursing staff had been identified as end of life link workers with a particular interest in promoting good quality end of life care on the wards. However, we were told that link nurses had not always had specific end of life care training and did not currently attend regular end of life care meetings.
- When we spoke with the end of life lead nurse, we were told that there were difficulties in releasing nursing staff from the wards to attend non-mandatory training and that, where possible, the clinical nurse specialists would deliver micro-teaching sessions on the wards where this was useful. We did not see records of micro-teaching sessions and we were told that these were done on an informal basis; however, we did see posters on the walls in some ward areas about training available on the new end of life care guidance and care plans.
- We saw from minutes of a specialist palliative care directorate meeting that one of the plans to address the issue of releasing staff to attend study days included the provision of one-to-one shadowing placement with the SPCT.

Multidisciplinary working

End of life care

- A weekly specialist palliative care meeting was held on-site at the hospital and included staff from James Cook and Friarage hospitals, regional community teams and local hospice staff.
- The palliative care consultant told us that the integration of a single locality multidisciplinary team had led to closer working and included quarterly education events.
- Patients known to the SPCT were discussed at the weekly multidisciplinary meeting and treatment plans were developed.
- The palliative care consultant also told us that the team work closely with other multidisciplinary teams to identify people in the last year of life, including oncology and neurology.
- On the wards we saw that multidisciplinary discussions were held about patients' treatment and care and multidisciplinary staff members told us they worked together to promote good standards of end of life care.
- Weekly multidisciplinary meetings were carried out between hospital and community palliative care staff and daily handovers were incorporated as part of the SPCT working.

Seven-day services

- The SPCT was not currently staffed or funded to provide a seven-day-a-week, face-to-face service. The service was available Monday to Friday 8.30am to 4.30pm.
- An out-of-hours consultant on-call rota was in operation, with palliative care consultants from two localities providing telephone advice. We viewed patients' medical records that included notes from the palliative care consultant reminding ward staff of the availability of the consultant on call.
- We were told that, from January 2015, there would be the introduction of a Macmillan-funded pilot for palliative care specialist nurses to be on call for telephone advice during the evenings and at weekends.
- The chaplaincy service provided multi-faith pastoral and spiritual support, including out-of-hours cover.

Access to information

- Risk assessments and care plans were in place for patients at the end of life. Patients were cared for using relevant plans of care to meet their individual needs. Once a patient had been identified as being in the last few days of life they were started on the last days of life care pathway. The pathway incorporated prompts for assessments of the patient's symptoms and monitoring the effectiveness of interventions.
- The pathway was used appropriately in most instances, however, we saw one patient who had been identified by the medical team as being in the last days of life who had not been commenced on the pathway, despite the decision to do so being documented in the medical notes. Investigation into this identified that the decision had not been communicated effectively between staff. This meant that, in this instance, the information needed was not necessarily available in a timely way for the delivery of effective care for this individual.

Consent, Mental Capacity Act and deprivation of liberty safeguards

- We viewed six DNA CPR forms across different ward areas where a patient had been identified as lacking capacity to make their own decisions or be involved in discussions about their DNA CPR status. In all but one example there was no record of a mental capacity assessment having been carried out.
- DNA CPR guidance included a statement that decisions should be made in the person's best interest, following the best interests' process as required by the Mental Capacity Act 2005. The trust's DNA CPR policy stated that, "Healthcare documentation needs to reflect that the decision for CPR or completion of a DNA CPR has been made in adherence to the best interest principle of the Mental Capacity Act 2005. Completion of the trust capacity assessment documentation will provide this required documentation".
- While there were references to decisions being made in a patient's best interest, it was not clear what process had been followed in the absence of a clear mental capacity assessment.
- We viewed an example of a trust-wide audit (July 2014) of DNA CPR forms that identified issues such as recording of discussions with the patient or relatives and ensuring the DNA CPR form was correctly completed. We saw that action taken following the audit included the circulation of relevant guidance. We did not see evidence of follow-up audits, although, we did see that the annual monitoring of DNA CPR had been added to the trust's audit plan for 2014/15.

End of life care

Are end of life care services caring?

Good

We observed patients being cared for with dignity and respect. Staff were seen to be compassionate and caring and we saw examples of staff involving patients and their families in their care. Patients we spoke with told us that staff were caring and they felt that the quality of care they received was of a high standard. Bereavement support services provided people with a good standard of support and we saw that some staff had received training in communication skills. Relatives we spoke with told us the level of care and compassion shown to them was good.

Compassionate care

- Throughout our inspection we observed patients being treated with compassion, dignity and respect. Curtains were drawn and privacy was respected when staff were supporting patients with personal care.
- Patients and relatives we spoke with were positive about the way they were supported with their care requirements. One family member told us, "It's one team with everybody involved. They have a lot of compassion on the wards and the palliative care team are very supportive". Another relative told us, "Everyone – from the ward sister to the cleaner – are brilliant. They are very caring and do whatever they can to make us comfortable".
- Relatives told us that a specific area of support from the trust was the availability of reduced parking rates for family and friends who were visiting on a regular basis, with the availability of longer-term parking tickets in these situations.
- Nursing staff, patients and relatives told us that, where possible, patients in the last days of life were nursed in side rooms to enhance privacy and there were flexible arrangements for visiting or staying with relatives.
- The results of a bereaved relative survey from July 2014 showed that discussion with family members about the commencement of the last days of life care pathway was very positive. There were also positive responses about the compassion shown to patients, the level of bereavement support and the information given to family members.

Understanding and involvement of patients and those close to them

- Patients told us they felt involved in their care.
- We observed doctors and nurses speaking with patients and relatives about care and treatment plans so that they could understand and be involved in decisions being made.
- We viewed records in patients' notes that included details of discussions with patients and their relatives around their care and treatment options.
- We observed on a number of wards that, when a patient's condition had deteriorated, staff included family members in discussions about care in the last days of life.
- Information was provided to patients and their relatives in various formats, including face-to-face discussions with medical and nursing staff and other members of the multidisciplinary team.
- A Macmillan information centre was located within the hospital, providing a variety of informative literature to people affected by cancer.
- We viewed information leaflets available to people following bereavement that included registering the death, referrals to the coroner and arranging the funeral.
- We viewed an information leaflet for families dealing with what to tell children in the event of bereavement. This included information on emotional responses, the process of loss and grief and local support services available.

The trust's website included useful links for patients and carers relating to palliative and end of life care. The links included support groups and information services relating to specific conditions as well as details of local hospices.

Emotional support

- Throughout our inspection we saw that staff were responsive to the emotional needs of patients and their relatives.
- We observed instances where emotional support was given to patients and those close to them. One example we witnessed was family members being taken to a quiet family room when a patient's condition had deteriorated.
- A bereavement service had been developed by the end of life lead nurse. Staff we spoke with told us that, since this service had been developed, the process of support for bereaved relatives had improved.

End of life care

- Bereavement service staff provided support to relatives and told us that they were able to access additional support from the end of life lead nurse if it was needed.
- Chaplaincy staff were visible within the hospital and there were prompts available as part of the last days of life guidance documents to ask patients and relatives if they would like support from the chaplaincy.
- Multi-faith chaplaincy support could be accessed as required. Support included counselling and pastoral care as well as the provision of memorial services.
- The chaplaincy service included bedside visits as well as the provision of visualisation and relaxation sessions at the Trinity Holistic Centre based at James Cook. The chaplain we spoke with told us that these sessions were available to all, were not based on a specific faith, and focused on using mindfulness techniques and meditation.
- We saw that patients on the oncology ward were offered alternative therapies from the Trinity Holistic Centre and we were told that there were plans to extend this service to patients with a non-cancer diagnosis.
- We visited the family room on the oncology ward and saw that this was decorated in a calm and peaceful way, providing a quiet space for families. We saw from comments in a visitors' book that this space was appreciated and provided an area of support for relatives and friends.

Are end of life care services responsive?

Good

End of life care at this hospital was responsive to people's needs. All patients requiring end of life care could have access to the SPCT. We saw that referrals to the service from 1 October 2013 to 31 March 2014 totalled 537. The majority of referrals required support with pain and symptom management, with additional needs identified in relation to psychological and family support. The SPCT had an 82% response time on the same day as referral. Ward staff told us the SPCT responded quickly to requests for support and we viewed evidence of continuing input in our review of patient records.

Out-of-hours specialist palliative care input was of a good standard, with a palliative care consultant on call for advice 24 hours a day and new plans to pilot a specialist nurse on-call system from January 2015. We saw evidence of systems to discharge patients home quickly when that had been identified as their preferred place of care at the end of life. There was good evidence of learning from complaints and feedback relating to end of life care.

Service planning and delivery to meet the needs of local people

- The hospital-based SPCT worked closely with community, hospice and other regional partners to ensure that support was available to ward-based staff and patients 24 hours a day.
- The SPCT provided support to facilitate rapid discharge home for patients who wished to die at home. Survey results indicated that a number of patients preferred to die in hospital, however, it had also been identified that information about advanced care planning was not necessarily being discussed with the patient or wasn't being communicated between community staff and hospital staff.
- The SPCT had developed a colour-coded (yellow) patient discharge prescription form so that medication for symptom management could be obtained through the hospital pharmacy more quickly for patients being discharged home in the last days of life.
- Staff on the wards told us that they were able to discharge patients quickly once a decision had been made and that support was available from the SPCT to facilitate this.

Meeting people's individual needs

- Staff on the wards told us that patients with complex needs would be referred to the SPCT for additional support.
- Staff told us that translation and interpretation services were available and accessible when needed.
- Support was available for people with dementia. There was a dementia nurse specialist within the hospital and dementia training was available to all staff. We also saw that the 'This is me' booklet was used in the hospital to help staff better understand the needs of individual patients with dementia.
- There was a learning disability specialist nurse available in the hospital to support the individual needs of patients and provide advice and information to staff.

End of life care

- Patients and family members we spoke with told us that their care was individualised and we observed discussions around care and treatment decisions that demonstrated this.
- Mortuary and bereavement staff told us they had access to information about different cultural, religious and spiritual diversities and that they were able to respond to the individual needs of patients and their relatives.

Access and flow

- Daily multidisciplinary board meeting rounds were undertaken by the SPCT and, during this time, plans relating to care, treatment and discharge were discussed.
- Staff told us that the SPCT were responsive to patients' needs and referrals and that mostly patients would be seen by a member of the team within a couple of hours of referral.
- The SPCT recorded response times showed that urgent referrals were seen as soon as possible, whereas routine referrals would be responded to within one day and face–to-face contact made within two working days. Response time data from October 2013 to March 2014 showed that 82% of patients were seen on the same day they were referred.
- We reviewed a summary report of a pilot of a proactive SPCT intervention from October 2013 to March 2014. The aim of the pilot was to highlight patients on admission to the hospital to the SPCT so that the team could review every known palliative care patient rather than waiting for a referral. The pilot enabled the team to explore the issue of late referrals for specialist support and intervention.
- An audit of the preferred place of death from April to October 2014 showed that, of 143 deaths included in the audit, 79 of these were expected and the patient was on the last days of life care pathway. Of the 79 patients, 53 (67%) had their preferred place of death recorded on the pathway with 49 (92%) achieving their preferred place of death.
- We saw that timely identification of patients who may die in the next 12 months had been incorporated into the work plan of the end of life steering group and members of the SPCT told us this was a priority area for the future care planning process.

Learning from complaints and concerns

- Complaints were handled in line with the trust's policy.
- The specialist palliative care consultant told us they would be informed of complaints specific to end of life care and would participate in a review to inform learning for the future. We were also told that specific failings and actions from substantiated complaints would be reported to the quality assurance committee and the patient experience sub-group as well as the hospital board.
- There had been five complaints relating to end of life care in the last 12 months. We viewed details of two of these complaints. Learning from one complaint about discussions with family members about DNA CPR decisions led to a trust-wide audit of resuscitation decisions, documentation and communication.
- The SPCT were represented as part of trust-wide mortality and morbidity meetings so that all deaths were reviewed with specialist input. One example of a case reviewed as part of this included staff learning about the symptom management of one patient and sharing with the person's relatives.

Are end of life care services well-led?

Good

Leadership of the SPCT was good, with evidence of strategic and operational leadership in terms of both development and delivery of the service. We saw evidence of good team working and cross-organisational relationships, including excellent partnership working across acute, community and hospice services. Key strategies had been identified by the trust and these had been incorporated into an action plan led by an end of life steering group that had representation at board and patient/carer level.

We saw evidence of good leadership at ward level and an understanding of the importance of good quality end of life care among frontline staff. A key area that needed to be developed further was the approach to end of life care education for frontline staff – while we saw a commitment to this from the specialist team, clear action needed to ensure a robust and consistent approach so that staff were equipped to care for people at the end of life. Innovation

activities included the implementation of an enhanced specialist on-call system, a pilot to highlight patients on admission from the community and a bereavement support service.

Vision and strategy for this service

- The trust had created an end of life steering group from September 2014 and had developed a work programme with identified themes, including the provision of care in the last year of life, evaluation, education, staff support and board engagement and assurance.
- We met with the non-executive director with nominated responsibility for end of life care and heard from members of the steering group that work had begun to ensure that good quality end of life care was part of the core business of the trust.
- We were told that one of the key themes was to drive education on end of life care. There was acknowledgement of issues with ward staff attending relevant training due to pressures on their time. Strategies planned to promote end of life care education, including agreeing mandatory training in some aspects of end of life care, the use of e-learning resources, and the provision of nutrition and hydration in end of life care education.
- Strategies proposing to provide support for staff delivering end of life care included establishing regular drop-in support and reflection sessions and undertaking a scoping exercise to establish formal and informal support arrangements on the wards.

Governance, risk management and quality measurement

- Specialist palliative care services report within the structure of specialty medicine.
- We viewed a specialist palliative care directorate structure that reported through to the managing director, head of nursing and chief of service for specialty medicine.
- We viewed minutes from specialist palliative care directorate meetings and saw that these were attended by members of the directorate including the directorate manager, nurse consultant and clinical director.
- There was evidence that complaints, incidents, audits and patient experiences were reviewed and that action was taken as a result.
- We saw from the end of life work programme and the change action report from the National Care of the Dying Audit that there were action plans to develop and improve the end of life care service across the trust.

Leadership of service

- There was strong leadership of the SPCT by the palliative care consultant and the end of life lead nurse.
- We found that engagement between the SPCT and ward-based staff was of a good standard and we saw evidence of good quality end of life care being promoted throughout the hospital.
- We were told that the SPCT was visible on the wards and that they were accessible and responsive to the needs of patients and the support needs of staff working on the wards.
- The SPCT had done good work in raising the awareness of the phasing out of the Liverpool Care Pathway and the development of new guidance, with training sessions advertised on wards and staff having attended micro training sessions on their own wards.
- We saw evidence of Trust Board involvement in end of life care through representation at end of life steering group meetings and we saw that action had been taken to ensure the end of life steering group included patient/carer representation.
- We viewed an example of how patient experiences were presented to the Trust Board to ensure learning, transparency and momentum for continued improvement of services for patients and their relatives.
- A non-executive director was the nominated lead for end of life care from September 2014.

Culture within the service

- Staff talked positively about the quality of care they felt able to provide for patients at the end of life and there was positive feedback from ward staff about the support and input they received from the SPCT.
- It was clear from our conversations with staff that there was commitment to provide the best care possible to people at the end of life. Relatives we spoke with told us they found the approach of staff from different work areas to be consistently supportive and committed to good quality care.
- As part of the development of good quality end of life care services within the trust, there was a strategic intent to further develop a culture of learning and education to improve end of life care services.

End of life care

Public and staff engagement

- A bereavement survey was used to ensure ongoing feedback from relatives to provide information on patients' experience and ensure good care and areas for improvement were identified.
- The trust was participating in a 'Family's Voice' research study where friends and relatives were asked to complete a daily diary of their experience, detailing information about comfort and support given in the last days of life. The aim of the study was to give family and friends a voice and provide feedback to staff and the SPCT.
- The trust had appointed a patient/carer representative to the end of life steering group.

Innovation, improvement and sustainability

- The SPCT was using national guidance and tools to develop the service.
- The Liverpool Care Pathway still in use at the time of our inspection and the SPCT acknowledged that there had been delays in developing the new guidance to replace it. We saw that a pilot of new guidance/documentation had been carried out and that feedback from ward-based staff had been used to streamline and improve the document with a start date of early January 2015 for full implementation. Training sessions had been scheduled for staff to attend and there was a good level of knowledge among ward staff that the new guidance was being implemented.
- A pilot study to improve access and referral to the SPCT had been evaluated, with plans to further develop this work in the coming year with a view to improving patient outcomes.
- A pilot of a specialist nurse on-call system was due to commence in early 2015 following a successful bid for funding from Macmillan. The aim of this pilot was to improve advice and support to patients at the end of life in hospital and in the community.
- Difficulties in recruiting a second palliative care consultant had been addressed by appointing a half-time respiratory consultant with a special interest in palliative care to improve the level of medical input to the SPCT.
- Staff told us that the development of a bereavement service, making use of volunteers and providing information and support to relatives of people who had died in the hospital had been a positive innovation within the service.
- Plans were in place to create work shadowing placements for ward-based nursing staff to work with the SPCT as an approach to improving the ward nurses' knowledge and skills in caring for patients at the end of life

Outpatients and diagnostic imaging

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

Information about the service

The James Cook University Hospital had outpatient departments in 12 locations across the site in Middlesbrough. There was a main outpatient department and 11 other outpatient departments where specialty-specific clinics such as cardiology, dermatology and neurology were held. There was one main radiology and imaging department and a number of other specialist imaging departments such as neuroradiology. PET Computerised tomography (CT) scans were carried out on-site by Allied Healthcare on behalf of the trust. There was a total of 667,652 new and review outpatient appointments between April 2013 and March 2014.

The outpatient departments ran a wide range of clinics, some nurse-led, some led by allied healthcare professionals and some by doctors across a large number of specialties such as urology, gynaecology, orthopaedics, general surgery, breast surgery, orthodontics, ophthalmology, ear, nose and throat (ENT), respiratory medicine, radiotherapy, pain management and neurology. Most imaging services were conducted from one location on the site, however some, specialised radiology services were delivered in specially designed imaging areas.

During the inspection we spoke with 12 patients and six relatives, six senior managers, 20 nurses, six doctors, seven radiographers, 13 healthcare assistants and five administrative staff. We observed the radiology and outpatient environments, checked equipment and looked at patient information.

Summary of findings

Overall, the care and treatment received by patients in the James Cook University Hospital outpatients and imaging departments was effective, caring, responsive and well-led. There were some areas within safety that needed improvement, such as the storage of medication in the imaging department and the regular checking of resuscitation equipment in the imaging department and some outpatient departments. A number of patient information leaflets across the departments were past their review date.

Staff were supported and worked within nationally agreed guidance to ensure that patients received the most appropriate care and treatment for their conditions. Patients were protected from the risk of harm because there were policies to make sure that any additional support needs were met. Staff were aware of these policies and how to follow them.

Patients were happy with the care they received and found it to be caring and compassionate.

Different outpatient departments and imaging sub-specialties carried out local satisfaction surveys and looked at patients' feedback as a way to improve services provided.

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

Outpatients and diagnostic imaging

Are outpatient and diagnostic imaging services safe?

Requires improvement

We rated safety as required improvement. Some checks on equipment had not been carried out regularly in the imaging department and the dermatology department. This was brought to the attention of department managers who took immediate action. In the imaging department, we found that some medication was not stored correctly and there was no stock control in place. Staffing levels were based on the knowledge and expertise of department managers and were flexible to meet the different demands of clinics and patients. There were some vacancies across the departments; however, there were sufficient staff to make sure that patient care was not compromised.

Incidents were reported using the hospital's electronic reporting system. Incidents were investigated and lessons learned were shared with all of the staff. The cleanliness and hygiene in the departments was within acceptable standards. Personal protective equipment was readily available for staff and was disposed of appropriately after use.

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

Patients were, on the whole, protected from receiving unsafe care because medical records were available for outpatient clinics, with only few exceptions. Staff in all departments were aware of the actions they should take in the case of a major incident.

Incidents

- There had been six serious incidents in the outpatient departments across the James Cook site. However, when we looked at these, we found that three were attributable to A&E, one related to ophthalmology theatres and one to a day-case procedure. The two incidents attributable to outpatient clinics related to patients developing pressure sores while wearing plaster casts for broken limbs. These had been investigated and lessons learned had been disseminated to staff.
- There were eight reported radiation incidents across the trust. Details of these were not available by site and the information provided did not grade the incidents. Clear actions had been taken to address these incidents within the imaging departments.
- The trust used an electronic system to record incidents and near misses. Staff we spoke with had a good working knowledge of the system and said they could access the system and knew how to report incidents.
- Staff were able to give examples of incidents that had occurred, and investigations that had resulted.
- Staff were aware of their responsibilities in terms of the recently introduced Duty of Candour regulations.
- The departments had robust systems to report and learn from incidents and to reduce the risk of harm to patients.

Cleanliness, infection control and hygiene

- We saw, and patients reported, that staff washed their hands regularly before attending to each patient.
- Personal protective equipment such as rubber gloves, protective eye glasses and aprons were available to staff And, once used, was disposed of safely and appropriately.
- The imaging department, outpatient areas and clinic rooms were clean and tidy and we saw staff maintaining the hygiene of the areas by cleaning equipment in between patient use, reducing the risk of cross-infection or contamination.
- The imaging and outpatient departments' staff took part in a regular, rolling programme of hand-washing and environment audits. We saw examples of the latest reports which showed high levels of compliance.

Environment and equipment

- The environments of the outpatient departments were well-lit, clean and tidy. Signposting in the departments was clear.
- During our inspection we saw that some of the waiting rooms got busy and staff told us that sometimes there was not sufficient seating for patients in the waiting areas, particularly if clinics were running late. In some of the clinics we observed patients having to stand.

Outpatients and diagnostic imaging

- We saw that there was sufficient equipment to meet the needs of patients, which staff confirmed.
- We looked at the resuscitation equipment in the departments. In most areas the equipment had been checked regularly as required. We noted that the equipment had not been routinely checked in the dermatology, the main imaging and the neuroradiology departments. We noted that there were signatures missing from the documentation. We brought this to the attention of department managers who took immediate action to make sure the equipment was checked.
- Areas in the diagnostic imaging areas where substances, such as cleaning fluids, were stored were not properly secured and could be easily accessed by patients. This was brought to the attention of staff who secured the area.
- Equipment was cleaned regularly and serviced in line with manufacturers' guidance. Staff showed us how they cleaned equipment, which looked clean when we checked it. There were maintenance contracts to make sure that any faulty equipment was repaired or replaced in a timely manner. Staff we spoke with confirmed this.
- A review of the imaging departments by the Radiation Protection Adviser in November 2014 identified no concerns about the imaging departments across the trust.
- During our observations we saw that there was clear and appropriate signage regarding hazards in the imaging department.

Medicines

- The outpatient departments kept a limited supply of medication. This was stored in locked areas, cupboards and trolleys, and kept at the right temperature. Patients who needed medication such as insulin were asked to bring their own supply when they visited.
- One of the departments occasionally used controlled drugs. They had a system for ordering the drugs from pharmacy only when needed by a specific patient and there were checks to make sure the drugs were stored and given to patients safely and appropriately. On occasion when a patient did not attend, controlled drugs were returned to the pharmacy and not stored in the department. We saw completed records when this had happened.
- The imaging departments held some medication associated with imaging procedures. We found that, for some of this, there was no stock control system. Additionally, the product was stored on the floor in a stock cupboard rather than on shelves as it should be.
- Doctors in all of the departments could prescribe additional medication needed by patients.

Records

- Records in the outpatient department were paper based. Within the imaging department, records were digitised and available to be viewed across the trust.
- Records contained patient-specific information relating to the patient's previous medical history, presenting condition, demographic information and medical, nursing and allied healthcare professional interventions.
- Between the two sites, there had been 17 instances recorded on the Datix healthcare software relating to medical records and outpatient departments. The information was not available for individual sites. Records were either lost, unavailable or delayed in all cases. Staff, however, told us that they did not always report missing patient records as an incident.
- Information sent to us by the trust showed that, between April and October 2014, the percentage of notes available for outpatient clinics was consistently above 99.8%.
- Staff told us that they were able to access some information about patients using the electronic records system where some clinic letters were held, although they were not able to access letters relating to the patient from other departments. Staff all agreed that a patient would always be seen as long as there was some information about them available.
- Within the imaging departments, patients' imaging records and reports were securely available for staff to access electronically.
- Nursing assessments of blood pressure, weight, height and pulse were routinely completed when patients attended the outpatient department. We observed these checks being undertaken during our inspection.

Safeguarding

- According to information provided by the trust, by September 2014, 78% of staff requiring level 1

safeguarding for children had completed the training, 60% had completed level 2, 78% had completed initial level 3 training and 83% had completed level 3 plus training.

- Safeguarding adults training varied across the different outpatient departments: dermatology department was 100%; ophthalmology 83%; ENT 88%; main outpatients 53%; trauma 81%; gynaecology 95%; paediatrics 88%; rheumatology 86%; radiotherapy 81%; and cardiology 91%.
- Safeguarding Adults training varied across the different radiology departments with some achieving 100% compliance and others achieving 30% compliance. The average compliance rate was 63%. Safeguarding children training also varied across the different radiology departments with some achieving 100% and others achieving 50%. The average compliance rate was 63%.
- Staff we spoke with were able to describe the action they would take if they had any safeguarding concerns for either children or adults.
- Staff were aware that the trust had safeguarding policies and a safeguarding team they could contact for advice and support if they had any concerns.

Mandatory training

- The outpatient and imaging departments had systems and processes to ensure staff training was monitored.
- Some training was accessed via e-learning and some was classroom-based training sessions.
- Across James Cook outpatient departments, mandatory training rates varied, however, the average rates were: for fire safety 76%; health and safety 83%; infection prevention and control 83%; basic life support 72%; moving and handling 90%; mental capacity 71%; and information governance 94%.
- Across JCUH imaging departments, the mandatory training rates varied however the average rate for consent was 87%, fire safety was 61%, infection prevention and control 71%, medicines management 75%, mental capacity 40%, information governance 77% and slips, trips and falls 76%.

Assessing and responding to patient risk

- There was a process for managing patients who were deteriorating. This included admission via the surgical bed manager or transferring patients to the A&E department which was on-site when required.
- There were emergency assistance call bells in all patient areas, including consultation rooms, treatment rooms and imaging areas. Staff confirmed that, when emergency call bells were activated, they were answered immediately.
- There were policies and procedures in the imaging department to ensure that the risks to patients from exposure to harmful substances was managed and minimised.
- The Radiation Protection Adviser report highlighted that all new equipment had been risk-assessed to ensure the safety of staff and patients.

Nursing and diagnostic imaging staffing

- We looked at the staffing levels in each of the outpatient departments. There were some vacancies; however, all department managers told us that staff were flexible to be able to ensure cover was available. There were no departments with significant vacancies that would affect the way they were able to function.
- Managers told us they were able to adjust the number of staff covering clinics to accommodate those that were busy or where patients had greater needs. The managers in the outpatient departments were experienced staff who were very familiar with the clinics running in their departments as well as the dependencies of the patients attending them.
- Within the imaging departments, there were sufficient radiography and nursing staff to ensure that patients were treated safely. There were current vacancies, however, these were being recruited to.

Medical staffing

- Medical staffing was provided to the outpatient departments by the various specialties which ran clinics. Medical staff undertaking clinics were of all grades, however, we saw that there were always consultants available to support lower-grade staff when clinics were running.
- Staff told us that there was only limited use of locums in the outpatient clinics.

Outpatients and diagnostic imaging

- In the imaging department, staff worked across the trust, taking turns to cover each site. There were no problems with making sure the site had sufficient medical staff to meet patients' needs.

Major incident awareness and training

- There was a major incident policy and staff were aware of their roles in the case of an incident.
- There were business continuity plans to make sure that specific departments were able to continue to provide the best and safest service in the case of a major incident.

Are outpatient and diagnostic imaging services effective?

Not sufficient evidence to rate

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

Patients were protected from inappropriate decisions being made on their behalf because staff understood about consent and mental capacity.

Patients were able to access imaging services 24 hours a day, seven days a week, although some interventional radiology was not available out of hours – although, as a major trauma centre, practice standards state that it is required. Outpatient clinics occasionally ran at weekends and phlebotomy services operated extended opening hours.

Evidence-based care and treatment

- National Institute for Health and Care Excellence (NICE) guidance was disseminated to departments, with a lead clinician taking responsibility for ensuring implementation. Staff we spoke with were aware of NICE and other guidance that affected their practice.
- The outpatient departments had key performance indicators (KPIs) displayed in staff areas. We saw that, on the whole, departments were meeting these targets.
- Managers and staff told us that the KPIs were discussed at team meetings.
- The departments were adhering to local policies and procedures. Staff we spoke with were aware of the impact they had on patient care.
- The imaging department carried out quality control checks on images to ensure that the service met expected standards.
- The trust had a standard operating procedure for Ionising Radiation (Medical Exposure) Regulations.
- There had been six Ionising Radiation incidents in the trust since October 2013.

Pain relief

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

Patient outcomes

- There was a total of 667,652 new and review outpatient appointments between April 2013 and March 2014. Of these, 440,650 were new appointments and 173,589 were review. The ratio of new to review appointments was about 3:1.
- All images were quality checked by radiographers before the patient left the department. National audits and quality standards were followed in relation to radiology activity.
- The outpatient departments took part in trust-wide audits, such as record-keeping, and there was also some local auditing being carried out, however, this was limited as staff had other priorities.
- We saw evidence of clinical audits being carried out by the imaging department, although staff acknowledged that they would like to do more. Audits carried out were based on adherence to Royal College of Radiologists' standards of practice.
- Where audits had taken place, there were action plans to assist with service improvements.

Competent staff

- Staff confirmed that they had received appraisals in the last year. There were systems within departments to make sure that staff received an annual appraisal. We

requested information about the percentage of staff in outpatient and imaging departments who had undergone an appraisal, however, we did not receive this information.
- Staff told us that they did not receive formal clinical supervision as per the trust's policy, but that they felt supported and that department managers were accessible.
- There were formal arrangements for induction of new staff. All staff completed full local induction and training before commencing in their role.
- In all of the departments we visited, managers and staff told us that performance and practice was continually assessed through appraisals.
- All qualified radiographers completed equipment competencies. Continual professional development was planned by the manager on an annual basis to ensure that all statutory and topical subjects were covered.
- Medical revalidation was carried out by the trust. There was a process to ensure that all consultants were up to date with the revalidation process.

Multidisciplinary working

- There was evidence of multidisciplinary working in the outpatients and imaging department. For example, nurses and medical staff ran joint clinics and staff communicated with other departments such as radiology and community staff when this was in the interest of patients.
- Specialist nurses ran clinics alongside consultant-led clinics.
- We saw that the departments had links with other departments and organisations involved in patient journeys such as GPs, support services and holistic treatments.
- A range of clinical and non-clinical staff worked within the outpatients department and they told us they all worked well together as a team. Staff were observed working in partnership with a range of staff from other teams and disciplines, including radiographers, physiotherapists, nurses, booking staff, and consultant surgeons.
- Staff were seen to be working towards common goals, asked questions and supported each other to provide the best care and experience for the patient.

Seven-day services

- The outpatient departments occasionally ran clinics on a weekend; however, most activity within the department happened between Monday and Friday.
- The imaging department provided general radiography, CT, magnetic resonance imaging (MRI), breast imaging, ultrasound scanning and fluoroscopy services for outpatients and inpatients every day. There was a rota to cover evenings and weekends so that patients could access diagnostic radiology when they needed to.
- The trust did not deliver interventional radiology seven days a week; Standards of practice for a major trauma centre clearly state that interventional radiology should be delivered seven days a week. The trust had an informal rota in place to deliver interventional radiology seven day cover.

Access to information

- All staff had access to the trust's intranet to gain information relating to policies, procedures, NICE guidance and e-learning.
- Staff were able to access patient information such as imaging records and reports, medical records and physiotherapy records appropriately through electronic and paper records.

Consent, Mental Capacity Act and deprivation of liberty safeguards

- Staff we spoke with were aware of how to obtain consent from patients, and they were able to describe to us the various ways they would do so. Staff told us that, in the outpatients department, consent was obtained verbally. This was the case for the majority of imaging procedures, although consent for any interventional radiology was obtained in writing on the ward prior to attending the imaging department.
- The hospital had specific paperwork for adults who are unable to consent to investigation or treatment which included sections about assessing people's capacity, best interests and involvement of the family and carers.
- Staff we spoke with were aware of who could make decisions on behalf of patients who lacked or had fluctuating capacity. They were aware of when best interest decisions could be made and when Lasting Power of Attorney could be used.
- Most staff – 90% – were up to date with Mental Capacity Act 2005 training.

Outpatients and diagnostic imaging

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

Are outpatient and diagnostic imaging services caring?

Good

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

Compassionate care

- All of the patients we spoke with spoke highly of the care and treatment they received in the departments. There were no negative aspects highlighted to us.
- During our inspection we saw patients being treated respectfully by all staff.
- We saw that, on the whole, people's privacy was respected.
- Consultation and treatment rooms had solid doors.
- Staff made sure that patients were kept up to date with waiting times in clinic and patients told us they appreciated this.
- We saw that patients and staff had a very good rapport, especially as many patients had been attending clinics for a number of years. Some patients told us that they knew staff so well, they felt like family. Some staff told us the same about patients.
- Staff were observed to knock on doors before entering and curtains were drawn and doors closed when patients were in treatment areas.
- Staff told us that the trust had mechanisms for identifying patients with additional support needs, although we didn't see any examples of this in the records we looked at.

Understanding and involvement of patients and those close to them

- We spoke with 12 patients and six family members in the outpatient and imaging departments. All those we spoke with told us that they knew why they were attending an appointment and had been kept up to date with their care and plans for future treatment.
- Patients felt that they were given clear information and had the time to think about any decisions they needed to make about different treatment options available to them. They also told us that the treatment options had been explained to them clearly with enough information about side effects and outcomes for them to make informed decisions.
- Staff told us that they encouraged patients to involve their families and loved ones in their care, however, they respected the decision of patients when they chose not to involve others.

Emotional support

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

Are outpatient and diagnostic imaging services responsive?

Good

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

There were mechanisms to ensure that services were able to meet the individual needs, such as for people living with dementia, a learning disability or physical disability, or

those whose first language was not English. There were also systems to record concerns and complaints raised within the department, review these and take action to improve patients' experience.

Service planning and delivery to meet the needs of local people

- Staff were supported by colleagues within the wider department at busy times, or when there were absences. This made sure that clinics were only cancelled as a last resort. Between 5 October and 30 November 2014, 5.4% of clinics were cancelled at short notice. This was 0.8% worse than the previous three months and 0.5% worse that the baseline. There was no trust target rate defined.
- The treatment rooms in the department could be used flexibly and were shared between the various outpatient clinics which ran from the site.
- Some of the outpatient departments were busy and staff told us that space was always at a premium.
- The imaging department was able to provide a comprehensive service across the community, in local community hospitals as well as at James Cook University Hospital.
- The imaging department had the capacity to deal with urgent referrals.

Access and flow

- 98% of patients were seen within 18 weeks of referral, for patients not admitted. This was consistently better than the standard of 95% and better than the England average.
- The average referral-to-treatment times for patients with incomplete episodes of care ranged from 94% (meeting the target in June 2014) to 96% (in August 2014). Over the six-month period from June to November 2014, an average of 95% met the target. This was on par with the national target of 95%.
- The trust was performing in line with the England average for patients with all cancers being seen urgently within two weeks.
- The trust was performing better than the England average for the percentage of people waiting less than 62 days from urgent GP referral to first definitive treatment for all cancers.
- Department managers told us that they consistently monitored waiting times and were able to run additional clinics if there were concerns that patients would not be seen within the target waiting times.
- The trust did not routinely collect information about the average waiting time for patients once they arrived at an outpatient clinic and before being called in to their appointment.
- The rates of patient non-attendance for the outpatients department for the October to November 2014 was 7.7%. This was above the trust's target of 5% but was a 0.4% improvement on the previous three months. Managers told us that work was underway to try to reduce the non-attendance rates. One example of this was to send text messages to patients to remind them about their appointment.
- Staff told us that there was always capacity in clinics to see patients who were referred urgently and that double booking two patients in to one clinic slot only happened occasionally to make sure that waiting time targets were met. Information about how often this happened was not routinely collected by the trust and therefore is not quantifiable.
- Within the diagnostics department, the trust was performing better than the England average for patients waiting more than six weeks for a diagnostic test. Although still better than the England average, the percentage had increased from 0.2% in April 2013 to 2.1% in April 2014. By July 2014, the rate had somewhat improved to 1.6%.
- In the imaging department, GP referrals were reported within five days, ultrasounds reported immediately, inpatient CT scans within one day and outpatient CT scans within four days.

Meeting people's individual needs

- Staff were able to access interpreting services if they needed to. Staff understood that it was poor practice to use a patient's family member to interpret.
- The outpatient and imaging departments had information leaflets for patients, some available in different languages on request.
- A number of patient information leaflets across the outpatient departments were past their review date, some by a number of years. From a sample of 17, four trust-produced leaflets and four externally produced

leaflets were out of date. This showed that the trust did not have a mechanism for reviewing information available to patients to ensure that it was still accurate and up to date.

- Staff told us that when patients with learning disabilities attended the department, wherever possible, the patient was seen as a priority. Staff were also aware of the support that was available within the trust and were aware to allow carers to remain with the patient if this was what the patient wished.
- Each department had a dementia champion who had undergone specific training about how to support people living with dementia. Staff in the departments knew who their dementia champion was and were able to consult them for advice.
- Staff were aware of how to support people with dementia. They told us that most patients with dementia were accompanied by carers or relatives and provisions were made to ensure that patients were seated in quiet areas and seen quickly.
- There were a number of catering facilities available for patients to use and departments had access to food and drinks for vulnerable patients or those with conditions such as diabetes. There was a system to make sure that patients who had attended by wheelchair and were waiting to return home were also able to access food and drinks.
- On the whole, departments were able to accommodate patients in wheelchairs or who needed specialist equipment, although some waiting areas could become overcrowded if more than one patient with a wheelchair attended at the same time.
- In the radiotherapy department, CT scanning staff had made simple changes to the environment and recognised the need for additional patient support during the scanning procedure. They had linked with the holistic care centre to provide a calm waiting environment and also to offer massage and other complementary therapies.
- In some outpatient departments, we saw that reading literature and games consoles were provided for patient entertainment.

Learning from complaints and concerns

- There were 117 complaints about the outpatient and imaging departments raised between October 2013 and September 2014. Of these, 17 were substantiated, 27 partially substantiated and 40 unsubstantiated. The most common category of complaint was 'all aspects of treatment' (52). Other common themes were 'delays' (29) and 'attitude of staff' (10).
- We saw comments boxes in a number of outpatient and imaging departments. This meant that patients were able to give instant, informal feedback to services without the need to raise a formal complaint.
- In some of the outpatient and imaging departments, we saw that patient comments and complaints were displayed on the wall in waiting areas. The trust used 'You said, we did' noticeboards to demonstrate to patients that their comments and concerns were listened to and addressed.
- Staff were aware of the local complaints procedure and were confident in dealing with complaints as they arose.
- Information about how to access the Patient Advice and Liaison Service or make a complaint was available in waiting areas.
- Managers and staff told us that complaints, comments and concerns were discussed at local team meetings and any learning was shared. We looked at two sets of team meeting minutes; discussions about complaints were on the agenda for each.
- None of the patients we spoke with had ever wanted or needed to make a formal complaint. Some had raised concerns during their attendance. They told us that their concerns had been dealt with professionally and, where possible, action taken to address the concern. On the whole they were happy with the experience they received from the departments.

Are outpatient and diagnostic imaging services well-led?

Good

The outpatient and imaging departments of James Cook University Hospital were well-led. Staff and managers had a vision for the future of the departments and were aware of the risks and challenges. Staff felt supported and were able to develop to improve their practice. There was an open and supportive culture where incidents and complaints were discussed, lessons learned and practice changed. The department was supportive of staff who wanted to work more efficiently, be innovative and try new services and treatments.

Outpatients and diagnostic imaging

Vision and strategy for this service

- The department managers we spoke with demonstrated vision for the future of the outpatients and imaging services. They were aware of the challenges faced by the departments and the trust as a whole.
- The trust was working on strategies to ensure that the departments worked effectively and efficiently.
- There was a strategy in the outpatient departments to introduce electronic patient records.
- Staff within the services were aware of the challenges faced by their departments and the organisation – for example, the financial challenges. Most told us they were aware that there was a strategy for the trust to make sure it met those challenges.

Governance, risk management and quality measurement

- There were strong governance arrangements which staff were aware of and participated in. The departments had regular clinical governance meetings. For example, staff were given feedback about incidents and lessons learned and the trust regularly produced newsletters to communicate these.
- The organisation had systems to appraise NICE guidance and ensure that any relevant guidance was implemented in practice.
- Within the imaging department, there were examples of audits taking place to ensure that NICE and other guidance was being adhered to. For example, an audit of trauma radiology had recently been undertaken and results and action plans were awaited. Audits of the accuracy of extended radiographer reporting and the accuracy of shoulder ultrasound versus arthroscopy had also taken place.
- Both outpatients and diagnostic imaging had risk registers. These were reviewed and updated regularly. We saw that action was being taken to manage, minimise or eliminate risks.

Leadership of service

- Staff found the managers of the service to be approachable and supportive. All the staff we spoke with told us they were content in their role but that the departments were changing as staff left and new staff started. Many staff we spoke with told us that they had worked at the hospital for many years.
- On the whole, staff within the outpatient departments felt that they were well-led.
- The imaging department had recently restructured its line management and reporting lines of accountability. Staff were aware of the changes and the impact these were having on the service. Staff overall within the imaging department felt that the department was well-led.
- Staff felt that managers communicated well with them and kept them informed about the running of the departments.
- Staff told us that they had annual appraisals and were encouraged to manage their own personal development.
- Staff were able to access some training and development provided by the trust, although this was not as easy as it had been in the past due to staffing level and financial pressures.

Culture within the service

- Staff and managers told us that the trust had an open culture. They felt empowered to express their opinions and felt that they were listened to.
- Staff told us that the chief executive was very approachable and accessible. They were able to tell us about the different ways the chief executive communicated with staff, such as via the blog, core briefing and staff bulletin.
- Staff were encouraged to report incidents and complaints and felt that these would be investigated fairly.
- Managers told us that they felt well-supported by the organisation.
- Members of the board occasionally visited the departments, however, this was not a regular occurrence.

Public and staff engagement

- Governance arrangements were in place and complaints and comments were discussed at team meetings.
- The outpatient department managers told us that their services would be taking part in the national NHS Friends and Family Test once it had been fully implemented across the trust but that there were currently no regular satisfaction surveys being carried out by the department.

Outpatients and diagnostic imaging

- The imaging department was currently carrying out ultrasound satisfaction surveys. This demonstrated high levels of patient satisfaction with this service.
- There was no specific information from the staff survey relating to the outpatient and imaging departments, however, the trust as a whole performed within or better than expectations in all but three elements of the staff survey: the percentage of staff attending health and safety training in the last 12 months; percentage of staff feeling under pressure to attend work when unwell; and staff motivation score.

Innovation, improvement and sustainability

- Staff were being encouraged to look at ways the trust could work more efficiently, make savings and improve quality of care for patients. They told us about how they were encouraged to try changes and then evaluate them to make sure quality of care did not fall when money was saved.
- Staff and managers reported that they were able to influence changes in the way the outpatient and imaging departments were organised and run. We were given examples of changes that had been made to the way the services were run which had improved the patient experience and made the clinics run more efficiently. For example, within the imaging department, work was taking place in collaboration with the local clinical commissioning group to improve imaging services. One outpatient department had introduced colour-coded clinics to assist patients to identify which consultant their appointment was with.
- Of respondents to the NHS staff survey, 66% said they felt they were able to contribute towards improvements at work. There was no specific information for the outpatient departments or the imaging departments.

Outstanding practice and areas for improvement

Outstanding practice

- In medical care services, a team of therapeutic volunteers had been created which was led by a therapeutic nursing sister who had been in place for 18 months. The volunteers had mandatory and dementia training and were in operation 24hours a day. The role of the volunteers was to support patients who may be living with dementia or other illnesses which affected their behaviour and level of supervision required. This included engaging with patients, such as playing board games or other interests patients may have. They also supported patients who required help with eating or wanted to explore their environment. This included supporting them overnight if they were disorientated. The volunteers predominantly worked on wards 10, 12 and 26. The team had been regionally recognised for its work.
- In maternity services, the Families and Birth Forum was involved in the design of the induction of labour suite and championing the take-up of breastfeeding rates through the use of peer supporters, as well as improving information to raise awareness and promote the service to women when they had left the hospital.
- In maternity services, lay representatives were actively involved in the patient experience rounds and 15 Steps Challenge – a series of toolkits used as part of the productive care work stream. The toolkits helped look at care in a variety of settings through the eyes of patients and service users, to help determine what good quality care looks, sounds and feels like.
- In maternity services, a 'baby buddy' mobile phone app was being piloted by the community midwives to inform women of pregnancy issues, common ailments and reasons to seek advice.
- We found outstanding areas of practice in the care and involvement of young people, including a young people's unit, participation and accreditation in the You're Welcome toolkit in four clinical areas, the development of a young person's advisory group, inspections of services by young people and the involvement of young people in staff interviews.

Areas for improvement

Action the hospital MUST take to improve

The trust must:

- Ensure there is a robust safeguarding assessment process in A&E. The safeguarding assessment tool must be consistently completed and regularly audited for all types of presentation. If there are concerns recorded in the safeguarding tool, there must be a contemporaneous (notes made at the time or shortly after an event) documented outcome within the care record.
- Ensure the paediatric environment in A&E is reviewed so it is fit for purpose; including a process to make sure that robust risk assessments are readily accessible and available to all staff in the department.
- Review and address nurse staffing levels in the A&E department.
- Continue to ensure that paediatric care records in A&E are contemporaneous, appropriately completed and regularly audited to monitor staff compliance.
- Ensure all toys in A&E are cleaned regularly to reduce the risk of infection.
- Ensure that there is sufficient numbers of suitably qualified and experienced staff particularly in the A&E department, medical wards, surgical wards and children's wards, particularly the paediatric intensive care unit (PICU).
- Ensure that there are sufficient assisted bathing facilities and moving and handling aides within the children's and young people's ward areas.
- Ensure the timely completion of the refurbishment of the medical block, especially wards 10 and 12, to enable people living with dementia to be cared for in a safe environment.

Outstanding practice and areas for improvement

- Ensure that staff have received an appraisal and appropriate supervision so that the trust can be assured they staff are competent to undertake their role.
- Ensure that there are appropriate arrangements in place for the safe handling and administration of medication, including the reconciliation of patients' medications that all controlled drugs are appropriately checked particularly on CCU and that medication omissions are monitored, investigated and reported in line with trust policy.
- Ensure that all patients' records are maintained up to date, including the recording of identification and stored confidentially in accordance with legislative requirements.
- Ensure that the system for nurse calls is reviewed to ensure that there is no confusion over patients calling for assistance and the emergency alert for cardiac arrest potentially causing delays in treatment.
- Ensure that, where a patient is identified as lacking the mental capacity to make a decision or be involved in a discussion around resuscitation, a mental capacity assessment is carried out and recorded in the patient's file in accordance with national guidance.
- Review arrangements for the recording of do not attempt cardio-pulmonary resuscitation (DNA CPR) decisions, including records of discussions with patients and their relatives to ensure that they are in accordance with national guidance.
- Ensure robust monitoring of the safe use of syringe drivers, with sharing of results and learning from safety audits.
- Ensure that an appropriate concealment trolley is in use for the transfer of the deceased, that risks have been assessed, and that all staff using the trolleys are aware of safe moving and handling practices.
- Ensure staff receive appropriate training, including the completion of mandatory training, particularly the relevant level of safeguarding and mental capacity training so that they are working to the latest up to date guidance and practices, with appropriate records maintained.
- Ensure that ward-based nursing staff are educated in the use of syringe drivers, including best practice in the use of continuous administration of medication for the management of key symptoms at the end of life.
- Provide training for ward-based medical and nursing staff in the assessment of nutrition and hydration for people at the end of life and monitor how assessments are carried out and decisions made.
- Ensure that resuscitation equipment in surgical wards and in outpatients and diagnostic imaging areas is checked in accordance with trust policies and procedures and that this is monitored.
- Ensure there is a system to monitor the stock of contrast media in the diagnostic imaging department.

Action the hospital SHOULD take to improve

In addition the trust should:

- Review College of Emergency Medicine audit data to ensure that good patient outcomes are met.
- Continue to review and reduce the mortality outliers for the Hospital Standardised Mortality Ratio (HSMR) within the trust.
- Consider the commencement of a restraint-training programme for staff in A&E.
- Introduce a formal toy-cleaning schedule in A&E.
- Identify a formal board-level director who can promote children's rights and views. This role should be separate from the executive safeguarding lead for children.
- The trust should ensure that, in medical care services, patients who are medically fit are discharged in a timely manner to the appropriate setting to reduce the number of delayed discharges.
- Review the content and access of risk registers in medical care to ensure that these are robust to appropriately inform decision making regarding actions taken to mitigate any risk. Review the systems in place for learning lessons from complaints to improve the patient's experience.
- Review the progress of mitigating actions taken to prevent patient falls and the development of pressure ulcers, including ward based action plans, on medical care wards.
- Review the care of patients receiving non-invasive ventilation to ensure that care is delivered in line with national guidance, particularly nurse staffing ratios.
- Ensure that there are mechanisms for reviewing and, if necessary, updating patient information, particularly in the outpatients department.
- Introduce patient surveys specific to the outpatients department.

This section is primarily information for the provider

Requirement notices

Action we have told the provider to take

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

Regulated activity	Regulation
Treatment of disease, disorder or injury	Regulation 17 HSCA (RA) Regulations 2014 Good governance The provider must: Ensure that resuscitation equipment in surgical wards and in outpatients and diagnostic imaging areas is checked in accordance with trust policies and procedures and that this is monitored. Ensure that there are mechanisms for reviewing and, if necessary, updating patient information, particularly in the outpatients department. Ensure that there are appropriate arrangements in place for the safe handling and administration of medication, including the reconciliation of patients' medications that all controlled drugs are appropriately checked particularly on CCU and that medication omissions are monitored, investigated and reported in line with trust policy. This was in breach of regulation 10 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, which corresponds to regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Regulated activity	Regulation
Treatment of disease, disorder or injury	Regulation 22 HSCA 2008 (Regulated Activities) Regulations 2010 Staffing The trust must:

This section is primarily information for the provider

Requirement notices

Ensure that there is sufficient numbers of suitably qualified and experienced staff particularly in the A&E department, medical wards, surgical wards and children's wards, particularly the paediatric intensive care unit (PICU).

This was in breach of regulation 22 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, which corresponds to regulation 18 (1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Regulated activity	Regulation
Treatment of disease, disorder or injury	Regulation 18 HSCA (RA) Regulations 2014 Staffing The trust must: Ensure staff receive appropriate training and support through appraisal including the completion of mandatory training, particularly the relevant level of safeguarding and mental capacity training so that they are working to the latest up to date guidance and practices, with appropriate records maintained. Ensure that ward-based nursing staff are educated in the use of syringe drivers, including best practice in the use of continuous administration of medication for the management of key symptoms at the end of life. Provide training for ward-based medical and nursing staff in the assessment of nutrition and hydration for people at the end of life and monitor how assessments are carried out and decisions made. This was in breach of regulation 23 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, which corresponds to regulation 18 (2) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Regulated activity	Regulation

This section is primarily information for the provider

Requirement notices

Treatment of disease, disorder or injury

Regulation 17 HSCA (RA) Regulations 2014 Good governance

The provider must:

Ensure the paediatric environment in A&E is reviewed so it is fit for purpose; including a process to make sure that robust risk assessments are readily accessible and available to all staff in the department.

Ensure that, where a patient is identified as lacking the mental capacity to make a decision or be involved in a discussion around resuscitation, a mental capacity assessment is carried out and recorded in the patient's file in accordance with national guidance.

Review arrangements and improve arrangements for the recording of do not attempt cardio-pulmonary resuscitation (DNA CPR) decisions, including records of discussions with patients and their relatives to ensure that they are in accordance with national guidance.

This was in breach of regulation 20 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, which corresponds to regulation 17 (2) (d) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.