Care Quality Commission

Northumbria Healthcare NHS Foundation Trust

Northumbria Specialist Emergency Care Hospital

Quality Report

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

Ratings

Overall rating for this hospital	Outstanding ☆
Urgent and emergency services	Good ●
Medical care (including older people's care)	Good ●
Surgery	Outstanding ☆
Critical care	Outstanding ☆
Maternity and gynaecology	Requires improvement ●
Services for children and young people	Outstanding ☆
End of life care	Outstanding ☆
Outpatients and diagnostic imaging	Outstanding ☆

Summary of findings

Letter from the Chief Inspector of Hospitals

Northumbria Specialist Emergency Care Hospital (NSECH) is one of the acute hospitals providing care as part of Northumbria Healthcare NHS Foundation Trust. NSECH opened on 16 June 2015, providing specialist emergency care for seriously ill and injured patients from across Northumberland and North Tyneside. It is England's first purpose-built specialist emergency care hospital, with emergency consultants on site 24 hours a day, seven days a week, as well as consultants in a range of specialties working seven days a week. NSECH provides emergency care, critical care, medical and surgical services, a neonatal unit, children and young people's services, maternity services and a full range of outpatient and diagnostic imaging services. The opening of this hospital had resulted in new models of care and different patient pathways in all of its services, with some services, departments and staff teams coming together from different hospitals within the trust.

Northumbria Healthcare NHS Foundation Trust provides services for around 500,000 people across Northumberland and North Tyneside with 999 beds. The trust has operated as a foundation trust since 1 August 2006. Northumbria Specialist Emergency Care Hospital has 337 beds.

We inspected Northumbria Specialist Emergency Care Hospital as part of the comprehensive inspection of Northumbria Healthcare NHS Foundation Trust, which included this hospital, North Tyneside General Hospital, Wansbeck General Hospital, Hexham General Hospital, and community services. We inspected Northumbria Specialist Emergency Care Hospital between 9 and 13 November 2015 and 2 December 2015.

Overall, we rated Northumbria Specialist Emergency Care Hospital as outstanding. We rated it outstanding for being effective, caring, responsive and well-led, and requires improvement for safe care.

We rated surgical services, critical care, children and young people's services, end of life and outpatient and diagnostic imaging services as outstanding. Urgent and emergency services and medical care we rated as good. Maternity and gynaecology was rated as requires improvement.

Our key findings were as follows:

- The opening of NSECH had resulted in a new model of care and different patient pathways in emergency, maternity and medical and surgical care at this hospital. This had resulted in different ways of working for some staff.
- Staff felt fully informed about all the changes which had taken place and were proud of the hospital and the care it provided to the local community and beyond.
- Strong governance structures were in place across the hospital and there was a systematic approach to considering risk and quality management. Senior and site level leadership was visible and accessible to staff. Leadership was encouraged at all levels and staff supported to try new initiatives.
- Managers at all levels understood the challenges of the new model of care and were actively addressing any issues that this had presented, specifically around nursing and medical staffing and patient acuity.
- Staff and patient engagement was seen as a priority with several systems in place to obtain feedback.
- The "Northumbria Way", which incorporates the trust's values, behaviours and culture was evident when we spoke with managers and staff throughout the hospital.
- Staff delivered compassionate care, which was polite and respectful and went out of their way to overcome obstacles to ensure this. All patient feedback was extremely positive.
- Access and flow within the hospital was improving. The new model of care was becoming embedded after only a short time. This was due to the positivity and commitment of staff at all levels embracing the new way of working.

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- The hospital had infection prevention and control policies in place, which were accessible, understood and used by staff.
- Patients received care in a clean, hygienic and suitably maintained environment.
- There was adequate personal protective equipment (PPE) such as aprons and masks available to staff. We routinely saw staff using this equipment during our inspection. Patients told us that staff washed their hands and used gloves and aprons.
- The hospital routinely monitored staff hand hygiene procedures and compliance at the time of inspection was high.
- Between April and October 2015 there had been no cases of methicillin resistant staphylococcus aureus (MRSA) at this hospital and six cases of c-difficile (five of which dated from October 2015 or earlier).
- The hospital had implemented a 'Safer Nursing Care Tool' (SNCT) to assess the staffing requirements across wards. Nurse staffing was maintained at safe levels in most areas.
- The ratio of consultants was better than the England average at this hospital.
- The hospital utilised advance nurse practitioners to support doctors.
- Mortality and morbidity meetings were held at least monthly and were attended by representatives from teams within the clinical business units.
- There was representation from the specialist palliative care team at regular mortality review meetings. Their remit was to review and comment on the end of life care journey of patients and provide constructive feedback and advice in relation to ongoing learning and improving patient care.
- Patients were assessed regarding their nutritional needs using the Malnutrition Universal Screening Tool (MUST).
- Nutritional assistants were employed to provide patients with eating and drinking assistance if required.
- Most wards followed the 'well organised ward' model to ensure that equipment storage was standardised and consistent across the trust.

We saw several areas of outstanding practice including:

In critical care services:

- Over 300 days without an avoidable pressure ulcer and the overall safety thermometer results.
- Patient outcomes and the access and flow data were adjusted internally to monitor the standardised mortality ratio following the trust's change to the model of delivery of care.
- A member of staff had been nominated for multiple awards for their compassionate care: The NHS FAB stuff awards; patient champion of the year: North East, and the team came second in the patient experience national awards.
- The culture of everyone was valued and had a voice seemed embedded in the daily multidisciplinary safety huddle.
- The pit stop handover for all admissions to the unit had been developed with human factors training using formula one pit-stop models, to facilitate a structured handover and improve patient safety.
- Staff considered patients individual preferences and evidently went out of their way to exceed expectations to meet their wishes particularly in end of life care.

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- Staff had adapted the "This is me" booklet and used it for long term patients where they included information from relatives and visitors about patients personal preferences.
- The rehabilitation after critical illness service.
- Leadership of the service was excellent particularly in relation to the planning, preparation and the move to NSECH. Time was taken to engage staff in cross-site working prior to the move and work undertaken to standardise guidelines, procedures and equipment.

In children and young people's services:

- Planning for the new model of care and facilities in the hospital was excellent. Managers had fully engaged staff in planning which resulted in a smooth transition into the new build and services being quickly up and running. Following a training needs analysis, staff had received additional training to ensure they had the correct skills to deliver the new model of care. There was ongoing work to further support staff in adjusting to the new services especially in the Children's Unit.
- The volume of information collected from service users was outstanding. The trust had innovative ways of engaging with patients and used a number of different methods for collecting information. This was shared with managers and clinical staff in order to improve services for children and young people.
- A mother told us that while she was in recovery following the birth of her baby, a member of staff from the special care baby unit brought her a picture of her baby. She was extremely happy with this, as she was upset that she had to be separated from her new born baby. We thought this was extremely caring and responsive to her needs.
- A parent passport was in place in the special care baby unit. This was held and completed by parents to increase their involvement in caring for their baby. The passport summarised the parents confidence and competence in carrying out this care. Following discharge, it provided a record for other healthcare professionals to understand the continuing needs of the parents in caring for their baby.
- The trust was supporting a Consultant Clinical Psychologist in a longitudinal study to address the question of how health services could contribute most effectively to facilitating successful transition of young people with complex health needs from childhood to adulthood. The study involved young people from the conception of the research idea and throughout the course of the programme. Information from the study was fed into the National Institute for Care Excellence (NICE) as part of a consultation on draft guidelines on transition. The trust had a robust trust policy, which included transition and transfer of young people with long-term conditions and disabilities, which was being rolled out across business units. We thought the work on transition was outstanding.

In end of life care:

- The model of end of life care services working alongside acute services at NSECH and out into the community was an innovative and pioneering approach to care.
- Specialist palliative care was aligned with emergency care to ensure patients received specialist palliative care at the earliest opportunity.
- The trust had responded to a higher than anticipated number of referrals to the specialist palliative care team by increasing the specialist palliative care resource within the hospital.
- The trust had adopted an innovative approach to providing an integrated person-centred pathway of care in partnership to provide services that were flexible, focused on individual patient choice and ensured continuity of care.
- The trust had taken positive action to increase the number of patients who were dying in their usual place of residence.

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- The trust was supporting increasing numbers of non-cancer patients.
- The leadership, governance and culture were used to drive and improve the delivery of high quality person-centred care through collaboration and partnership working. The trust had clear leadership for end of life care services that was supported at the top of the organisation.
- Investment in end of life and palliative care services was apparent and staff we spoke with consistently told us they felt that end of life care was a priority for the trust.
- Innovations were seen in relation to a focus on spiritual support and an assessment model that aimed to increase staff's understanding of spirituality and confidence around assessment.
- Partnership working with Marie Curie and joint management and nursing posts enabled the trust to provide prompt support and continuity of care for patients being discharged to their preferred place of care in the community.
- The development of a tool for the assessment of patients spiritual needs that focused on providing staff with prompts that would make it easier for them to have this discussion with patients. The tool also helped staff to engage in a clearer way to ensure patients understood.

In outpatient and diagnostic imaging services:

- The hospital provided a seven day a week consultant led outpatient trauma service for people from across Northumberland and North Tyneside to access, as well as a teleconference clinic for patients who lived in Berwick, almost 60 miles away.

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

Importantly, the trust must:

- Complete a comprehensive gap analysis against the recommendation made for the University Hospitals of Morecambe Bay NHS Foundation Trust.
- Ensure that the maternity and gynaecology dashboard is fit for purpose, robust and open to scrutiny.
- Ensure that the entry and exit to ward 16 in Maternity are as safe as possible to reduce the risk of infant abduction.
- Ensure that the storage of emergency drugs, within maternity services, are stored safely in line with the trust's pharmacy risk assessment.
- Ensure risk assessments in relation to falls, pressure ulcers, VTE and nutrition are consistently completed for all patients within medical care services.

In addition the trust should:

- Ensure that levels of staff training continue to improve in the hospital so that the hospital meets the trust target by 31st March 2016.

In the emergency department:

- Ensure nursing care documentation is completed consistently throughout the department.
- Create a more dementia friendly environment (cubicle) to support patients with dementia.

In medical care services:

- Continue to review staffing levels on medical care wards.

In critical care services:

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- Review the nurse staffing establishment to consider the inclusion of an additional supernumerary registered nurse over and above the clinical co-ordinator as recommended in Core Standards for Intensive Care Units (2013).
- Review the provision of the critical care outreach service following the change in model of delivering care and in relation to national critical care outreach standards.
- Consider the role of a clinical nurse educator on the unit as recommended in Core Standards for Intensive Care Units (2013).

In Maternity and gynaecology services:

- Ensure that the clinical strategy for maternity and gynaecology services which is embedded within the Emergency Surgery and Elective Care Annual Plan, sets out the priorities for the service with full details about how the service is to achieve its priorities, so that staff understand their role in achieving those priorities.
- Ensure all Patient Group Directions are signed by staff as appropriate.
- Consider sorting emergency drugs in tamper evident boxes if they are stored in an open ward area.
- Ensure that record keeping is consistent across all services.
- Consider reviewing midwifery staffing levels across the trust to ensure the midwife to birth ratio at NSECH is reduced from 1:36 to 1:28 as recommended.
- Consider the reconfiguration of pregnancy assessment unit to the Northumbria Specialist Emergency Care Hospital, to improve assess and flow of patients.
- Consider the provision of midwifery support for Teenage mothers in Northumbria in order to provide an equitable service throughout the Trust.

In children and young people's services:

- Fully embed the Duty of Candour with all staff.
- Ensure patients clinical records are always available for children attending for day surgery at the hospital.
- Address the issue of clerical support at weekends in the Children's Unit, to ensure there is not a delay in sending out electronic discharge summaries to GPs.
- Ensure that non-qualified staff in the Children's Unit have clearly defined job roles and have robust competencies in place.

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	We rated the emergency department at this hospital as good because: There was an open and transparent culture with regard to the management of risk. Staff reported incidents and we saw examples of the duty of candour. The department was visibly clean and we observed good hand hygiene. There was a programme of mandatory training and managers were working towards training and staff appraisal targets. The completion of documentation was variable. Staffing levels had been increased as a result of the increasing demand on the service and the department was achieving the government's 95% target for admitting, transferring and discharging patients within four hours of arrival to the emergency department. There was an effective and comprehensive process in place to identify, understand, monitor and address current and future risks. However, processes and systems were still new and, as alternatives to improve patient flow, experience and outcomes were explored, were being revised. The department had an ongoing audit programme that encompassed both local and national audits. Where performance was noted below national standards, the department had implemented action plans to improve the care and treatment of patients. Feedback from patients and their relatives regarding the care they received while using the service was consistently positive. Where people had cause to complain, the senior management team had processes in place for responding to their concerns. Staff were observed to engage with patients in a compassionate and caring manner. The nursing documentation was not comprehensive regarding the nursing assessments and care and there was no specific guidance or facility for caring for a patient with dementia or a learning disability. All staff within the emergency department were clearly engaged with the new model of specialist emergency care at NSECH. The vision and strategy had been developed through a structured planning

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process with engagement from internal and external stakeholders, including people who use services, commissioners and others. The department's clinical and managerial leadership drove a culture where change was embraced and where the focus was on the patient experience. The purpose built emergency department was equipped with new technology and equipment.

Medical care (including older people's care)

Good

Overall, we rated medical care services at this hospital as good, with safe as requires improvement because:
Staffing levels and skill mix were planned and reviewed. Any staff shortages were responded to however there were times when rosters indicated that registered nurse staffing levels did not meet planned levels, particularly on one ward. This was managed and senior staff were regularly reviewing ward establishments following the collation of patient dependency data. We found varying degrees of completeness across all wards in relation to both nursing and medical records, specifically in relation to pressure area, falls and nutritional risk assessments. VTE assessment was variable on the medical wards. The lowest compliance was 55% on one ward in September; a second ward also reported only 60% compliance in assessment in August 2015. Data received from the trust indicated that, when VTE assessment compliance was low, this corresponded with lower percentages of patients receiving prophylactic treatment.In some areas, for example, when the assessment was identified at 55%, only 86% of patients received the appropriate preventative treatment. People were protected from avoidable harm and abuse. Staff fulfilled their responsibilities to raise concerns and report incidents and near misses. There was evidence of robust sharing and learning from incidents. All areas were visibly clean and well maintained. Staff were aware of and adhered to infection control procedures. When necessary patients were appropriately isolated to minimise the risk of cross- infection. The trust had policies and procedures in place for the safe management

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of medicines. Incidents relating to medicines were low. The trust had installed an electronic fingerprint recognition system for the safe and secure handling of medicines.

Local pathways, policies and guidelines (that were regularly reviewed to ensure that these were in line with national guidance) and formal procedures to audit compliance with standards, were implemented. There was limited evidence of specific patient outcomes because of the limited period of time that the hospital had been open. Staff were aware of key quality performance indicators. Robust multi-disciplinary working with all disciplines was evident across all areas of the hospital. Seven day services were part of the new model of care and were becoming embedded within the hospital.

Feedback from patients and visitors was overwhelmingly positive. Patients felt involved in their care and their physical needs were not the only consideration. All patients said they felt emotionally supported by staff. Patients and relatives understood what their plan of care was and were able to be involved with this. Staff were committed to providing high quality patient focused care.

Engagement with local stakeholders was excellent. The service had many innovative projects in place to engage and respond to the health needs of the local population. The model of care at NSECH provided benefits for the trust's other hospital sites. Separating serious emergencies from planned care meant that patients attending for planned operations, tests, and outpatient clinic appointments at other bases did not have their care affected by the need to prioritise seriously ill emergency patients. Patients could access the service in a timely way and continuity of care was maintained. Since opening 6,336 (93%) of patients had been admitted and discharged from the same ward or unit. 452 (7%) had only moved ward once during their admission and 16 patients had moved wards twice. This meant that the majority of patients had consistency in relation to their care and treatment.

The medical services were managed by an experienced and cohesive team who demonstrated

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an understanding of the challenges of providing high quality, safe care. Within this hospital, local managers had particular challenges regarding staffing issues and completion of risk assessments which were acknowledged but still required addressing and embedding. Governance processes were in place which allowed clear identification and monitoring of risk and we saw evidence of related progress and action plans. Staff and patient engagement was seen as a priority with several systems in place to obtain feedback. Innovation was encouraged. Diabetes research, in particular the long term self-management of diabetes, was at the forefront of medical research within the medical directorate.

Surgery

Outstanding ☆

We rated surgery services as outstanding because: The hospital provided a new model of elective and emergency care to its population and at the time of inspection NSECH had been open for 5 months. The provision of specialist emergency surgical care, with consultants on site 24/7, as well as consultants in a range of specialties working seven days a week was embedded across the trust and appeared to be working well. The change to the provision of emergency and high risk surgical services centred at NSECH ensured patients received the right care and treatment, support services, nursing and clinical staff at the appropriate time and location. The strategy of the service clearly identified the new model of emergency and high-risk surgery provided at NSECH and the relationship between NSECH and the base hospitals. The new model was under constant review to determine the most effective site to undertake different procedures depending upon risk and safety. Local communities had been engaged in the consultation and development of the strategy for the new model of care. This had a positive effect upon the feedback received from patients and relatives received during the inspection at NSECH and also at the base hospitals. At the end of September 2015, the trust was meeting the NHS operational target of 92% of patients waiting less than 18 weeks for treatment. Six theatres were available at NSECH, seven days a week. There were innovative approaches to delivering patient care and evidence based practice

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based on national guidance and benchmarking was evident across the trust. A dedicated team contacted patients by telephone following discharge to gather information about any immediate concerns the patient may have and provide advice and guidance.
Strong governance structures were in place across surgery and there was a systematic approach to considering risk and quality management. Performance data and information was available and displayed at NSECH, albeit limited from the month of opening in June 2015. The trust team had been consistent in its approach to communication, and having good systems and processes in place to protect patients and maintain their safety. Staff we spoke with in surgery at NSECH understood the process for reporting and investigating incidents and there was a good reporting and feedback culture. There had been no serious incidents at NSECH and 150 reported incidents in surgery since June 2015, with very low incidence of minor patient harm being recorded at this site. Senior managers had a clear vision and strategy for the division and identified actions for addressing issues within the division. We were told the service had a commitment to a people centred approach delivering high quality care with robust assurance and safeguarding and saw this in practice during the inspection. Staff told us they were encouraged to challenge existing practices, look for improvements and suggest ways to develop and introduce innovative practice. Staff reflected on the strong leadership and visibility of senior members of the trust board. This motivated staff and they felt that senior leadership reflected the vision and values that they shared with the organisation.
Surgical staff we spoke with at NSECH and across all base sites understood the new model of care and consistently spoke of being proud to work for the trust.
The surgical wards were a modern design with majority single room accommodation. They were spacious and visibly clean.We observed new pharmacy technology and new systems for monitoring patient/nurse calls. Staffing levels were good at the time of inspection. Staffing had been reviewed since opening and an increase in both

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medical and nursing cover had been agreed. Senior and site level leadership was visible and accessible to staff at NSECH. Staff spoke very positively about their immediate line managers and senior leaders and a positive culture was evident during the inspection.
We observed patients being cared for with dignity, compassion and respect in all surgical wards and departments. The 22 patients we spoke with were very positive about the service and staff and surgical services in NSECH had received positive feedback scores and comments for the first few months of delivering services at this hospital site. There was a comprehensive approach used by the trust to capture the patient experience but information was limited at the time of inspection of NSECH. Patients commented they had been treated: '…very well, promptly and by staff who were caring and treated them well', '…although staff are busy, they always have time for a chat, couldn't be better' and '…the service was professional at all times'.

Critical care **Outstanding** ☆

We rated critical care as outstanding because:
People's individual needs were central to the planning and delivery of critical care services. The service involved patients and stakeholders in the new model of care and the build of the unit to ensure it provided an innovative approach to integrated person-centred care. The management team worked with leads in the trust to plan service delivery.
Governance and performance metrics were proactively reviewed. Governance arrangements enabled the effective identification of risks and monitored these risks and the progress of action plans. There was evidence that controls were in place to mitigate these risks.
An experienced and cohesive team managed the service. They demonstrated a clear understanding of the challenges of providing high quality, safe care. Continuous improvement was driven with the involvement of frontline staff that felt valued and who were engaged in service development. The

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leadership team motivated staff to succeed. It was clear that staff had confidence in the leadership at all levels and spoke highly of the culture within the unit. There were high levels of staff satisfaction.
All staff considered patients individual preferences and evidently went out of their way to exceed expectations to meet their wishes. Staff were motivated and inspired by leaders to deliver person centred, holistic care. One visitor told us the staff made them feel like their relative was the only patient on the unit and nothing was too much trouble. Staff had been nominated for awards for their compassionate care. Formal feedback from patients and relatives was continually positive about all aspects of their care.
Care was led 24 hours a day, seven days a week by a consultant in intensive care medicine and staffing was in line with Core Standards for Intensive Care (2013). Patient outcomes were the same as or better than the national average and care and treatment was planned and delivered in line with current evidence based guidance and standards. There was evidence of excellent joint and patient centred multidisciplinary team working. The culture of 'everyone had a voice' was embedded.
Governance arrangements enabled the effective identification of risks and monitored these risks and the progress of action plans. There was evidence that controls were in place to mitigate these risks.
The service had a good track record in safety. There had been no never events or serious incidents reported. Between July and October the unit achieved 100% harm free care on three out of four months and it had been over 300 days since there had been an avoidable pressure ulcer.

Maternity and gynaecology — **Requires improvement**

We rated maternity and gynaecology services as requires improvement because:
We found the infant abduction policy had not been tested since the move to the new unit, despite an incident reported by a member of the public who was able to leave and enter the unit unchallenged.
On inspection we found placentas were stored appropriately, however, we found inappropriate non-clinical items stored in the placenta freezer. We raised concerns with staff, and the items were removed immediately by senior staff. The storage of

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emergency drugs on the birthing centre and ward 16 were not in line with the trust's pharmacy July 2015 risk assessment, and the service was not using tamper evident boxes in which to store drugs required in ward areas. We reviewed 11 records of women who had completed the pregnancy pathway and found inconsistencies in the completion of which pathway women were following in particular who was the lead professional in antenatal and labour notes (partogram). This may lead to high risk women not receiving an appropriate plan of care or review by medical staff. We also found notes had incomplete fluid balance charts. Due to the unexpected levels of activity the unit had experienced staffing numbers which were worse than the national recommendations. However, service leads had recognised this and plans were in place to recruit additional staff. There were systems for reporting, investigating and acting on adverse events. The service collected and reviewed information about standards and safety and shared it with staff.

Although the senior management team were aware of the challenges to the service and had a vision for the future, the formal clinical strategy for maternity or gynaecology services which was contained within the surgical business unit annual plan was very generic in terms of outcomes and references to maternity and gynaecological services were minimal. This did not support identification of how the service was to achieve its priorities or support staff in understanding their role in achieving the services priorities. The risk register did not reflect the current concerns of the senior management team, and had no mention of the concerns raised about infant abduction. We found there were risk and governance processes in place; however, we were concerned with the levels of scrutiny provided by the directorate with regard to the clinical dashboard. Risks were reported and monitored and action taken to improve quality. The views of the public and stakeholders through participative engagement were actively sought, recognising the value and contributions they brought to the service. There was some evidence of innovative practice. The service used evidence based guidelines to determine the care and treatment they provided.

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We reviewed the annual audit plan; however, staff we spoke with informed us that since the move to the new hospital they had not been involved in any audit activity apart from the regular local audit. We found staff had the correct skills, knowledge and experience to do their job. Training ensured medical and midwifery staff could carry out their roles effectively. Competencies and professional development were maintained through supervision. Women told us their pain was managed, also they were provided with choice. Women were offed support to feed their baby's, and hot food and drinks were available for mothers 24 hours a day. Patient outcomes were monitored using the maternity dashboard but not all patient outcomes were within expectations; however, we saw that investigations were underway in areas of concern.

Patients were valued as individuals, and we were provided with examples of this. Following a number of complaints in 2014 at Wansbeck hospital, the service had put in place compassion training for all staff. In the 2015 CQC maternity experience survey placed the service in the top 10 hospital trusts. We observed patient care in the ward environment staff were seen to be supportive and respectful. Women received emotional support and were involved in their care.

The service had gone through a significant reconfiguration to a new model of care, which saw the amalgamation of delivery services previously based at Wansbeck and North Tyneside General Hospitals on the one NSECH site. Policies were in place to ensure that patients were seen at the right place and at the right time. We found the service had begun to engage with service users to inform developments within the service. There was no pregnancy assessment unit on site; women were triaged on the birthing centre. Staff we spoke with informed us on occasion this had reduced the capacity on the birthing centre for labouring women and the number of staff able to look after them. Service leads informed us this was high on their list of priorities and were working on short and long term plans for the future. There were a number of specialist midwifery roles to support women, for example, a high risk midwife and diabetes midwife

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

Services for children and young people

Outstanding ☆

We rated services for children and young people at NSECH as outstanding because:
Access to the Children's Unit and 24 hour care was excellent with patients reporting they were seen by relevant staff and treated quickly. The performance for children being seen and either discharged or admitted within 4 hours in the Children's unit was 99%. A triage assessment tool was in place to identify clinical acuity and fast track children when necessary. There were robust arrangements for the transfer of babies and children needing a higher level of care. Other organisations and the local community had been involved in the planning and delivery of this service. There was a proactive approach to understanding the needs of children and young people to ensure that care was delivered to meet their needs. The new facilities were excellent, met national standards and the needs of children and young people.
There was a clear vision for this service with strong leadership. The management team were very positive about their services and very proud of their staff. They sought to make continual improvements and were passionate about and strived to deliver high quality patient care. Staff told us that managers were both visible, approachable and open to new ideas. Robust and effective governance arrangements were in place to protect patients from harm. Governance arrangements and the risk register were proactively reviewed. There was a high level of staff engagement and excellent team working. Staff felt proud of the services they delivered to patients and there was a culture of continual improvement. There were inventive ways of engaging the public and service users in order to improve the patient experience. The service supported and encouraged innovation.
There were arrangements in place to protect patients from abuse and avoidable harm. There was a positive culture of reporting and learning from incidents. The clinical environment and equipment was clean and staff observed good infection control

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practices. Medicines, including controlled drugs, were stored securely and dispensed safely. Safeguarding systems were robust in protecting children and young people from harm. Staffing levels were safe although further work was being undertaken to ensure staffing levels in the Children's Unit could meet future demand. There were effective measures in place to assess and respond to a child whose condition was deteriorating.

Services for children and young people were effective. Clinical practice was based on local and national standards and was regularly audited to ensure standards continually improved. There was involvement in regional networks to learn and share good practice. Staff were competent to deliver care. Additional training needs were being identified and training planned as the new service continued to develop. Policies and procedures were in place, up to date, and staff knew how to access them.

Staff provided compassionate care and treated children and parents with kindness and respect. We heard consistent praise from children and parents who told us they felt well informed and involved in decisions about their care. Both the Children's Unit and the Special Care Baby Unit (SCBU) scored highly in patient surveys. In the Special Care Baby Unit, we saw that staff gave special attention to siblings to help them feel included. They also gave parents a call 48 hours after discharge to offer advice and support. Emotional support was good with the availability of specialist bereavement midwives in SCBU and easy access to in-reach mental health services in the Children's Unit.

End of life care — **Outstanding** ☆

We rated end of life care as outstanding because: We found that the hospital was providing high quality end of life care services using innovative approaches and effective partnership working. There had been significant investment in palliative and end of life care services and the trust was responsive to addressing issues as they arose with flexibility in relation to staffing and resources. There was a clear vision, strategy and leadership at all levels of the organisation with a focus on good quality end of life care. Patients were cared for

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using a truly holistic approach and staff teams were committed to working collaboratively to meet individual needs. The structure of the hospital liaison service that had been developed in partnership with Marie Curie provided additional flexibility to enable specialist palliative care staff to provide support to patients at the end of life irrespective of the complexities of their condition. This was sometimes in the form of supporting a rapid discharge to the patients preferred place of care in the community and as such involved a very hands on approach to ensuring as straightforward a transition as possible with hospital staff accompanying the patient in order to handover to community staff.

We saw evidence of the use of national guidance and appropriate anticipatory prescribing of medicines at the end of life. Multidisciplinary working was apparent between different disciplines and across services within the hospital and the community. The hospital liaison palliative care team worked well alongside the acute teams at NSECH to provide palliative and end of life care specialist support at the earliest appropriate opportunity. There was an emphasis on working to increase the confidence and competence of ward based staff to ensure all patients had access to good quality end of life care. Patients and their families were involved in care and we saw a number of initiatives in use to record patient wishes including advance care plans, emergency healthcare plans and treatment escalation plans.

There was consistent evidence that staff were motivated to go the extra mile. Spiritual care was seen to be important with initiatives having been developed in supporting staff in the assessment of spiritual needs through training and the use of an internally designed assessment tool. Chaplaincy support saw multi-denominational ministers and faith leaders available for patients, relatives and staff.

The leadership, governance and culture were used to drive and improve the delivery of high quality person-centred care through collaboration and partnership working. The trust had clear leadership for end of life care services that was supported at the top of the organisation. There was a clear

proactive approach to seeking out and embedding new and more sustainable models of care. Staff we spoke with consistently told us they felt that end of life care was a priority for the trust.

Outpatients and diagnostic imaging

Outstanding ☆

We rated outpatient and diagnostic imaging at NSECH as outstanding because:
The service was flexible and ensured continuity of care. People accessed services in a timely and convenient way. The hospital provided a seven day a week consultant led outpatient trauma service for people from across Northumberland and North Tyneside to access, and a teleconference clinic for patients in Berwick, almost 60 miles away. Trauma clinics and related services were organised so patients only had to make one visit for investigations and consultation or, if possible did not have to return to hospital for unnecessary appointments. It also provided patients with timely advice on the management of their injuries while at home. Radiology reporting was swift with an emphasis on “results within minutes” for trauma patients. This enabled medical teams to complete assessments and manage risks quickly. Reporting times for urgent and non-urgent procedures consistently met or were better than national and trust targets for all scans and x-rays for emergency patients, inpatients, and outpatients. There was widespread involvement with the local population, primary care, and commissioners to plan this new model of emergency care to ensure that the service met people’s needs. Since the departments opened in June 2015, there had been no formal complaints. However, the department teams recorded any concerns and informal complaints and used patient feedback proactively to prevent recurrence that might affect others.
Staff and managers had a clear vision for the future of the service. They knew the risks and challenges the service faced. Staff we spoke with at all levels felt supported by their line managers, who encouraged them to develop and improve their practice. Staff embraced change and there was a real focus on patient experience and leaders and managers drove this. There were well embedded systems and processes for gathering and responding to patient experiences and the results

Summary of findings

were well publicised throughout the departments. Early feedback provided by patients for the virtual trauma service was very positive. There were effective and comprehensive governance processes to identify, understand, monitor, and address current and future risks. These were proactively reviewed. There was an open, honest and supportive culture where staff discussed incidents and complaints, lessons learned and practice changed. All staff were encouraged to raise concerns. The departments supported staff who wanted to work more efficiently, be innovative, and try new services and treatments and ways of engaging with the public.

The hospital had good systems and processes in place to protect patients and maintain their safety. The departments were clean and hygiene standards were good. Medical records were stored and transported securely. Staff followed professional best practice guidelines to plan and deliver good quality care and took part in a wide range of national and clinical audits. Diagnostic imaging provided services for inpatients and emergency patients seven days a week and service availability was increasing and continuously improving. Staff undertook regular departmental and clinical audits to check practice against national standards.

Staff respected patients privacy, dignity, and confidentiality at all times. Staff spent time with patients and those close to them to give explanations about their care and encouraged them to ask questions.

Northumbria Specialist Emergency Care Hospital

Detailed findings

Services we looked at

Urgent & 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 & Diagnostic Imaging

Detailed findings

Contents

Background to Northumbria Specialist Emergency Care Hospital

Northumbria Specialist Emergency Care Hospital (NSECH) is one of the acute hospitals providing care as part of Northumbria Healthcare NHS Foundation Trust. NSECH opened on 16 June 2015, providing specialist emergency care for seriously ill and injured patients from across Northumberland and North Tyneside. It is England's first purpose-built specialist emergency care hospital, with emergency consultants on site 24 hours a day, seven days a week, as well as consultants in a range of specialties working seven days a week. This model of care supports Professor Sir Bruce Keogh, NHS England National Medical Director's future vision of urgent and emergency care in England as outlined in his report 'Transforming urgent emergency care services in England: Urgent and Emergency care Review: End of Phase 1 Report' (13 November 2013). One of the proposals in this report was that people with more serious or life threatening emergency needs should be treated in centres with the very best expertise and facilities in order to reduce risk and maximise chances of survival and a good recovery.

NSECH provides emergency care, critical care, medical and surgical services, a neonatal unit, children and young people's services, maternity services and a full range of outpatient and diagnostic imaging services. The opening of this hospital has resulted in new models of care and different patient pathways in all of these services, with some services, departments and staff teams coming together from different hospitals within the trust.

Northumbria Healthcare NHS Foundation Trust provides services for around 500,000 people across Northumberland and North Tyneside with 999 beds. Northumbria Specialist Emergency Care Hospital has 337 beds.

We inspected Northumbria Specialist Emergency Care Hospital as part of the comprehensive inspection of Northumbria Healthcare NHS Foundation Trust, which included this hospital, North Tyneside General Hospital, Wansbeck General Hospital, Hexham General Hospital, and community services. We inspected Northumbria Specialist Emergency Care Hospital between 9 and 13 November 2015 and 2 December 2015.

The emergency department at NSECH had a total of 36 cubicles, four resuscitation bays, one paediatric resuscitation bay and two mental health assessment rooms. The layout of the department was in three areas, referred to as 'pods'. There was a green, orange and red pod. Each had a central nurses' station surrounded by cubicles. They all led to each other. Patients were treated in the different pods according to the severity of their presenting condition. The resuscitation room was separate and was opposite two relatives' rooms. The paediatric area was adjoining the paediatric short stay ward. From 15th June 2015 to the end of October 2015, 33,894 patients were seen. Each month there was an average of 7,612 patients attending the emergency department and each month this number was increasing.

Detailed findings

The critical care unit at NSECH opened on 15 June 2015. Prior to this the trust provided critical care services across two units, one at North Tyneside General Hospital and one at Wansbeck General Hospital. The unit at NSECH had eighteen beds arranged in two pods of nine beds. Fifty percent of the beds were single side rooms which meant the unit had capacity to isolate patients who had acquired infectious diseases as well as ensuring single sex accommodation. It was staffed to care for a maximum of nine level three patients (who require advanced respiratory support or a minimum of two organ support) and eight level two patients (who require pre-operative optimisation, extended post-operative care or single organ support).

Inpatient maternity services were transferred to NSECH in June 2015 from the Wansbeck General Hospital. The trust offered a range of maternity services for women and families based in NSECH.This included antenatal and postnatal inpatient care for women with low-risk pregnancies to specialist care for women who needed closer monitoring. There was also an emergency gynaecology service provided on the surgical assessment unit. Between June 2015 and September 2015 there were 827 births at NSECH.

When NSECH opened in June 2015, the service for children and young people transferred here from other hospitals within the trust. Services for children and young people were provided at two main locations within NSECH. The Special Care Baby Unit and the Short Stay Paediatric Assessment Unit. The Special Care Baby Unit had relocated from Wansbeck General Hospital to NSECH and staff from Ward 10 at North Tyneside General Hospital and the Children's Unit at Wansbeck had moved across to the Short Stay Paediatric Assessment Unit when it opened in June. The Special Care Baby Unit (SCBU) provided level one care for infants born less than 30 weeks gestation and weighing less than 1.5 Kg birth weight. The Short Stay Paediatric Assessment Unit (the Children's Unit) provided emergency and short stay (24 hour) care for children aged sixteen and under. This was a consultant led service where children could be assessed, investigated, observed and treated within 24 hours. Day surgery was also provided for children and young people at NSECH and staff from the Children's Unit supported a day surgery service once a week at North Tyneside General Hospital.

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 hospital liaison palliative care team. Where appropriate patients who required ongoing hospital admission were transferred from NSECH to specialist palliative care units or general hospital beds at either North Tyneside or Wansbeck hospitals. Specialist palliative care was provided as part of an integrated service across the hospital and community teams and the palliative care service sat within the trust's community and social care business unit.

The Northumbria Specialist Emergency Care Hospital provided outpatient orthopaedic trauma clinics only as well as diagnostic imaging. The trauma clinics were located within the main entrance to the emergency department. There were three private consulting rooms and two treatment rooms available for use by the clinics. The X-ray department provided two plain x-ray rooms, two CT scanners, two ultrasound rooms, three mobile x-ray machines, and three image intensifiers in theatre. There was also a plain x-ray room situated in the emergency department and a dedicated paediatric x-ray room with direct access to the paediatric emergency area. An independent company provided a managed MRI service although trust radiologists reported the MRI images.

The diagnostic imaging department (x-ray department) offered several imaging techniques including plain x-ray, CT, diagnostic ultrasound and Magnetic resonance imaging (MRI).

Our inspection team

Our inspection team was led by:

Chair: Dr Linda Patterson OBE, Consultant Physician.

Team Leader: Amanda Stanford, Head of Hospital Inspections, Care Quality Commission

Detailed findings

The team included a CQC inspection manager, 23 CQC inspectors and a variety of specialists including: a non-executive director, Director of Nursing, consultant anaesthetist, consultant physician and gastroenterologist, consultant in obstetrics and gynaecology, consultant obstetrician and specialist on feto-maternal medicine, accident and emergency nurses, paramedic, nurse consultant in critical care, palliative care modernisation facilitator, head of midwifery, risk midwife, infection control nurse, surgical nurse, matron, head of children's services and junior doctor. We also had experts by experience that had experience of using healthcare services.

How we carried out this inspection

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

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

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)
- 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 local clinical commissioning groups, NHS England, Monitor, Health Education England and Healthwatch.

We carried out an announced visit between 9 and 13 November 2015. We held focus groups 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 hospital, 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 2 December 2015.

We held listening events on 22 October and 6 November 2015 in Alnwick, Hexham, Cramlington and Whitley Bay 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 Northumbria Specialist Emergency Care Hospital

Northumbria Specialist Emergency Care Hospital is one of the acute hospitals providing care as part of Northumbria Healthcare NHS Foundation Trust. This trust provides services for around 500,000 people across Northumberland and North Tyneside with 999 beds.

During 2014/15, the trust saw71,000 patients on wards, carried out 36,476 operations and is responsible for 1.4milion appointments with patients outside of its hospitals.

Detailed findings

The health of people in Northumberland is varied compared with the England average. Deprivation is lower than average, however about 17% (9,300) children live in poverty. Life expectancy for women is lower than the England average.

The health of people in North Tyneside is varied compared with the England average. Deprivation is higher than average and about 19% (6,800) children live in poverty. Life expectancy for both men and women is lower than the England average.

Northumberland was ranked 135th and North Tyneside was ranked 113th most deprived out of the 326 local authorities across England in 2010.

From 15th June 2015 to the end of October 2015, 33,894 patients were seen in the Accident & Emergency.

Intensive care national audit and research centre (ICNARC) data showed that between 15 June and 30 September 2015 there were 365 admissions into critical care.

Our ratings for this hospital

Our ratings for this hospital are:

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

Notes

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

Urgent and emergency services

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

Information about the service

Northumbria Specialist Emergency Care Hospital (NSECH) is the first purpose built hospital of its kind in England dedicated to providing emergency care, with emergency care consultants and consultants in a range of specialities, working seven days a week. The aim is for patients to be seen quickly by the right expert. Using state-of-the-art technology, diagnosis will be quicker so that people can start on the right treatment sooner, leading to better outcomes for patients. There is widespread clinical evidence which shows that, in an emergency, getting seriously ill or injured people to the right specialists can greatly improve, not only chances of survival, but also chances of making a fuller recovery. By separating serious emergencies from the planned and ongoing care, the aim is to bring significant benefits for patients.

The emergency department at NSECH had a total of 36 cubicles, four resuscitation bays, one paediatric resuscitation bay and two mental health assessment rooms. The layout of the department was in three areas, referred to as 'pods'. There was a green, orange and red pod. Each had a central nurses' station surrounded by cubicles. They all led to each other. Patients were treated in the different pods according to the severity of their presenting condition. The resuscitation room was separate and was opposite two relatives' rooms. The paediatric area was adjoining the paediatric short stay ward.

From 15th June 2015 to the end of October 2015, 33,894 patients were seen. Each month there was an average of 7,612 patients attending the emergency department and each month this number was increasing.

During our inspection, we spoke with 49 members of staff including receptionists, nurses, doctors, domestics and paramedics, nine patients and 11 relatives. We viewed 28 sets of records and reviewed a range of performance information about the emergency department.

Urgent and emergency services

Summary of findings

We rated the emergency department at this hospital as good because:

There was an open and transparent culture with regard to the management of risk. Staff reported incidents and we saw examples of the duty of candour. The department was visibly clean and we observed good hand hygiene. There was a programme of mandatory training and managers were working towards training and staff appraisal targets. The completion of documentation was variable. Staffing levels had been increased as a result of the increasing demand on the service and the department was achieving the government's 95% target for admitting, transferring and discharging patients within four hours of arrival to the emergency department. There was an effective and comprehensive process in place to identify, understand, monitor and address current and future risks. However, processes and systems were still new and as alternatives to improve patient flow, experience and outcomes were explored, were being revised. The department had an ongoing audit programme that encompassed both local and national audits. Where performance was noted below national standards, the department had implemented action plans to improve the care and treatment of patients.

Feedback from patients and their relatives regarding the care they received while using the service was consistently positive. Where people had cause to complain, the senior management team had processes in place for responding to their concerns. Staff were observed to engage with patients in a compassionate and caring manner. The nursing documentation was not comprehensive regarding the nursing assessments and care and there was no specific guidance or facility for caring for a patient with dementia or a learning disability.

All staff within the emergency department were clearly engaged with the new model of specialist emergency care at NSECH. The vision and strategy had been developed through a structured planning process with engagement from internal and external stakeholders, including people who use services, commissioners and others. The department's clinical and managerial leadership drove a culture where change was embraced and where the focus was on patient experience. The purpose built emergency department was equipped with new technology and equipment.

Urgent and emergency services

Are urgent and emergency services safe?

Good

We rated the emergency department as good because:

Openness and transparency about safety was encouraged and there was a strong culture of reporting incidents. While feedback processes were not fully embedded, staff were aware and actions were being taken to improve this.

The department was visibly clean and we observed good hand hygiene. An electronic dispensing system for dispensing medicines was used which was accessed using finger print technology which also provided an audit pathway and improved inventory control.

To ensure care provided reflected national and professional guidance and legislation, staff training was in place. Staff responded in a timely way to patients who showed signs of deterioration and had robust plans in place to deal with medical emergencies. Safeguarding vulnerable adults and children were given sufficient priority and there was active and appropriate engagement in local safeguarding procedures.

Staffing levels and skill mix was planned, implemented and following a review appropriate steps were taken to increase both medical and nursing staffing levels.

The completion of documentation was variable.

Incidents

- There was a strong culture of reporting incidents. From 16th June 2015 to 30th July 2015 there were 73 reported incidents. Two resulted in 'moderate harm', six resulted in 'minor harm' and the remaining resulted in 'no harm'.
- To report incidents staff used an electronic system which automatically alerted the unit manager. Staff were encouraged to report incidents and they told us they were aware of how to report an incident and had reported incidents.
- Between 16th June 2015 and 30th July 2015 the emergency department did not report any 'never events', (which are defined as serious, wholly preventable patient safety incidents that should not occur if the available preventative measures have been implemented).
- During a nursing assessment, nurses checked if patients had a pressure ulcer. Pressure ulcers were the most commonly reported incidents.
- Following investigations of incidents of harm or risk of harm, staff told us they did not always receive feedback. The senior nursing staff knew this and recently, if requested, feedback by an email was provided and other feedback mechanisms were being explored.
- In the monthly governance meetings incidents and any actions taken because of those incidents, as well as lessons learnt, were discussed.
- Mortality and Morbidity meetings took place regularly across the directorate. They were attended by a member of staff from the Emergency department who reported any findings or lessons learned at departmental meetings.
- Staff told us they were aware of the statutory duty of candour.The duty of candour is a regulatory duty that relates to openness and transparency and requires providers of health and social care services to notify patients (or other relevant persons) of certain 'notifiable safety incidents' and provide reasonable support to that person. The department had a system to ensure patients were informed and given an apology when something went wrong and informed of any actions taken as a result. Examples were given where the duty of candour had been used.

Cleanliness, infection control and hygiene

- The department was visibly clean and tidy and we saw cleaning in progress during the visit.
- We reviewed areas including the sluice, blood gas analyser, administration stations and relatives waiting areas and found them clean and tidy.
- Needle sharp bins in the areas were no more than ¾ full and all the bins we looked at were dated and signed by a member of staff, (as required by the trust's policy).
- We checked three commodes and found one commode was dirty underneath.
- Staff adhered to the infection control policy and used personal protective equipment (PPE) when delivering personal care.
- We observed medical and nursing staff following the trust policy for hand washing and 'bare below the elbows' guidance in clinical areas. There were adequate hand washing facilities throughout the department and hand gel dispensers were available in each cubicle and around the department.

- Monthly audits of hand hygiene and the cleanliness of commodes were undertaken. The results improved each month from June 2015, (when compliance was 50% for both) to September 2015, (when compliance for both was 100%).
- Staff did not routinely carry out mattress checks. On inspection, we found a mattress to be dirty underneath and the trolley dusty and dirty. We later observed checks being carried out and cleaning in progress.
- As all cubicles were separate, the majors and minors areas had appropriate facilities for isolating patients with an infectious condition. One cubicle had a toilet in it.
- Disposable screening curtains were in use and each cubicle had a door.
- The children's waiting area was clean, tidy and well equipped. Toys were visibly clean and there was a clear recorded or monitored cleaning schedule for them.
- A completed daily checklist for cleaning the bays was in place, which indicated high levels of cleaning compliance.
- Waste was managed in line with effective infection control practices.
- Mandatory training for staff included infection prevention control.

Environment and equipment

- The department was laid out in three 'pods' with a nurses' station in the middle of each 'pod', surrounded by 12 cubicles with branches leading to each other. Patients who had a minor injury or illness were treated in the 'green' pod, while those with a major injury or illness were treated in either the 'orange' or 'red' pod. The red pod was for the more seriously ill however, depending on the availability of cubicles within the orange and red pods, patients could go to either.
- A separate four-bedded resuscitation room was equipped appropriately. We checked a range of resuscitation equipment, and found it accessibleand fit for purpose.
- A separate resuscitation bay was set up specifically for the management of children. Paediatric nurses and medical staff delivered care in this area.
- The resuscitation bays were similarly set up which helped staff care and treat patients in a timely and efficient manner.
- The paediatric area of the emergency department was integral to a 14 bedded ward area for children who required admission for up to 24 hours. Any child who required a longer in-patient stay was transferred to the Royal Victoria Infirmary in Newcastle.
- There were four cubicles for children who were waiting for investigations or required a period of observation for up to four hours.
- There was one triage room and three treatment/ consulting rooms.
- There were two rooms used for assessing patients with mental health issues. These had two doors, and an alarm for security.
- The lay out of the waiting room was open and patients who were waiting to be seen with a minor injury or illness were sat waiting in the entrance of the hospital, which was busy and noisy at times, providing little privacy. A patient complained to the inspection team that she had been sent by her GP and felt the noise was 'unbearable' as she was unwell and wanted quiet. Staff were aware of this and plans were in progress to separate sections of the waiting area.
- To ensure staff had the correct equipment available, equipment trolleys had a checklist which listed the equipment on each trolley.
- There were four identical resuscitation trolleys in the department. The policy was to check these weekly however, the checklist showed these were checked most days.
- There were adequate stocks of equipment and we saw evidence of good stock rotation.
- The medical engineering department carried out safety testing of electrical equipment and on a rolling programme basis serviced all equipment. Stickers were used to confirm servicing had been done.
- Security arrangements were in place 24 hours a day. Closed circuit television (CCTV) was also in operation throughout the hospital.

Medicines

- Staff followed systems that demonstrated compliance with the Medicine Act 1968 and the Misuse of Drugs Act 1971.
- The department used an electronic dispensing system for dispensing medicines which used finger print

technology to control access and provided an audit pathway and improved inventory control. Staff told us they felt this system had definitely improved patient safety.
- All intravenous infusions were stored in their original boxes or in appropriately labelled containers.
- A locked medicine fridge was part of the electronic dispensing system which meant the pharmacy department were automatically alerted if the temperature of the fridge was 'out of range'.
- Medical gases were stored safely in a separate room.
- Medicine prescribing was done on paper records.
- The department did use patient group directions.
- We reviewed eight paediatric and 20 adult patient records and found none had medicines omitted that had been prescribed.

Records

- Patient records were in paper format. Following discharge the patient record was scanned into an electronic system. The paper record was stored for three months in a secure place. The scanned document was available in a timely way.
- We reviewed 28 sets of patients records and found completion of documentation was variable.
- For example, we could not tell if nursing care was actually given because no record of nursing care was seen in any of the notes, althoughwe saw a check list known as a 'comfort round' document. Nurses were meant to complete this regularly because it asked if the patient was comfortable, and if they needed anything, such as pain relief or food and drink. On checking, these were not completed.
- All writing was legible and 26 patients records were dated and timed.
- The frequency and documentation of the recording of patients observations was appropriate.
- The recording of the patients allergy status was on all the paediatric records and on five out of 20 adult patient records. The absence of a recorded allergy status increased the risk that patients may be given inappropriate medicines that could have a harmful effect.
- The electronic system alerted staff to any patient specific concerns or risks. For example, if a patient had a previous infection or a safeguarding concern.
- Reception staff collated and filed the patient notes at the end of the visit, generated a GP letter and arranged for the safe storage of notes.

Safeguarding

- The department had systems in place for the identification and management of adults and children at risk of abuse (including domestic violence).
- We reviewed eight children's records. All the children had been assessed regarding safeguarding.
- Staff said they knew how to recognise and report both adult and children safeguarding concerns and this reflected what we saw.
- There was safeguarding lead nurses and robust referral systems in place.
- Mandatory training records indicated staff received safeguarding adults level one training and completed workbooks. In addition, staff had face-to-face level two training.
- Staff received the appropriate level of children's safeguarding training.
- Staff were aware of the assessment for child exploitation and female genital mutilation and a policy was in place.

Mandatory training

- The department was 73% compliant with mandatory training (against a target of 80% - except for information governance - which had a target of 95%). The department had a schedule in place to be 96% compliant in January 2016 (the department was 79% compliant with mandatory training at the end of November 2015).
- Staff completed most mandatory training using e-learning however there were some clinical skills that resulted in competency based classroom sessions.
- Time was allocated in the off-duty for mandatory training.
- New staff received a corporate induction programme that included some face to face mandatory training.
- Consultants and junior doctors received training in paediatric life support and a paediatrician provided additional support. All senior doctors (middle grade and above) and senior nurses (band 6 and above) received advanced paediatric life support training.
- All trained nursing staff and doctors completed an adult intermediate life support course.

Assessing and responding to patient risk

- A National Early Warning Score (NEWS) system for acutely ill patients was used, which supported the process for early recognition of those patients who were becoming unwell. This ensured early, appropriate intervention from skilled staff.
- Patients who walked into the department were registered by the receptionist and directed to the waiting room where a nurse triaged them.
- Patients arriving by ambulance entered through a different entrance specifically for ambulances. They were booked in by the ambulance staff at a reception desk before progressing to see a nurse co-ordinator who triaged the patient into the appropriate area (unless the patient required immediate access to the resuscitation bay).
- Children were seen in the separate paediatric area which had an adjoining paediatric ward.
- The trust used a modified recognised triage system in the 'minors' area. Use of a colour system of red, yellow and green was used. Red being for seriously ill patients, yellow moderately ill and green ambulatory or patients with a minor illness or injury.
- Once triaged, patients received an initial assessment by a doctor. Investigations that would assist with diagnosis and treatment were undertaken. For example, blood samples were taken, electrocardiograms (ECG) carried out, analgesia prescribed and x-rays ordered.
- Guidance issued by the College of Emergency Medicine (CEM) states a face-to-face assessment should be carried out by a clinician within 15 minutes of arrival or registration. From June 2015 to September 2015, the service's median performance against the 15 minutes standard for ambulance patients is 1 minute for all months.
- From June 2015 to September 2015 the time to treatment target was 60 minutes or less. The trust performed better than this target achieving a median performance of 1 to 45 minutes.
- A handover process to the wards was used known as 'SBAR'. (This is used to describe the patients medical Situation, Background, Assessment and Recommendations). This allowed staff to communicate assertively and effectively, ensuring key information was passed to relevant staff and reducing the need for repetition. At times, this was in written format only and wards did not always receive a verbal handover.
- An escalation process was in place that gave staff actions for how to manage the department during periods of extreme pressure.

Nursing staffing

- In accordance with the safer staffing initiative put in place as part of the NHS response to the Francis enquiry, we saw displayed for each shift the actual versus planned numbers of nursing staff on duty.
- Following the opening of the new department, a review of the nurse staffing had been undertaken, which resulted in an increase of one registered nurse each shift.
- On the days of our visit, the actual numbers of registered and unregistered nurses on duty did match the planned numbers. The department had the skill mix and flexibility of the staff on duty that they were able to deploy themselves as demand and workload dictated across the different parts of the department.
- We viewed off duty and overall the department was able to provide its planned 14 registered nurses plus 2 support grades on an early shift, 14 registered nurses and 4 support grades on a late shift and 9 registered nurses and 2 support grades on a night shift. These numbers were supported by a further trained nurse on a twilight shift before handing over to the night team at midnight.
- The paediatric unit was staffed separately. To support flexibility in the use of staff, the same staff worked between the ward and the paediatric emergency department. Within the paediatric emergency department, two registered nurses and one support grade worker worked between 09.30am to 9.30pm. A further registered nurse worked a twilight shift 6pm to 2am. In line with the recommendations of the 'Royal College of Paediatrics and Child Health (RCPCH) Standards for Children and Young People in Emergency Care Settings (2012)', all the registered nurses working within the paediatric emergency department were registered children's nurses providing 24 hour seven day a week cover.
- The department used experienced emergency care bank and agency nurses. The same nurses were re-booked providing familiarity to the department.
- Due to varying reasons, the department had seen a loss of 12 nursing staff since opening. Recruitment was

ongoing and the trust undertook generic recruitment monthly, enabling timely recruitment to vacancies. At the time of the inspection, there were four registered nurses due to come into post.

Medical staffing

- We examined the medical staffing rota and talked with consultants, middle grade and junior doctors. Medical cover was patient demand driven so that at busy times there was more medical cover. Rotas were complex and varied on a day-to-day basis. Junior doctor start and finish times fluctuated throughout the day.
- Within the department a high proportion of the medical staff were of consultant grade at 36% compared to the England average of 23%. They also had a much higher percentage of junior doctors at 36% compared to 24%. However, the registrars and middle grade proportions were noticeably lower than the England average at 8% compared to 13% middle grades and 20% compared to 39% registrars.
- There were 20 whole time equivalent (WTE) A&E consultants employed by the trust (and a vacancy of 3.0 WTE).
- Consultant rotas demonstrated that the emergency department provided 24-hour consultant cover three days a week, with the remaining days staffed for 16 hours each day plus on-call cover for an additional two hours. In the absence of a consultant, overnight middle grade cover was available in the department.
- When the current consultant vacancies are filled, there will be consultant cover in the emergency department 24 hours a day, seven days a week.
- There is a dedicated Paediatric unit open 24/7 with an ambulance bypass policy in place from 11pm to 8am. During the day, there was paediatric consultant cover. Overnight, a middle grade doctor or a paediatric nurse practitioner (acting in a middle grade capacity) covered the service.

Major incident awareness and training

- The trust had a learning and development strategy, which set out the learning and development activities which were to be implemented between 2015 and 2017. It supported the achievement of the goals set out in the 'Northumbria Incident Management System (NIMS) Policy 2012 to 2015'. The 'Emergency Preparedness Programme Board (EPPB)' had agreed it. The aim of the strategy was to provide assurance to internal and external stakeholders on the knowledge and competencies of its staff in the response to incidents and emergencies.
- Staff we spoke with had an understanding of their roles and responsibilities with regard to any major incidents.
- There was a designated storeroom for major incident equipment and the emergency planning team checked this. It contained: a major incident management plan with action cards; documentation which would be used in the event of a major incident; and specialist suits, which staff were trained to wear in the event of dealing with casualties contaminated with hazardous materials, such as chemical, biological or radiological materials.
- Staff could describe processes and triggers for escalation. They described to us the arrangements to deal with casualties contaminated with hazardous materials (HAZMAT) such as chemical, biological or radiological materials.
- Staff had undertaken training and practice that included a table top exercise and practice in wearing the protective suits.
- Staff had received training on how to care for someone who may have symptoms of Ebola.
- The department could be locked down easily to ensure the safety of patients should the need arise.

Are urgent and emergency services effective?

(for example, treatment is effective)

Good

We rated the emergency department as good for effective because :

Policies and procedures were developed in conjunction with national guidance and best practice evidence from professional bodies such as the 'College of Emergency Medicine (CEM)', the 'National Institute of Clinical Effectiveness (NICE)' and the 'Resuscitation Council UK'.

The department had an ongoing audit programme that encompassed both local and national audits. Where performance was noted below national standards, the department had implemented action plans to improve the care and treatment of patients. At the time of the

inspection, due to the department only opening in June 2015, no national published audit results were available specifically for NSECH. Staff were supported through a process of meaningful appraisal. Furthermore, there were systems in place for ensuring that staff who were newly appointed to the department were supported and that their competency was assessed to ensure they had the skills and knowledge to safely care for patients presenting to the emergency department.

There was evidence of multidisciplinary working especially the integrated ways of working between the emergency department and ambulatory care, the short stay unit and the medical assessment unit. This working relationship helped to ensure timely and appropriate care and treatment for patients who presented with medical conditions. There was also a surgical assessment unit and effective surgical referral systems in place.

There was quick access to all key diagnostic services 24 hours a day, seven days a week to support clinical decision making.

Patients had comprehensive mental health assessments and treatment, and people who were subject to the Mental Health Act (MHA) had their rights protected and staff had regard to the MHA Code of Practice. Staff used Fraser competency principles when assessing capacity and obtaining consent from children.

Evidence-based care and treatment

- There were a range of pathways that complied with the National Institute for Health and Care Excellence (NICE) guidelines and the College of Emergency Medicine's (CEM) clinical standards for emergency departments.
- The trust aimed to adhere to the 2012 standards for children and young people in emergency care settings.
- The trust participated in the national CEM audits so it could benchmark its practice against other emergency departments.
- As a result of audit findings, we were told how the department continually improved pathways and guidance. This included changing a pathway for patients admitted with a gastro-intestinal bleed. As a response to National Institute of Care Excellence guidance, patients went to a specialist ward.
- Compliance to the treatment of severe sepsis had improved monthly from June 2015 to October 2015 (full sepsis 6 compliance in June 2015 was 50% and in October 2015 compliance had increased each month to 86%).
- Guidelines were easily accessible on the trust intranet page and there were paper copies of pathways. Junior doctors were able to demonstrate ease of access and found them clear and easy to use.
- Two out of the nine pathways/guidelines viewed were in need of reviewing to ensure current evidence based practice is reflected.

Pain relief

- A pain score tool was used to assess if a patient had pain. Pain was scored as zero for no pain up to 10 for severe pain.
- We reviewed 28 sets of patients notes for the completion of pain scores.16 records had documented the patient pain score.
- Patients told us they had been asked their pain score and had been treated for pain. However, one relative informed us that the triage nurse had not treated their family member for pain during the initial assessment.
- There was no recent audit of pain scores.

Nutrition and hydration

- We did not see patients being offered food or hot drinks however, we were told snack boxes were available which contained a sandwich, crisps and a biscuit. Hot and cold drinks were available.
- There was no set meal time regime.
- We noted that staff did not record in the patients records whether food and drink had been given or offered to patients, therefore, staff could not see if a patient had eaten or drank while in the department.
- In the waiting room, there was a shop which sold hot and cold drinks plus food.
- Eating could cause a potential problem if a patient needed treatment such as sedation or surgery but there was no notice on the wall to inform patients to ask staff if they could eat.
- The children's ward supplied baby food and there was a room in the waiting area for breast-feeding. However, this did not have a chair in it.

Patient outcomes

Urgent and emergency services

- From June 2015 to September 2015 the unplanned re-attendance rate to the emergency department within seven days of discharge was consistently better than the England average and below the threshold of 5%, scoring between 0 to 0.1%.
- To ensure optimal clinical outcomes, The College of Emergency Medicine (CEM) has a range of evidence based clinical standards to which all emergency departments should aspire. The emergency department had participated in a number of audits to benchmark their performance against the CEM standards, such as 'the initial management of the fitting child' and 'the sepsis' audit. However, due to the department opening a few months prior to the inspection, no national audit results were available.
- In 2014 to 2015, prior to the opening of the new department, a CEM audit of mental health services in the emergency department was undertaken in the trust. Overall, they performed well in meeting the standards, with good performance in the documentation for patients presenting with mental health problems. The biggest areas for improvement were in the provision of a dedicated and suitable mental health assessment room and obtaining a review by a mental health professional within one hour. The new department has now provided two dedicated mental health assessment rooms and a mental health liaison service was based within the department providing a service 9am until 12 midnight. Out of hours, patients were referred to the crisis team which is community based.
- The department closely monitored its performance against a range of clinical indicators and presented a monthly report in a dashboard format. This presented a comprehensive and balanced view of the care delivered by the emergency department. It also reflected the experience and safety of the patients and the effectiveness of the care they received. This included ambulance handover times, time to treatment, four hour breaches and attendance rates.

Competent staff

- Medical and nursing staff had an annual appraisal and most staff spoke positively about the process.
- A target of completing all appraisals by March 2016 was on track.
- Senior nurses were responsible for undertaking a number of appraisals.
- New nursing staff received emergency department specific competency based training. A mentor supported their learning, and they had a supernumerary period of time that varied depending on their previous experience and learning needs.
- A 'buddy' worked alongside the new health care assistants and they completed a competency based care certificate. The care certificate is an identified set of standards designed with the non-regulated workforce in mind; the care certificate gives everyone the confidence that workers have the same introductory skills, knowledge and behaviours, to provide compassionate, safe and high quality care and support.

Multidisciplinary working

- Care was delivered in a co-ordinated way using a number of different care pathways between the emergency department, ambulatory care, short stay and the acute admissions unit.
- Clinical nurse specialists came to the department to provide clinical expertise and review patients (if needed) and they would see patients on the short stay ward.
- The mental health team was based within the emergency department providing timely assessment to patients with mental health needs between 9am and 12 midnight seven days a week. Out of hours, the department referred patients to the crisis team.
- There were alcohol liaison workers who supported patients with alcohol misuse issues. They visited the department Monday to Friday between 9am and 5pm. Out of hours a referral form was completed.

Seven-day services

- There was quick access to all key diagnostic services 24 hours a day, seven days a week to support clinical decision making.
- Access to radiology services was available 24hours a day, seven days a week excluding Ultrasound which is 8am-8pm and MRI which is 6am to Midnight.
- There was 24-hour consultant cover three days a week, with the remaining days staffed for 16 hours each day plus on-call cover for an additional two hours. In the absence of a consultant, overnight middle grade cover was available in the department.
- There was availability of pharmacy and physiotherapy services seven days a week and 'out of hours'.

- Community multidisciplinary teams (nursing, social worker and support staff), as well as the hospital to home team, facilitated discharges and potentially helped to avoid admissions.

Access to information

- Patient records were in paper format. Following discharge or transfer to the ward the patient record was scanned into an electronic system. The paper record was stored for three months in a secure place. A copy of the paper record was sent to the ward.
- Previous medical records were kept off-site at North Tyneside General Hospital. These could be requested.
- The receptionists sent discharge letters to the patients GP.
- By using the trust's intranet, staff had access to relevant guidance and policies.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- Where possible, doctors and nurses obtained verbal consent from patients before providing care and treatment. We heard staff explaining treatments and diagnoses to patients, checking their understanding, and asking permission to undertake examination and perform tests.
- Doctors gained written consent from patients who required sedation.
- Training in the Mental Capacity Act 2005 and Deprivation of Liberty Safeguards was included within the mandatory safeguarding training.
- Staff were clear about their responsibilities in gaining consent from people including those who lacked capacity to provide informed consent to care and treatment.
- Staff used Fraser guidelines and Gillick competency principles when assessing capacity, decision making and obtaining consent from children. The 'FraserTest' helps clinicians to identify children aged under 16 who have the legal capacity to consent to medical examination and treatment. They must be able to demonstrate sufficient maturity and intelligence to understand the nature and implications of the proposed treatment, including the risks and alternative courses of actions.

Are urgent and emergency services caring?

Good

We rated caring as good because:

The emergency department provided a caring and compassionate service. We observed staff treating patients with dignity and respect. Patients told us staff were caring, attentive and helpful.

Feedback from patients, relatives and carers was consistently positive. Patients told us staff in the emergency department kept them well informed and involved them in the decisions about their care and treatment. Care was person-centred and staff were observed to provide care which maintained the dignity and privacy of patients.

Compassionate care

- We observed patients being treated with privacy and dignity. When patients had treatments or nursing care delivered, curtains were pulled round and doors closed.
- We observed a number of interactions between staff and patients and relatives. Staff were always polite, respectful and professional in their approach.
- We spoke to nine patients and eleven relatives who all praised the care they had received. All described how they were treated with care, dignity and respect.
- Survey results from the trust showed that 93% of patients thought they had enough privacy when discussing their symptoms and 95% thought they had enough privacy and dignity when being examined and treated. This was compared to the trust average of 93% when discussing symptoms and 95% when being examined or treated.

Understanding and involvement of patients and those close to them

- From June 2015 to November 2015, according to patient feedback, 91% of patients thought that staff had explained their condition or treatment in a way that they understood. This was compared to the trust average of 83%. 94% of patients thought that nurses and doctors listened to what they had to say and 82% of patients thought that staff addressed any fears or worries they

had. 88% of patients thought they were involved as much as they wanted to be in decisions about their care and treatment and 84% of patients had the results of tests explained to them in a language they could understand. 90% of patients were happy with the amount of information they received when visiting the department.

- Patients told us staff ensured they understood medical terminology and literature was given about their condition when required.
- We observed that patients were given a clear explanation at discharge and were advised what to do if symptoms re-occurred.
- Patients and relatives told us they were kept informed of what was happening and understood what tests they were waiting for.
- Comments received to the trust's social media site included: 'the doctor who treated me was very helpful and explained everything in detail'.

Emotional support

- We observed staff offering emotional support to patients who were anxious. They spent time reassuring them and explaining what was happening and why.
- There was support available for the bereaved from the multi-faith chaplaincy service.
- The spiritual needs of patients are provided by a 24 hour chaplaincy support which provides sacramental care in the trust chapels and at the bedside and through supporting patients at the end of life.

Are urgent and emergency services responsive to people's needs?
(for example, to feedback?)

Good

We rated the emergency department as good for responsive because:

From the 15th June 2015, the trust implemented this new model of emergency care. This model was the result of 10 years' work led by the clinical teams and the approach has been endorsed by Professor Sir Bruce Keogh, NHS England National Medical Director. There is widespread clinical evidence, which shows that getting seriously ill or injured people to the right specialists in an emergency can greatly improve survival. Separating serious emergencies from the planned and ongoing care aims to bring significant benefits for patients. This vanguard site aimed to meet the needs of the local population.

The department was able to demonstrate that despite a higher number of patients attending than previously expected and increasing demands on emergency care services, they responded actively to surges in activity and changed practices to meet the demand.

They were able to demonstrate changes in care pathways as a result of audit and national guidance and their performance to the 95% standard of patients admitted, transferred or discharged within four hours of arrival was consistently met throughout July 2015 to September 2015.

Some processes needed to be embedded and the triage system and rapid assessment and treatment for walk-in patients remained under review.

Service planning and delivery to meet the needs of local people

- From the 15th June 2015, the trust implemented a new model of emergency care.
- From 15th June 2015 to the end of October 2015, 33,894 patients attended the emergency department. This averaged out at 7,612 patients each month and each month attendances were increasing. For instance, in October 2015 there were 592 more patients attending than in September 2015.
- In order to manage the higher than expected demand of walk-in patients, the team implemented a change in the triage system for walk-in patients enabling early assessment and treatment.
- A performance improvement plan was initiated to meet the challenges of increased attendances to the emergency department; this supported the specific ambulance handover action plan. A range of initiatives were introduced which included:-
  - Possible re-direct of suitable patients in incoming ambulances to other local urgent care centres.
  - To improve the patient flow throughout the emergency care centre, by introducing a proposed plan for a 'perfect week' exercise.
  - The introduction of a 'rapid assessment and treatment' model.

- Following results of the ongoing sepsis audit, an infection-screening tool was introduced, fluid balance completion was promoted and weekly data feedback to doctors, challenging their decision-making processes, was introduced.
- The paediatric pathway had improved with the opening of the new unit by providing paediatric emergency care together with paediatric care within the department.
- As a vanguard site, the trust was continuing to work alongside NHS Northumberland CCG and the Northumberland County Council to deliver an integrated primary and acute care system for the county.

Meeting people's individual needs

- The department was accessible for people with limited mobility and people who used a wheelchair. Wheelchairs were available in the department if required and disabled toilets were available.
- The reception area had a designated hearing loop.
- Within the paediatric department, there was access to a play specialist, who provided distraction when children underwent medical procedures. They also accompanied children for investigations and procedures.
- Staff told us they did not have any specific guidance to assist them on how to support patients with a learning disability. They told us they would encourage their carer to stay with the patient to help alleviate any anxieties the patient may have.
- There was no specific 'dementia friendly' cubicle or support for caring for patients with dementia.
- A specialised bariatric bed could be ordered although this would create a wait as the department did not have a specialised bariatric trolley or bed.
- A range of information leaflets were available for patients to help them manage their condition after discharge however, leaflets were available in English only. We were told most patient information was available in different formats such as large print, audio, CD, braille and languages other than English on request.
- Interpreting services were available.
- There were two relatives' rooms near the resuscitation room, both having direct access to an adjoining viewing room. There were hot and cold drinks and a telephone available.
- The new department created improved access to mental health services for patients. The mental health team was based within the department providing a service seven days a week from 8am until midnight. The crisis team, which was community based, would see patients out of hours.
- There was an embedded referral process for patients with alcohol dependency or substance misuse.

Access and flow

- The Department of Health's standard for emergency departments is to admit, transfer or discharge patients within four hours of arrival. Since the opening of the new department, the target of seeing 95% of patients within four hours was consistently met throughout July 2015 to September 2015.
- The College of Emergency Medicine recommends that the time patients should wait from time of arrival to receiving treatment is no more than one hour. The median waiting time to receiving treatment for patients in the emergency department was 45 minutes.
- The median amount of time people could expect to spend in the emergency department before being discharged, admitted or transferred was 2 hours and 27 minutes.
- Once a decision to admit had been made, there had been no reported breaches of patients waiting more than 12 hours in the emergency department.
- The national average for the percentage of patients who leave the department before being seen (recognised by the Department of Health as potentially being an indicator that patients are dissatisfied with the length of time they have to wait), was between 2% and 3%.The emergency department at NSECH was 2%, measured against a threshold of 5%.
- The emergency department aimed to ensure patients who arrived by ambulance were kept waiting for no more than 15 minutes before patients are handed over to the care in the department. This was achieved for 94% of patients, which is better than the England average.
- Black breaches occur when the time from an ambulance's arrival to the patient being formally handed over to the department is longer than 60 minutes. The emergency department had 33 patients who waited over one hour from July 2015 to the end of September 2015. However, the trust are disputing eight of these.
- During the inspection, we observed flow of patients and reviewed current information on waiting times. We

spoke with five patients in the waiting room who had been waiting up to 80 minutes. There were four electronic advertising boards displaying trust and health information that stated the waiting time. During the inspection it stated waiting was up to 2 hours. (There was no clock in the waiting room).

- We reviewed the notes for 12 patients who had arrived by ambulance. Time to initial assessment was between 0 and 19 minutes, with the average time being 4.5 minutes.
- We observed the flow of children who had attended the department. We spoke with the parents of a child who was seen immediately by the children's nurse. We reviewed eight children's notes, which showed they were assessed within 2 to 19 minutes; the average time was 9 minutes.
- The bed management team office was within the emergency department and meetings took place at least twice a day (more frequently if needed) to understand the bed situation at NSECH, and Wansbeck, Hexham and North Tyneside, General Hospitals, to enable planning for expected admissions and discharges, ensuring patient flow throughout all the hospitals was timely.

Learning from complaints and concerns

- Between June 2015 and the end of September 2015 there were 43 complaints made. The top three complaints were associated with communication, waiting times and clinical care.
- Staff told us they were aware of how to deal with complaints. We were told doctors would look at the complaints, which involved medical staff or medical issues, and the matron or senior sister would deal with complaints related to nurses or nursing care.
- Feedback was given to staff face to face or by e-mail. Any lessons learnt were discussed in the monthly governance meeting and department staff meeting. An information board displayed the top five complaints themes for the month and the actions taken to resolve them.
- Complaints were discussed in the monthly governance meeting.
- There was a page on the trust website that encourages patients to raise concerns.
- The emergency department had a process that addressed both formal and informal complaints that were raised through the Patient Advocacy and Liaison Service (PALS). Formal complaints involved the matron investigating the complaint. For informal complaints or complaints raised on the trust website the senior sister would investigate and then as soon as possible (and with a view to rapidly resolving the issues), she would either e-mail the complainant or speak with them on the telephone.
- Response letters to complainants included an apology when things had not gone as planned. This is what we would expect to see and is in accordance with the expectation that services operate under a duty of candour.

Are urgent and emergency services well-led?

Good

We rated well-led in the emergency department as good because:

All staff within the emergency department were clearly engaged with the new model of specialist emergency care at Northumbria. The vision and strategy had been developed through a structured planning process with engagement from internal and external stakeholders, including people who use services, commissioners and others. There was a culture where change was embraced and there was a real focus on patient experience and this was driven by the department's leadership both clinical and managerial.

There was an effective and comprehensive process in place to identify, understand, monitor and address current and future risks, however processes and systems were still premature and were being amended as alternatives to improve patient flow, experience and outcomes were explored.

There was a culture of openness, transparency and honesty. Staff were proud of working in the new department. Staff worked well together as a newly formed team and had a 'can do' attitude.

Vision and strategy for this service

Urgent and emergency services

- Northumbria specialist emergency care hospital is the first purpose-built hospital of its kind in England dedicated to emergency care. It is part of an innovative new model of emergency care.
- The new model at Northumbria is in line with the vision recently outlined in the NHS Five Year Forward View to develop networks of linked hospitals that ensure patients with the most serious needs get to specialist emergency centres, and that hospital patients have access to seven-day services where this makes a difference to outcomes. The approach has been endorsed by Sir Bruce Keogh who, as part of his Urgent and Emergency Care Review, is calling for "patients to receive the right treatment at the right place", with consistent levels of senior staffing in order to maximise chances of survival and a good recovery for patients.
- We were told about the planning and preparation that had taken place in order to open this new facility and that in the next few weeks planning for the next year was to take place.
- Staff we spoke with were proud to work in the new facility. It was evident from talking with staff that there was a pace of change in the department, as new ways of working were refined in line with the changing demand. The team focused on patient experience and care, which was driven by the department's leadership both clinical and managerial.

Governance, risk management and quality measurement

- The emergency department was part of the medicine and emergency care directorate.
- A governance system was in place with the production of incident summaries and themes, complaints, compliments, workforce statistics and admission data.
- A monthly strategy meeting took place that discussed finance, performance data, changes to clinical practice and audit activity. Staff we spoke with were clear about the challenges the department faced and they were committed to improving the patients journey and experience. Both these meetings fed into trust wide governance meetings.
- The department risk register was available and was continually under review to ensure it reflected current risks relevant to the operational effectiveness of the department. Ten risks were recorded on the register at the time of our inspection. Each risk was graded, dependent on severity. There were three low risks, four moderate risks and three high risks. A lead officer was assigned to each risk and descriptions of key controls to mitigate risks were given. Examples of the high risk were the increase in the number of attendances since the department opened and the difficulty in obtaining timely transfers to the tertiary sites.

Leadership and Culture of the service

- The emergency department had a clear management structure at both directorate and departmental level.
- From our discussions with staff, the leadership was strong, supportive and staff felt they were listened to. There was confidence and respect in the management and staff told us they were proud to work in the hospital.
- The team appeared to be efficient and teamwork was evident.
- Three teams had come together from emergency departments at Wansbeck, Hexham and North Tyneside.At the time of the inspection the team had been together for only four months and displayed a cohesive and supportive team with a 'can do' attitude.
- Staff described the culture as open and transparent. Some staff commented on too much negative feedback and not much positive feedback and stated that they were working under pressure.

Public and staff engagement

- The trust used a combination of methods as an approach to understanding the experience of patients. These include four different surveys, which include face-to-face interviews, a short exit survey, a patient perspective survey and they participate in national patient experience surveys.
- The public were part of the consultation regarding the opening of the new specialist emergency care hospital.
- At the time of the inspection, due to the unit opening only four months earlier, the results of a patient survey were not available. We were told that a focus group was to be planned in the next month to listen to the views of patients and relatives.
- The trust website enables patients and the public to comment on the care they have received. Within the department, there is a list of compliments and complaints received over the last month.
- Staff felt they were listened to and they had opportunities to contribute towards the development of the new unit.

- At the time of this report, there were no staff surveys available relating to the new department.

Innovation, improvement and sustainability

- This new innovative model of care is in its infancy, however, the department has demonstrated improved performance and improved outcomes for people.
- The team have worked actively throughout this process of change and demonstrated that when at times it became apparent there needed to be changes to the way the department needed to be configured, they were open to trying alternative ways of working to improve patient experience.

Medical care (including older people's care)

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

Information about the service

Northumbria Healthcare NHS Foundation Trust provides medical care, including older people's care, across four sites including Northumbria Specialist Emergency Care Hospital. This hospital opened on 16 June 2015 providing specialist emergency care for seriously ill and injured patients from across Northumberland and North Tyneside. Medical services provided at this hospital included cardiology, respiratory, stroke, gastrointestinal.There is also an endoscopy room, a cardiac catheter lab and ambulatory care for the rapid assessment of patients with specific conditions, without the need for emergency admission.

We visited the acute medical unit, the ambulatory care unit and all other medical care areas where we observed care and the environment. We spoke with 14 patients, 28 staff members including senior managers, doctors (consultants and junior doctors), matrons, nurses and health care assistants. We observed medical and nursing handovers, including safety huddles and board rounds. Prior to the inspection we reviewed the hospital's performance data.

Summary of findings

Overall, we rated medical care services at this hospital as good, with safe as requires improvement because:

Staffing levels and skill mix were planned and reviewed. Any staff shortages were responded to however there were times when rosters indicated that registered nurse staffing levels did not meet planned levels, particularly on one ward. This was managed and senior staff were regularly reviewing ward establishments following the collation of patient dependency data. We found varying degrees of completeness across all wards in relation to both nursing and medical records, specifically in relation to pressure area, falls and nutritional risk assessments. VTE assessment was variable on the medical wards. The lowest compliance was 55% on one ward in September; a second ward also reported only 60% compliance in assessment in August 2015. Data received from the trust indicated that, when VTE assessment compliance was low, this corresponded with lower percentages of patients receiving prophylactic treatment in some areas, for example, when the assessment was identified at 55%, only 86% of patients received the appropriate preventative treatment. People were protected from avoidable harm and abuse. Staff fulfilled their responsibilities to raise concerns and report incidents and near misses. There was evidence of robust sharing and learning from incidents. All areas were visibly clean and well maintained. Staff were aware of and adhered to infection control procedures. When necessary patients

Medical care (including older people's care)

were appropriately isolated to minimise the risk of cross infection. The trust had policies and procedures in place for the safe management of medicines. Incidents relating to medicines were low. The trust had installed an electronic fingerprint recognition system for the safe and secure handling of medicines.

Local pathways, policies and guidelines that were regularly reviewed to ensure that these were in line with national guidance and formal procedures to audit compliance with standards were implemented. There was limited evidence of specific patient outcomes because of the limited period of time that the hospital had been open. Staff were aware of key quality performance indicators. Robust multi-disciplinary working with all disciplines was evident across all areas of the hospital. Seven day services were part of the new model of care and were becoming embedded within the hospital.

Feedback from patients and visitors was overwhelmingly positive. Patients felt involved in their care and their physical needs were not the only consideration. All patients said they felt emotionally supported by staff. Patients and relatives understood what their plan of care was and were able to be involved with this. Staff were committed to providing high quality patient focused care.

Engagement with local stakeholders was excellent. The service had many innovative projects in place to engage and respond to the health needs of the local population. The model of care at NSECH provided benefits for the trust's other hospital sites. Separating serious emergencies from planned care meant that patients attending for planned operations, tests, and outpatient clinic appointments at other bases did not have their care affected by the need to prioritise seriously ill emergency patients. Patients could access the service in a timely way and continuity of care was maintained. Since opening 6,336 (93%) of patients had been admitted and discharged from the same ward or unit. 452 (7%) had only moved ward once during their admission and 16 patients had moved wards twice. This meant that the majority of patients had consistency in relation to their care and treatment.

The medical services were managed by an experienced and cohesive team who demonstrated an understanding of the challenges of providing high quality, safe care. Within this hospital, local managers had particular challenges regarding staffing issues and completion of risk assessments which were acknowledged but still required addressing and embedding. Governance processes were in place which allowed clear identification and monitoring of risk and we saw evidence of related progress and action plans. Staff and patient engagement was seen as a priority with several systems in place to obtain feedback. Innovation was encouraged. Diabetes research, in particular the long term self-management of diabetes, was at the forefront of medical research within the medical directorate.

Medical care (including older people's care)

Are medical care services safe?

Requires improvement

We rated safe as requires improvement because:

Staffing levels and skill mix were planned and reviewed. Any staff shortages were responded to however there were times when rosters indicated that registered nurse staffing levels did not meet planned levels, particularly on one ward. This was managed and senior staff were regularly reviewing ward establishments following the collation of patient dependency data. We found varying degrees of completeness across all wards in relation to both nursing and medical records, specifically in relation to pressure area, falls and nutritional risk assessments. VTE assessment was variable on the medical wards. The lowest compliance was 55% on one ward in September; a second ward also reported only 60% compliance in assessment in August 2015. Data received from the trust indicated that, when VTE assessment compliance was low, this corresponded with lower percentages of patients receiving prophylactic treatment in some areas, for example, when the assessment was identified at 55%, only 86% of patients received the appropriate preventative treatment.

People were protected from avoidable harm and abuse. Staff fulfilled their responsibilities to raise concerns and report incidents and near misses. Systems and processes were in place to support staff. Learning from incidents was based on a thorough analysis and investigation. There was evidence of robust sharing and learning from incidents. Safety performance was improving.

All areas were visibly clean and well maintained. Staff were aware of and adhered to infection control procedures. When necessary patients were appropriately isolated to minimise the risk of cross-infection. The trust had policies and procedures in place for the safe management of medicines. Incidents relating to medicines were low. The trust had installed an electronic fingerprint recognition system for the safe and secure handling of medicines.

Incidents

- There had been no never events for this core service at the hospital. Never events are serious incidents that are wholly preventable as guidance or safety recommendations that provide strong systemic protective barriers are available at a national level and should have been implemented by all healthcare providers.
- The hospital used an electronic reporting system. Nearly all staff we spoke with were aware of the system.
- The National Reporting and Learning System (NRLS) is a central database of patient safety incident reports. Sixty-five serious incidents were reported for this core service between August 2014 and July 2015. Forty-five (69%) of these incidents were slips, trips or falls, five were pressure ulcers and five were hospital acquired infections which met the criteria for serious incident reporting.
- During our inspection we attended the weekly incident reporting meeting (IR1 meeting). At this meeting all incidents that had been reported during the previous week were discussed. Matrons and ward managers from all medical wards attended and discussed the incidents pertaining to their areas of responsibility including detailing the actions that had been implemented. Matrons advised of any further requirements and also tracked any ongoing incidents and updates were provided. We saw the minutes of these meetings.
- On ward 7, staff we spoke with told us that all incidents were reported including every pressure ulcer, falls and safeguarding concerns. Staff we spoke with told us that safety incidents were discussed at team meetings and also at safety huddles on ward 7.
- Nursing staff told us that most doctors reported incidents to them and they then inputted the incidents onto the electronic reporting system although some doctors did use the system. We were told that junior doctors were informed of incidents.
- A ward manager we spoke with told us that she received a copy of all incident reports and the findings were fed back at the weekly IR1 meetings. This manager had delegated a band 6 to be responsible for pressure ulcer incidents.
- We were told that root cause analysis was completed if required, again these would be fedback at the IR1 meeting and the monthly clinical governance meeting.
- We spoke with a health care assistant who told us that they didn't use the electronic reporting system. They

told us that they would ask a registered nurse to input data for them. This member of staff said that incidents were discussed at team meetings and minutes were available.
- Two other junior doctors from another medical ward told us that they were aware of the reporting system but they had never reported an incident.
- We saw evidence that the hospital held a mortality and outcomes data group meeting where mortality and morbidity was discussed. Mortality rates were also discussed at the Medicine & Emergency Care Business Unit Governance Group (BUGG) meeting.
- In November 2014, the Duty of Candour statutory requirement was introduced and applied to all NHS Trusts. The duty of candour is a regulatory duty that relates to openness and transparency and requires providers of health and social care services to notify patients (or other relevant persons) of certain 'notifiable safety incidents' and provide reasonable support to that person.
- Most staff we spoke with were aware of the Duty of Candour however there were two staff who told us they had not heard of this. After speaking with these staff, both made a conscious effort to ask us about the Duty of Candour.
- Two junior doctors we spoke to told us that they were made aware of the Duty of Candour when they joined the hospital. Another junior medic told us that they had completed an e-learning course about the statutory duty and also completed a module at medical school.

Safety thermometer

- The NHS Safety Thermometer is an audit tool that allows organisations to measure and report patient harm in four key areas (pressure ulcers, urine infection in patients with catheters (CAUTI), falls and venous thromboembolism (VTE)) and the proportion of patients who are "harm free". The England average for harm free care is 95%.
- We saw safety thermometer data displayed on every ward we visited during our inspection. Staff we spoke with were aware of the safety thermometer.
- VTE assessment was variable on the medical wards. The lowest compliance was 55% on one ward in September; a second ward also reported only 60% compliance in assessment in August 2015. Data received from the trust indicated that, when VTE assessment compliance was low, this corresponded with lower percentages of patients receiving prophylactic treatment in some areas, for example, when the assessment was identified at 55%, only 86% of patients received the appropriate preventative treatment.
- One ward had reported three falls with harm: one in July and two in September, 2015.
- One ward had one reported CAUTI.
- Safety thermometer data provided by the trust indicated that there had been no hospital acquired pressure damage of category 2 or above on any of the medical wards at the hospital since it opened in June 2015.
- We were told that the tissue viability nurses visited every ward on the day that the safety thermometer data was collated and that they would check and certify data for patients with pressure damage and provide support with the care and treatment of these patients

Cleanliness, infection control and hygiene

- All areas we visited were visibly clean and well maintained.
- The hospital had reported four cases of clostridium difficile since opening in June 2015. The respiratory ward had two cases between July 2015 and August 2015. Two cases were identified on ward 7 in September 2015.
- The trust provided evidence that robust root cause analysis had been completed for all four patients. These contained evidence of the lessons learned as a result of the analysis.
- There had been no Methicillin-resistant Staphylococcus aureus (MRSA) reported for the service at this hospital from April to October 2015.
- Deep cleaning and disinfection of single rooms and bays is an important measure to protect incoming patients from infection. Hydrogen peroxide vapour (HPV) technology can be used for the disinfection of patient rooms and bays. During our inspection we saw rooms being cleaned using this method. Staff we spoke with told us that this was available 24 hours each day.
- A member of nursing staff we spoke with told us that patients with diarrhoea were isolated and barrier nursed at the onset of symptoms. If the patient was not already nursed in a single room they would be moved to one. A tool was in place to monitor the symptoms of the

clostridium difficile to ensure that cases were classified and those which were moderate or severe were recognised in the early stages and escalated appropriately.
- Hand hygiene observation data provided by the trust indicated that hand hygiene compliance was 100% compliant across all grades of staff each week between 21st June 2015 and 23rd August 2015.
- We spoke with a patient who had a cannula in place and we noted that the date of insertion was documented on the cannula dressing. This meant that staff could monitor the cannula insertion date.
- We observed staff using appropriate hand hygiene before and after providing care to patients.
- A senior nurse told us that the infection control team performed audits and produced a report which was e-mailed to staff along with an action plan which was followed through by the ward link nurse.
- We saw evidence of Patient-Led Assessments of the Care Environment (PLACE) audit results and action plans for several wards. All of these evidenced that standards of cleanliness were consistently maintained.

Environment and equipment

- The hospital was a purpose built specialist emergency care unit. During our inspection we visited eleven medical units. These were based in six wards and a discharge lounge. Three wards had sub-units. These were a hyper acute stroke unit (ward 9a); a coronary care unit (ward 10) and a respiratory support unit (ward 12). Each of these units had eleven beds. Ward 6 comprised of ambulatory care and a short stay unit.
- All medical wards we visited at the hospital had three 'pods', there was an eight bedded pod and two pods with eleven beds. Some pods consisted of single rooms and some had single rooms and bays with four beds. On each ward there was a designated bariatric room which was bigger than the other single rooms. Each of the single rooms had en suite facilities.
- We also visited the discharge lounge. The unit was visibly clean and well maintained. The room was light and airy and had a large television and there was also reading material available for patients. The unit had a resuscitation trolley and this had been checked and maintained in line with trust procedures.
- We looked at the checklists for the resuscitation equipment on all wards we visited and found that on the whole these were completed in line with the trust policy.
- On all wards we visited we checked medical equipment and found that these contained stickers to evidence when they were last serviced and the due date of the next planned maintenance. In total we checked 40 items of equipment and found this consistent in all cases.
- On ward 7 we observed pre-prepared equipment for some procedures such as a lumbar puncture set. This meant that in the event of equipment being needed it was readily available.
- Bariatric equipment was available for patients when required. All wards had appropriate disability access. There was access to bariatric equipment onsite.
- Staff told us that access to equipment was very good.
- We were told by a senior nurse on ward 6 that they had a system in place to monitor stock levels including expiry dates. This was part of the 'Well organised Ward' (WOW) initiative and was the responsibility of one of the Care Support Workers (CSW).
- We saw evidence of 15 steps audits. This is a series of toolkits which are part of the productive ward work stream. It was developed by various staff groups, patient and volunteers to help capture what good quality care, looks, feels and sounds like. They used the Care Quality Commission five domains as a basis and looked at all aspects of care and the environment. Areas for improvement were identified and an action plan produced, and this was shared with staff through team meetings. A ward manager showed us an example of a completed action plan and described how this had been fedback to her team.

Medicines

- The Trust's Pharmacy Department was located in North Tyneside General Hospital. There was no on site dispensary at the hospital but there was a clinical pharmacy service from 8.15am to 4.45pm seven days a week.
- The seven day week clinical pharmacy service at the hospital supported current guidance (Medicines optimisation: the safe and effective use of medicines to enable the best possible outcomes – The National Institute for Health and Care Excellence (NICE) 2015)

that requires reconciliation to be completed within 24 hours and the trust's current figures showed that the majority of patients (94%) were reconciled within 24 hours by the pharmacy team.

- We saw trust policies that were regularly reviewed, covered most aspects of medicines management and were accessible through the hospital intranet to all staff.
- We were told that the senior pharmacy team were reviewing the service to the hospital to ensure the needs of the service were being met.
- A finger print recognition system (Omnicell) was being used on all wards to help improve medicines organisation and storage. The Omnicell contained controlled drugs (a medicine controlled under the Misuse of Drugs legislation) and the trust had obtained a certificate from the police to authorise the use of the Omnicell for controlled drug storage.
- We asked a staff member about the Omnicell system and were told that while it could be time consuming it benefited patients as it reduced the risk of medication errors and therefore improved patient safety.
- A self-medication policy was available to make sure patients were supported to do this safely, however this was not used routinely on the wards we visited.
- Medicines management was regularly audited across the trust and included antibiotic management, missed medicines doses (which reported missed critical medicine doses separately), controlled drugs and the storage of medicines.
- We reviewed these audit results and noted that actions resulting from the audits were fed back by lead clinical pharmacists and matrons to wards through individual monthly dashboards. These included personalised action plans which were monitored by clinical pharmacists.
- The hospital provided data which indicated that monthly antimicrobial care bundle audits were undertaken. The results of these audits showed that medical wards were predominantly 100% compliant with most aspects of the audit. There were some areas of non-compliance in daily reviews of intravenous antimicrobial prescribing, patients switching to oral antibiotics once they were deemed to be clinically appropriate to do so and a review date or duration being documented.However,the lowest documented compliance score was 87% for one month of the six months observed.
- The antibiotic audit showed that the indication and duration of an antibiotic was always recorded.
- Staff we spoke with told us that a sedation protocol was used in endoscopy, where low dose sedation was used and that there had been no incidents of flumazenil, a sedation reversal agent, being used in the hospital. If this had occurred we were told that this would be reported through the electronic reporting system.
- On most wards we visited we found that controlled drugs checks had been completed in line with policy. On ward 7 we reviewed the controlled drugs register and found two entries whereby new stock had been received from pharmacy but the number of ampoules or tablets was not documented however the balance had been increased. We spoke with the ward manager who confirmed that the amount of stock received should always be documented and she advised that she would raise this with all staff.
- In the patients own controlled drug register, we saw two entries that stated: 'received from pharmacy'. We checked the cupboards and found that one item had been brought in from home by a patient. Again we raised this with the ward manager who agreed this should not state: 'received from pharmacy' and advised that this would also be raised with staff. The patients own register is a mechanism used for logging controlled drugs that patients had brought in from home.
- We looked at the drug fridge temperature recordings on ward 7 and found that between 11/7/15 and 8/11/15 the temperature had only been recorded on twelve occasions. We spoke with the ward manager about this and they told us that the fridge temperatures were recorded remotely; the manager received an e-mail each week which evidenced the daily minimum and maximum temperatures. It was also explained that in the event of the temperatures falling below the minimum or exceeding the maximum, an alert was sent to the facilities department who would then respond. We were told that this system was in place 24 hours each day.
- We were told that when patients went to the discharge lounge, controlled drugs would remain on the transferring ward and these would be collected when the patients transport arrived to take them home or to an alternative hospital site.

Records

Medical care (including older people's care)

- During the inspection, we reviewed sixteen sets of care records. We found varying degrees of completeness across all wards in relation to both nursing and medical records.
- All records indicated that patients were seen by a doctor within twelve hours of admission to a ward and had a diagnosis and management plan completed. All patients had been seen daily by a doctor. There was evidence of multi-disciplinary review in all applicable notes.
- However, five patients did not have a pressure risk assessment completed, seven patients did not have a malnutrition screen completed, five patients did not have a falls assessment completed, and nine patients did not have individualised care plans.
- Doctors documented the actions to be taken in the event of a patient triggering on their NEWS score in the patients notes but that this was not documented on the NEWS chart.
- The trust provided copies of records audits. These also showed results ranging from 25% to 100% compliance. The trust told us that in addition to a divisional record keeping audit, records were also monitored as part of the 15 steps audits. The trust advised and we observed that action plans were created and monitored following each audit.

Safeguarding

- Staff at the hospital completed safeguarding training as part of their mandatory training package. Data provided by the trust showed that this training was completed in line with NHS England priorities.
- All frontline staff we spoke with had a comprehensive understanding of the safeguarding process and were aware of their individual responsibilities regarding the safeguarding of both children and vulnerable adults.
- We saw evidence of policies for adult and children's safeguarding. There was a system in place for raising safeguarding concerns. There was an established safeguarding team for both adults and children.
- Training figures provided by the trust showed that 87% of staff at the hospital had completed Safeguarding Adults - Level 1 training. This was above the trust target of 85%.
- We saw that additional safeguarding events had been arranged for staff to attend to develop their skills and knowledge.
- A health care assistant was able to articulate their responsibilities in relation to safeguarding. We were told that they would report any concerns to the nurse in charge who would then raise a 'protect'.This was the term used by the trust for a safeguarding alert. This member of staff was aware of the trust's policies and told us that these were available on line and that printed copies were also available in the sisters' office.
- Nursing staff told us that a safeguarding would be raised in relation to pressure ulcers if this was indicated.

Mandatory training

- Training figures provided by the trust showed varying compliance in relation to mandatory training for staff at the hospital. Eight of the eleven wards were less than 80% compliant with all training. Overall the compliance was 76%. 56% of staff had completed Basic life support training.
- The trust had a target of 85% for most mandatory training subjects. The trust told us that staff completed training within a rolling year. This meant that staff would be expected to be fully compliant with training by the end of March 2016. There were plans in place to ensure that mandatory training was completed by this target date.
- Staff we spoke with told us that they were up to date with mandatory training.

Assessing and responding to patient risk

- We saw National Early Warning Score (NEWS) charts in use across all medical wards at the hospital to assess the early detection of a deteriorating patient.
- The trust advised that that compliance with the completion of NEWS charts and that an appropriate response was achieved following triggers being met, was audited. We saw the results for this hospital for August 2015. This showed completion of the NEWS charts as being 99% however an appropriate response to triggers was only 40%. This would indicate that nursing staff were potentially failing to appropriately escalate deterioration in a patient or medics were failing to respond when requested to do so.
- We asked the trust to provide further audit information and found that these figures were improving being 96% / 50% in September, 100% / 60% in October and 85% / 82% in November 2015.
- All wards at the hospital used Sepsis 6, a tool designed to identify sepsis in the early stage and to enable

prompt treatment. Each ward at the hospital displayed sepsis safety crosses which monitored the recognition of sepsis. This was audited daily by a team within the hospital.

- The endoscopy unit at the hospital catered for in patients requiring urgent endoscopy as well as out patients undergoing endoscopic retrograde cholangiopancreatography (ERCP). This meant that patients requiring endoscopy had their procedures performed on the same day.
- Patients who were seriously ill, for example, suffering from a major gastrointestinal haemorrhage, were also able to have emergency endoscopy under general anaesthetic in the hospital theatres, which were located adjacent to the endoscopy facility.
- We were told by staff that falls assessments were completed for patients as part of baseline risk assessments. Staff we spoke with told us that when a patient was identified as at risk of falls this would trigger the falls bundle being put in place which included a falls action plan, 'falling stars' stickers on the notes and a poster being displayed on the patients door or at their bedside to highlight the risk. We saw these measures in use during our inspection.
- We spoke with a nurse who also told us that patients at risk of falls would have a medication review performed and that sensor equipment was also available to support staff in caring for high risk patients. Staff were also able to refer patients to the falls team.
- A staff nurse told us that one to one observation or nursing within a high visibility area was available for high-risk patients. We saw this in place for patients who were at high risk of falls.

Nursing staffing

- The National Institute for Health and Care Excellence (NICE) state that, when making decisions about safe nursing staff requirements for adult inpatient wards in acute hospitals, assessing the nursing needs of individual patients is paramount. The service had implemented a 'Safer Nursing Care Tool' (SNCT) to assess the staffing requirements across wards.
- On most wards we found that the planned numbers of registered nurses (RN's) was less than the actual numbers on duty. When this happened additional care support workers (CSW) were deployed.
- We looked at the staffing 'fill rates' for September 2015 and found that these varied between 80% and 95% for registered nurses working day shifts and 81% and 100% for night shifts. CSW shifts varied between 82% and 100% on day shifts and 92% and 100% for night duties.
- Staff we spoke to on ward 6 raised concerns about the staffing levels. We looked at six weeks of rosters for ward 6 for 2nd November to 20th December 2015 and found that the planned staffing levels were only achieved on four days. On eleven days there were only two registered nurses identified as having worked or planned to work. On three of the eleven days there was only one registered nurse on the roster. We were told that staff were moved to support other areas but could not see evidence of this on the rosters we reviewed.
- We discussed this with managers who told us that the short stay and ambulatory care service provision had very quickly escalated after the hospital opened in June. As a result of this the business unit had met and agreed to increase the establishment to ensure that the planned staffing levels were increased from three to four RN's on duty during the day and from two to three RN's overnight. In addition to this a twilight RN would also be rostered. This was because the ambulatory care unit closed at around midnight therefore additional staff were needed until this time.
- We were told that an escalation procedure was in place on ward 6. This was based on staffing versus dependency of patients. There were also nurse practitioners and registered nurses at two other hospital sites who provided follow up clinics and also provided interventional clinics to deliver treatments such as blood transfusions. We were told that if no interventional treatments were planned, the registered nurses would move to this hospital to support staffing.
- In addition to the above staffing for the short stay unit, we were told that a nurse practitioner team worked alongside the medical staff (a consultant, a registrar, an FY2 and an associate specialist) in the ambulatory care unit. We were told that there were thirty beds on the unit and that these were flexed between short stay and ambulatory care based on patient need. Nurse practitioners were on duty from 8am until 8:30pm.
- During our unannounced inspection we visited ward 6 and were told that the ward had managed to secure two agency nurses who were working regular shifts. The ward manager told us that staffing levels were improving.

Medical care (including older people's care)

- On ward 12 (respiratory), there were 19 general respiratory beds and an 11 bedded respiratory specialist unit (RSU). The RSU accommodated level 2 patients (Patients requiring more detailed observation or intervention) including some who required non-invasive ventilation (NIV). The recommended staffing level for this type of unit was one RN to every two level 2 patients. We were also told that the bariatric room would often accommodate a patient requiring level 2 care. This room was outside of the RSU pod so the patient would require one to one nursing.
- The ward manager of the respiratory unit told us that the vacancies on the unit were 1.8 whole time equivalent (WTE) band 6's, 2.8 WTE band 5's and in addition there were 2.6 WTE band 5 staff on maternity leave.
- We were told that gaps in rosters within the respiratory unit were filled with bank or agency staff and also with overtime shifts for established members of staff to ensure recommended staffing levels. We saw evidence of this in the rosters we reviewed.
- There was one RN and two CSW's on duty when we visited the discharge lounge. Staff told us that they felt that the staffing levels were appropriate for the acuity of the unit.
- We asked the trust about any plans that were in place to address the staffing. The trust told us NSECH adult in-patient wards are planned to undertake the safer nursing care tool (SNCT) audit as part of the trusts six month staffing establishment reviews. This is planned to commence following training for ward managers in January 2016.

Medical staffing

- The proportion of consultants and junior doctors at this trust was very similar to the England average**.**
- Emergency care consultants were on duty at the hospital twenty four hours a day and specialists in a range of conditions also worked seven days a week. It was reported that this was the first purpose built hospital of its kind in England to have this level of medical cover.
- Nursing staff we spoke to told us that having senior medical staff on duty seven days a week was beneficial to patients and also improved patient flow.
- Locum medical staff were utilised but these were usually medics who had previously worked at the hospital.
- We spoke to a junior doctor who told us that they worked one weekend in four and one long day every four days. They said that consultants were available twelve hours each day and completed daily ward rounds.
- A junior doctor told us that consultant ward rounds were 'good' and that because of the consultant presence it was easy to escalate any concerns about a patient.

Major incident awareness and training

- There was a major incident plan in place and staff we spoke with displayed an understanding of this.
- The numbers of staff who had completed major incident training was not included within the training figures provided by the trust.
- The trust was part of the North East Escalation Plan (NEEP). Throughout the winter NHS organisations in the North East report their NEEP levels in relation to their level of activity they are having to deal with and the level of resources available (surge and capacity).
- The NEEP is based on six levels of escalation ranging from 1: normal working (white alert) to 6: potential service failure (black alert). All of the alerts have agreed triggers and actions whereby staff review individual systems and escalate command and control accordingly within their respective organisation.
- During our inspection, the trust was at a NEEP level 2. The modern matron told us that there is a dial in at 08.30 each day with the other business unit matrons to discuss pressures across the trust.
- Staff we spoke with told us that the discharge lounge opening times were being extended as part of winter planning.
- A manager we spoke to told us that regular emergency generator tests were performed.

Are medical care services effective?

Good

We rated effective as good because:

Local pathways, policies and guidelines were regularly reviewed to ensure that these were in line with national guidance and formal procedures to audit compliance with standards were implemented. There was limited evidence of specific patient outcomes because of the

limited period of time that the hospital had been open. Staff were aware of key quality performance indicators. From records we reviewed and from speaking to patients it appeared that appropriate pain relief was provided.

Patients received appropriate nutrition and hydration however there was limited evidence that this was assessed appropriately in their care records.

Staff were able to access the information to enable them to assess, plan and deliver care. Robust multi-disciplinary working with all disciplines was evident across all areas of the hospital. Seven day services were part of the new model of care and were becoming embedded within the hospital.

Staff obtained consent prior to treatment and had an understanding of the Mental Capacity Act and the Deprivation of Liberty Safeguards.

Evidence-based care and treatment

- Staff used both the National Institute for Health and Care Excellence (NICE) and Royal Colleges guidelines to determine the treatment they provided. Local policies were written in line with this.
- We reviewed policies during our inspection and found them to be relevant and validated.
- During 2014/15, 32 national clinical audits were relevant to the health services that Northumbria Healthcare NHS Foundation Trust provided. During that period the trust participated in 97% of the national clinical audits which it was eligible to participate in.
- The trust had an annual audit programme. The outcomes of audit undertaken at NSECH were limited due to the hospital only being open for five months. Senior staff we spoke with told us that they were involved in audits and that action plans were created and shared with staff.
- Diabetes research, in particular the long-term self-management of diabetes, was at the forefront of medical research within the medical directorate.
- There were specific care pathways for certain conditions in order to standardise and improve the care for patients. For example, care pathways were used for the care of patients with stroke and the assessment of thrombolysis.
- The Joint Advisory Group on gastrointestinal endoscopy (JAG) is a quality improvement and service accreditation programme for gastrointestinal endoscopy units. We were told that the unit was not JAG accredited; however the trust had plans to address this.

Pain relief

- Pain relief was provided as prescribed and there were systems in place to make sure additional pain relief could be accessed if required.
- Patient records included the management of pain relief and was incorporated into the elements of care. This included the management of pain and checks were recorded as required.
- Patients told us that they were asked about their pain and whether they required any pain relief. Patients we spoke with had no concerns about how their pain was managed.
- A patient we spoke to on ward 9 told us that when they requested pain relief it was always given quickly.

Nutrition and hydration

- Protected mealtimes are periods when patients and service users are allowed to eat their meals without unnecessary interruptions, and when nursing staff and the ward team are able to provide safe nutritional care. This meant that staff were able to provide support to those patients who required assistance.
- Mealtimes were protected, however visitors told us that there was flexibility to support relatives with their meals.
- Patients were assessed regarding their nutritional needs using the Malnutrition Universal Screening Tool (MUST). Completion of MUST was variable within the records we reviewed.
- Nutritional assistants offered nutritional support to patients who required assistance with feeding and drinking.
- We saw water jugs with red lids at patients bedsides. This initiative allows appropriate patients who require assistance to eat and drink to be easily identified.
- A patient we spoke to told us that the food was excellent and they had eaten more than they would usually do at home.
- Staff in the discharge lounge told us that a hot meal was provided for patients who were present at mealtimes. Hot drinks were offered throughout the patients stay on the unit.

Medical care (including older people's care)

Patient outcomes

- The trust provided evidence of their contribution to previous National Clinical Audit and Patient Outcomes Programme (NCAPOP) in relation to adult and inpatient diabetic patients, Cardiac Rhythm Management Devices and also to the National Institute for Cardiovascular Outcomes Research (NICOR), Ulcerative colitis, Lung cancer – mesothelioma and Sentinel Stroke National Audit Programme (SSNAP).
- The Sentinel Stroke National Audit Programme (SSNAP) is a programme of work that aims to improve the quality of stroke care by auditing stroke services against evidence based standards. In the SSNAP results for 2015, NSECH was rated A. This is the highest score possible.
- We saw evidence of action plans to address any deficits in the care and treatment of patients. For example, within the diabetic audit, key recommendations were highlighted and there was a trust response and action plan.
- There was limited audit outcome data available for the hospital due to the limited time that it had been open. The hospital was contributing to the audit programmes and this would be reflected in future audit outcomes.

Competent staff

- 46% of staff at the hospital had an up to date appraisal at the time of the inspection. Managers were aware of this and plans were in place to ensure that all appropriate staff would have an appraisal before the trust's target date.
- We spoke with three staff who told us that they had received an appraisal and were given opportunities for additional training.
- A ward junior doctor we spoke with said that they were well supported by the consultants and nurses, who would be present on ward rounds. This member of staff told us that some teaching was informal and varied depending on consultants and also the enthusiasm of junior staff. Formal on-site training was also available.
- This doctor told us that the model of care within the hospital meant that they gained less experience than when they had worked in hospitals with a more traditional model due to the greater presence of consultants.
- Endoscopy at NSECH was carried out by gastroenterologists.
- On the respiratory ward, the NIV was a physiotherapist led service and registered nurses working in the RSU were respiratory trained.

Multidisciplinary working

- We saw evidence of multi-disciplinary working across all medical wards.
- We attended three handovers and found that staff worked together to optimise the outcomes while ensuring the safe care and treatment of their patients.
- On ward 6 we observed a huddle at 9:30am and 1pm. On both occasions a multidisciplinary review of all patients on the unit took place with all staff on duty present including the ward physiotherapist. A discussion also took place in relation to any planned admissions and also any staffing issues which may affect the units.
- We attended a morning board round on ward 4 which was attended by the ward consultant, junior doctors, and all nursing staff including the ward manager. Board rounds are multi disciplinary handovers that all staff attend. These meetings took place in addition to nursing handovers. All members of the team attend to prevent duplication in communication.
- The board round was led by a band 5 registered nurse. All staff had an electronic handover sheet which gave a brief summary of all patients. The meeting started on time and was comprehensive. The team discussed specific details where required, such as a patient with a lack of mental capacity and the issues around this in relation to deprivation of liberty safeguards.
- We were told that a total hospital board round in A&E preceded this meeting.
- A manager we spoke with told us that the hospital consultants, including A&E and hospital at night team have a handover at 8pm each evening.
- Medical staff from ward 12 told us that regular multi-disciplinary handovers took place each day at 8am and 8pm, and these were attended by consultants.
- We were told that all consultants worked well together
- We were told that the ward social worker attended the board meeting for the HASU each morning.

Seven-day services

- All members of the multi-disciplinary team worked over the seven-day period. Consultant ward rounds took place every day.
- Xray, imaging and diagnostics including endoscopy were available seven days a week.

Medical care (including older people's care)

- Staff we spoke with told us that pharmacy staff including pharmacists were present at the hospital every day. A seven day dispensing service was provided from North Tyneside General Hospital. There was no on site dispensary provision at this site.
- The respiratory ward had a specialist respiratory physiotherapist and a respiratory consultant on duty seven days a week until 8pm and an on call service at all other times.
- We saw evidence of a physiotherapy weekend prioritisation flowchart for all teams on all sites. This was red, amber and green (RAG) rated meaning patients were prioritised dependant on need.
- The discharge lounge was open 9am until 5pm seven days each week. We were told that the lounge would extend the opening until 9pm for winter pressures.

Access to information Staff information/access guidance

- We were told that NICE guidelines were used and that all policies and procedures were available electronically on the trust intranet.
- Staff we spoke with during the inspection confirmed that they could access this information electronically. Some wards had paper based folders for staff to access.
- We spoke to four junior doctors all of whom told us that clinical guidelines were easily accessible on the hospital intranet

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

- Mental Capacity Act - Level 1 training had been completed by 93% of staff at the hospital.
- Consent to share information was documented in the care records we reviewed.
- We witnessed staff seeking consent before providing care and treatment during our inspection.
- Patients we spoke with told us that staff asked permission before undertaking any care or procedures.
- We were told that consent was obtained for patients undergoing endoscopy while they were on the ward.
- Staff we spoke with told us that they were aware of and had training in Deprivation of Liberty safeguards. Trust figures showed that more than half of the staff at the hospital had completed this training.
- Two junior doctors we spoke with told us that they had experience of DoLS and the documentation for this.

Are medical care services caring?

Outstanding ☆

We rated caring as outstanding because:

Feedback from patients and visitors was overwhelmingly positive. Patients felt involved in their care and their physical needs were not the only consideration. All patients said they felt emotionally supported by staff. Patients and relatives understood what their plan of care was and were able to be involved with this. Staff were committed to providing high quality patient focused care.

Patients privacy and dignity was maintained. The hospital had robust procedures in place to protect patients and to ensure that they were supported physically, socially and psychologically.

Nursing and medical staff were involved in innovative practice to ensure that patients and carers had positive experiences while in hospital and after discharge.

Compassionate care

- Overall response rates for the Friends and Family Test at the trust were 25% between July 2014 and June 2105, which was lower than the England average of 34%. Between 71-100% of patients on individual wards said they would recommend this service.
- Friends and Family data for the medical wards at this hospital in October 2015 showed a response rate of between 0 and 29%. Between 89 and 100% would recommend the ward where they were cared for.
- The real time inpatient survey data, which measured the patient experience over ten domains including respect and dignity, involvement, cleanliness, pain control, medicines, noise at night and kindness and compassion was used at this hospital. Overall the wards at this hospital scored 9.55 out of 10 patients who would recommend the service.
- All patients we spoke to told us they felt safe.
- We observed nurses on all wards we visited responding to patient call bells quickly.
- The hospital to home team went out of their way to ensure patients needs were attended to at the point of discharge.

Medical care (including older people's care)

Understanding and involvement of patients and those close to them

- Information provided by the trust highlighted a carers' task group, involving family carers, community and acute professionals, which had been set up in 2014. This group was founded primarily to support the Shared Purpose Programme to ensure that carer issues were integral to the improvement of compassion and dignity in care on the elderly care wards.
- The hospital also provided evidence of the work they have undertaken to ensure that doctors bring a positive attitude towards carers, throughout general practice and the hospital specialties they choose to specialise in.
- A second patient we spoke with told us that she had been admitted to the ward on the morning and was awaiting a bed on a different ward. They told us that they were 'nil by mouth' because they were waiting to be seen by a doctor. They said they: 'didn't really know the plan'. This patient told us that the staff were polite and friendly.
- We saw that patients were appropriately dressed in their own clothes to maintain their dignity.
- A patient we spoke to on ward 9 told us that they were aware of their plan of care. A second patient told us that the staff were 'wonderful'.
- A patient we spoke with on ward 10 told us that they had been: 'kept informed throughout' and that this admission had been: 'the best experience' of being in a hospital. They also said that because they were near the nurses' station they could hear the staff and felt that they were: 'working together'. They said that staff: 'go the extra mile' and everyone including the ward clerk 'are so nice'.
- A patient on ward 12 said that they felt able to ask questions and everyone spoke to them in a way they could understand. Their buzzer had been answered quickly and all the staff were lovely.
- A patient in the discharge lounge told us that they had come from A&E and that it was: 'great in here and much more comfortable'.
- The Trust audited the experience of in-patients and patients had reported that they were not always sure of what their new medication was for. As a result of the audit, a patient information leaflet 'Keep calm and ask a member of staff' was introduced by the pharmacy department, which asked three key questions: whether they understood the purpose for their new medicine; did they know of the side effects to watch out for; and how to safely take their new medicine. If the patient could not answer yes to the three questions, they should 'keep calm and ask a member of staff'.

Emotional support

- Almost all patients said they felt emotionally supported by staff.
- The mental health liaison team provided support for patients identified with low mood; we saw evidence of this interaction in patient notes and support plans.
- The medical service had strong links with the psychiatry old age service to look at emotional needs of patients. They could be accessed as required.
- A counselling service was available for patients.
- Clinical nurse specialists were available for support and advice, for example, for diabetes and respiratory conditions.
- Chaplaincy services were available 24hrs a day 7 days a week.

Are medical care services responsive?

Outstanding ☆

We rated responsive as outstanding because:

Engagement with local stakeholders was excellent. The service had many innovative projects in place to engage and respond to the health needs of the local population.

The model of care at NSECH provided benefits for the trust's other hospital sites. Separating serious emergencies from planned care meant that patients attending for planned operations, tests, and outpatient clinic appointments at other bases did not have their care affected by the need to prioritise seriously ill emergency patients.

Patients could access the service in a timely way and continuity of care was maintained. Since opening 6,336 (93%) of patients had been admitted and discharged from the same ward or unit. 452 (7%) had only moved ward once during their admission and 16 patients had moved wards twice. This meant that the majority of patients had consistency in relation to their care and treatment. Patients were not transferred between wards at night.

Medical care (including older people's care)

The needs of different people were taken into account when planning and delivering services. We saw a number of initiatives in place for patients suffering with dementia and the hospital was also actively involved in piloting other examples of innovation to improve patients individual needs. Written information was accessible for patients and those close to them.

We found that staff at all levels were engaged in dealing with complaints and that the learning from complaints was shared across teams.

Service planning and delivery to meet the needs of local people

- The development and subsequent opening of NSECH in June 2015 followed many years of discussion and planning with local stakeholders. It also included widespread public engagement.
- We saw evidence of ongoing engagement with external stakeholders such as local authorities, health and wellbeing boards, and clinical commissioning groups in the development of medical care services.
- We saw evidence of this in quarterly forum minutes and bulletins.
- NSECH utilised telemetry system connectivity with a local hospital in Newcastle to identify the most appropriate location to treat individuals with acute cardiac symptoms.
- The diabetes service was involved in Year of Care Partnerships (YoCP) exploring the role of care planning in diabetes care. The trust hosted the YoCP which supported numerous organisations locally, regionally and nationally to implement care planning in diabetes, other long term conditions and various other settings. The trust has a significant national profile and influence as a result, including research papers on person centred care in long term conditions.

Access and flow

- The model of care at NSECH provided benefits for the trust's other hospitals. Separating serious emergencies from planned care meant that patients attending for planned operations, tests, and outpatient clinic appointments at other bases should not have their care affected by the need to prioritise seriously ill emergency patients.
- Since opening 6,336 (93%) of patients had been admitted and discharged from the same ward or unit. 452 (7%) had only moved ward once during their admission and 16 patients had moved wards twice. This meant that the majority of patients had consistency in relation to their care and treatment. Patients were not transferred between wards at night.
- Information provided by the trust indicated that eleven medical speciality patients had been cared for in a surgical ward since the hospital opened in June 2015.
- Most staff we spoke with told us that patients were admitted through accident and emergency and then transferred to their required speciality ward. Patients would remain at the hospital during the acute phase of their illness and then be transferred either to an alternative hospital for the remainder of their recovery or they would be discharged to their own home.
- Staff we spoke with told us that they sometimes nursed patients from a different medical speciality but that the patients consultant would visit the ward to see these patients. Junior doctors told us that patients sometimes remained in A&E or were transferred to the short stay ward if a speciality bed was not available.
- A manager we spoke with told us that wards aimed for morning discharges and that 'golden' patients were identified at handovers. These were patients who would have their transfer or discharge arrangements made in a timely manner to relieve bed pressures and to further assist in the new model of care.
- We were told that most patients were admitted for 48 – 72 hours although we did see evidence of longer in patient stays for some conditions. A manager told us that all patients with an in-patient duration of ten days were flagged.
- Information provided by the trust indicated that nine cardiology patients had their procedures cancelled at this hospital. 2 in June, four patients (two day cases and 2 elective inpatients) in July, one elective inpatient in August and two elective inpatients in September 2015.
- Staff we spoke to told us that endoscopy waiting times were minimal and that patients had their procedure as soon as possible after the request was received.
- Nursing staff in cardiology told us that the increased consultant presence was reducing the numbers of patients who needed to be admitted overnight due to medical staff being available later in the day to review investigation results.

Medical care (including older people's care)

- The 'Hospital to home team' provided integrated discharge planning and support within the hospital discharge model to ensure prompt safe and effective discharge planning.
- The pharmacy team had highlighted that medication discharges were often delayed due to the time taken to write the discharge prescription. The trust had a high number of active pharmacist prescribers; one of which had started to write discharge prescriptions at the time that a consultant had informed the patient they can go home. This meant the time taken for these patients to be discharged home had now been reduced.
- Staff on ward 7 told us that delays in transfer of care to a base site hospital or patients homes were usually due to the ambulance service. When delays occurred staff reported these as incidents.
- Delays were also attributed to junior doctors not completing electronic discharge documentation but that these issues were usually resolved by the consultants.
- A discharge lounge was available in the hospital and we were told that this was used to relieve bed pressures.
- We were told by staff on the discharge lounge that they do ward rounds to identify any patients who may be suitable to be transferred to the unit. This meant that bed pressures were reduced in a safe and timely manner.

Meeting people's individual needs

- The trust had piloted a 'learning about the person' programme. They provided evidence of how this learning was structured to support staff when caring for patients with dementia. This had been evaluated by staff as valuable. The trust reported that 131 staff from five of the medical wards at the hospital had attended this training.
- On ward 7 we were told that patients were screened for dementia and that a dementia pass passport was used. There was also a dementia team available for support in addition to the ward dementia champion. The ward had bright coloured crockery to assist dementia patients.
- We saw dementia champions on many of the wards who were able to support and give advice to staff and relatives.
- Ward 7 also used a patient passport for patients with learning disabilities (LD). This highlighted individual patient needs and preferences. Staff were aware that there was an LD team who could provide support, in addition to this staff told us that they would involve the patients social worker and any care workers if available.
- Projects were in place across the trust, such as: older people's health champion's programme; a living with dementia course, which offered practical support to help with daily living; open the door to loneliness within older age events; and the supported walks programme for people with dementia in West Northumberland.
- Staff we spoke with were aware of translation services available for patients whose first language was not English.
- Junior doctors we spoke to said that end of life care at the hospital was extremely good becauseit was accessible and they were often involved in the care of these patients. They also told us that a care of the dying pathway was in use for these patients.
- Staff we spoke with told us that they had a good psychiatric liaison service available within the trust.
- Patients diagnosed with a dementia had an elderly patient assessment, which included a mental health assessment. The psychiatric team linked into theses assessments and offered 1:1 support to families.
- Access to information for patients and their families was good. We saw examples of comprehensive information for patients regarding the management of their health conditions in several languages.
- We saw written patient information leaflets available on all wards we visited during our inspection. These included information on the Patient Advice and Liaison Service (PALS), MRSA, infection prevention and control, falls, protected mealtimes, hospital chaplaincy, carer's information, alcohol consumption, smoking cessation and delirium.
- To support and promote patients individual religious and cultural needs there were relevant information sheets available within the clinical areas.

Learning from complaints and concerns

- Every ward we visited had information about how to make a complaint prominently displayed, which included PALS posters and support.
- The service had a positive approach in adhering to the Duty of Candour regulations.
- Staff followed the trust's complaints policy and provided examples of when they would resolve concerns locally.

Medical care (including older people's care)

- Patient experience information including concerns were captured in a variety of different ways. The trust completed real time surveys, '2 minutes of your time surveys', patient perspective surveys and national patient experience surveys. We saw feedback of this data at ward level including staff meetings, and on the intranet and performance display boards.
- Staff at the hospital felt that they did not receive many complaints. Information provided by the trust showed that there had been 32 complaints about the medical wards at the hospital since opening in June 2015
- Patients we spoke with told us that they would feel comfortable raising concerns if necessary and they would do this with the nurse in charge or their doctor.
- Matrons had an "open door policy" to support patients and discuss any concerns and had developed a culture of honesty to discuss all concerns.
- We saw evidence of complaint discussions at all levels from local supervision to board level.
- A ward matron told us that they visited a family at home following their discharge to resolve a complaint.
- A ward manager we spoke with told us that complaints were investigated and feedback was given as required to the team and individuals. Complaints were also discussed at the monthly clinical governance meeting.

Are medical care services well-led?

Good

We rated well-led as good because:

The trust had a clear strategy and vision which was known and embraced by staff at all levels. Staff survey results reflected this. Staff were aware of and respected the trust's values.

The medical services were managed by an experienced and cohesive team who demonstrated an understanding of the challenges of providing high quality, safe care. Within this hospital, local managers had particular challenges regarding staffing issues and completion of risk assessments which were acknowledged but still required addressing and embedding. Governance processes were in place which allowed clear identification and monitoring of risk and we saw evidence of related progress and action plans. Staff and patient engagement was seen as a priority with several systems in place to obtain feedback. Innovation was encouraged. Diabetes research, in particular the long term self-management of diabetes, was at the forefront of medical research within the medical directorate.

Governance processes were embedded which allowed clear identification and monitoring of risk and we saw evidence of related progress and action plans.

We observed a positive open culture with all staff focused on providing high quality, safe patient care.

Staff and patient engagement was seen as a priority with several systems in place to obtain feedback. Innovation was encouraged.

Vision and strategy for this service

- The opening of NSECH in June 2015 was a result of several years of planning and consultation. This was the first hospital in England to be built using a new model of care to optimise operational efficiency and improve patient experience and outcomes. The service had implemented its long term strategy with the opening of the new hospital and reconfiguring services at North Tyneside General Hospital.
- There were short term strategies to manage situations which had arisen as a result of the changes, for example a safer staffing review and a focus on recruitment. We were told about plans to relocate two wards within the hospital to areas where the environment would be more suitable for the patients they are caring for.
- There was a very clear vision of delivering the highest standards of patient care with quality and safety as a key focus. Staff from all areas we visited were aware of the vision of promoting safe and effective care to improve patient experience. This was reflected in the 2014 NHS staff survey results as 84% of staff said that care of patients is my organisations top priority, the national average for this was 70%.
- All staff we spoke with were aware of and able to describe the ethos of the trust's values.
- A manager we spoke with told us that they thought the emergency care model 'really works'. They said that staff were adapting to the new way of working and although there was a huge demand on resources patients were getting 'a really good deal'.

Governance, risk management and quality measurement

Medical care (including older people's care)

- There was a well-defined structure for risk management and governance. We reviewed minutes of the clinical governance meetings which took place every two months. There were systems in place to cascade and share information from these meetings to staff.
- The senior management team highlighted their top risk as nurse staffing. The wards we visited told the inspection team about the safer staffing tool which had been used to gather data between September and October 2015 and that they felt reassured that this would demonstrate the increased acuity of the patients they were caring for and help inform a review of ward establishments.
- We spoke to the ward manager on ward 6 who described the staffing difficulties that were being experienced on the ward. The manager told us that she 'doesn't like the ward to struggle' and that patient care is prioritised. This had resulted in her being unable to complete audits on time. The manager told us that senior staff were supportive but recruitment and retention was a concern. We looked at rosters and it was evident that the planned registered nurse staffing levels were frequently not met.
- The senior management team saw demand and volume as their other risk.The new way of working with NSECH opening had transformed the way healthcare was being delivered and it was acknowledged that some systems and processes were still developing and being adapted. In particular the complexities of patients were greater than expected so there was ongoing work with patient pathways.
- We reviewed the departmental risk register which was reviewed at the clinical governance meeting. This was separated into sub-business units with a designated officer for each. We reviewed the information on the risk register and found it was in alignment with what staff felt was the biggest risk or 'worry' to the service. There were action plans, review dates and completion dates attached to each risk. For example, the difficulty in recruiting qualified nurses into elderly medicine.
- Most of the staff we spoke with could talk about the Duty of Candour and we were provided with examples of when this had been used. We observed an open culture in relation to incident reporting and complaints and associated learning.
- We saw evidence of robust clinical internal audit activity covering a wide range, including sepsis, hand hygiene and nutrition. Much of this data was displayed in public areas and action plans were seen where improvement was required.
- The trust's Medicines Management Committee oversaw and managed patient safety alerts, medicines incidents and medicines use, including controlled drugs, within the trust. Minutes from these meetings showed appropriate actions and management of identified issues with clear action plans put in place where needed.
- On ward 7 we were told that the nursing staff were well supported by the consultant and that they jointly attended the monthly clinical governance meeting.
- Two junior doctors we spoke with were not aware of the governance meetings.

Leadership of service

- We saw evidence of strong leadership and clinical engagement. Leadership was encouraged at all levels and staff were supported to try new initiatives, for example due to flexible working some physiotherapy staff within the hospital were able to provide follow up at home for some patients to give continuity of care. This was seen in the 2014 NHS staff survey results which showed 76% of staff reporting they feel able to contribute to improvements at work; this was higher than the national average of 68%.
- A manager in one area explained that they were experiencing difficulties due to a lack of flexibility with the model of care. This appeared to be causing tension in the working relationships on the unit. The manager felt that retention of the current staff was a priority. Staff had been referred to occupational health for stress risk assessments. Safety huddles were held regularly throughout the day which highlighted staffing issues as well as patient need. This issue had been escalated to senior staff.
- The management team demonstrated a clear understanding of the challenge of providing high quality, safe medical care with the reconfiguration of services and ongoing review of patient activity and acuity.
- Staff told us the executive team were visible and senior managers supportive. This was particularly mentioned by senior nurses we spoke with as many were relatively new to the post.

- Staff told us there were good relationships with line managers and comments such as 'my manager is exceptionally supportive and knowledgeable' were made. This was reflected in the NHS 2014 staff survey results which showed a score of 3.89 for staff being supported by immediate managers; this was higher than the national average which was 3.65.
- We observed matrons in clinical areas during our inspection who demonstrated a good awareness of activity for that day and any risks within their service.
- A ward manager we spoke with told us that she had daily contact with the matron and the operational service manager.
- We were also told that 'general managers' were seen twice a week and a member of the executive team also visited weekly. The director of nursing had visited two weeks prior to our inspection but we were told that senior staff would also 'appear' if wards were busy.

Culture within the service

- We were told by the senior management team that a lot of energy was placed on the culture of the trust particularly in relation to the new hospital opening. This was evident throughout our inspection and although staff had gone through a significant period of change they were very positive.
- The senior management team told us the good relationships between doctors, nurses and management had helped support meaningful change.
- Staff told us they felt work was an environment which gave freedom to make decisions and all staff were on an equal footing. Staff referred to 'The Northumbria way' which brought together all the programmes of work within the trust. Senior management told us there had been occasions where staff had not been recruited if they were not supportive of this way of working.
- We were told the change had to be supported and led by consultants so a lot of time was spent building those relationships. In addition to this the recruitment process for new consultants has helped to recruit the right people by having a mixed interview panel of different grades of staff to gain a wider perspective.
- We observed strong multidisciplinary team working which was patient focused. Staff of all grades told us they felt valued and respected, and a junior doctor commented: 'it is the best trust I've ever worked in'. As a staff group they told us they are listened to if they raised concerns.
- Results from the 2014 NHS staff survey indicated 77% of staff felt that they would be secure raising concerns about unsafe clinical practice. This was better than the national average.
- A junior doctor we spoke with told us that the hospital was an: 'excellent place to work'. Four junior doctors said that it was a: 'good place to be treated' and that they 'would be happy for family or themselves to be admitted here'.
- We spoke to two further junior doctors who had worked at the hospital for three months. One described the hospital as: 'great'. They told us that the nursing staff were 'really good'. One negative was that the workload was 'very acute' but there was a positive team approach.
- Staff we spoke to told us endoscopy shared the general theatre recovery unit and that there appeared to be resentment from the theatre staff about this practice. There was no evidence that any patients were suffering any harm because of this and meetings were arranged to attempt to resolve this issue.
- We spoke with managers who told us that they felt the trusts innovation in aligning recruitment with their values was seen as being beneficial and that managers were seeing newly appointed staff with attributes which were expected within the caring profession**.**

Public engagement

- There was evidence of extensive engagement with patients and the public and the trust actively sought their views and opinions.
- The patient experience team visited the medical wards monthly and collected data from patients. Findings were fed back the following day to ward sisters. Comments from patients were also displayed on notice boards within each ward area.
- Data relating to inpatient experience was displayed on each ward and covered several areas such as dignity and respect, involvement and pain control, and each was given a score out of ten.
- Two minutes of your time feedback was also collected on discharge.This asked six key questions about the care patients received during their in-patient stay.
- Information about real time patient experience was displayed on all wards we visited. Staff we spoke with told us that the patient experience team collated the views of ten patients twice a month and the results were then used to produce statistical graphs and posters for

individual wards. Ward managers told us that they reviewed the data and fedback the data at team meetings. Themes and trends were also looked for and highlighted if necessary. All information including patients comments, good and bad, were displayed on wards.
- The service actively promoted projects relating to patient experience. An example of this was the 15 steps challenge.

Staff engagement

- Frontline staff told us they felt fully informed about all the changes which had taken place and the management team told us they were: 'enormously proud of how the staff had coped with the massive changes, particularly in areas where two wards had merged'.
- We saw evidence of regular monthly staff meetings and the staff we spoke with felt engaged with the service and senior management.
- Results of the 2014 NHS staff survey showed a score of 3.93 which was higher than the national average of 3.74 for staff engagement.
- Significant numbers of staff had experienced substantial change as a result of NSECH opening in June. Staff told us they had felt involved in discussions and were kept informed of any changes.
- We were told by junior doctors that the volume of patients ensured that they received 'plenty of experience' although the new model of care resulted in less opportunity for them to track a patients journey when patients were transferred to another site following the acute phase of their illness.
- Some junior doctors we spoke to said that it 'can be challenging' working with three different consultants in the same week in one speciality but that the consultants were supportive and they have structured teaching sessions three times each week. A further junior medic told us that structured teaching was provided twice a week and they also had ward based teaching.
- One manager told us that she had five band 6 sisters and she had asked each band 6 to take responsibility for one of the five domains within the 15 steps audits that were completed. The overarching responsibility however remained with the ward manager.

Innovation, improvement and sustainability

- The trust, with the support from the pharmacy team, had developed projects to support patient choice. This included the post discharge service for patients who were at high risk of readmission. Patients were telephoned by a pharmacist who would explain medication changes and to answer any questions the patient or carer would have.
- The falls co-ordinator told us about a pilot new patient information leaflet called 'get up and go'. This was a guide called 'staying steady ' produced by the Chartered Society of Physiotherapists and Public Health England. This provided patients with informative and practical advice on preventing falls. If feedback from the pilot was positive the trust will adapt this for its own use.
- A ward manager we spoke with told us that she held an away day for staff once a year.Usually this was held at the start of the financial year. It was explained that themes were discussed such as patient experience or complaints and that staff created action plans and incentives to address any areas of concern.
- Diabetes research, in particular the long term self-management of diabetes, was at the forefront of medical research within the medical directorate.
- The diabetes service was involved in Year of Care Partnerships (YoCP), exploring the role of care planning in diabetes care. The trust hosted the YoCP which supported numerous organisations locally, regionally and nationally to implement care planning in diabetes, other long term conditions and various other settings.
- The trust has a significant national profile and influence as a result, including research papers on person centred care in long term conditions.
- The tTrust, in partnership with West End Family Health and Health WORKS in Newcastle, and Deakin University in Australia were focusing on people with long-term conditions in primary and specialist care,using a 'Optimising Health Literacy and Access' approach to identify and address strengths and weaknesses in the healthcare system. (Health literacy describes how people find out about health, and understand and use that information to achieve better health).The project team focussed on parallel settings in primary and specialist care, initially the Czech-Roma population in the West End of Newcastle and also people with chronic

lung disease attending specialist clinics in North Tyneside General Hospital. This enabled clinicians and community members to co-produce innovative, locally relevant service redesign and improvements.

Surgery

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

Information about the service

Northumbria Specialist Emergency Care Hospital (NSECH) opened on 16 June 2015, providing specialist emergency care for seriously ill and injured patients from across Northumberland and North Tyneside.

It is England's first purpose-built specialist emergency care hospital, with emergency consultants on site 24 hours a day, seven days a week, as well as consultants in a range of specialties working seven days a week. The hospital treats serious emergencies such as suspected stroke, loss of consciousness, persistent and severe chest pain, sudden shortness of breath, severe abdominal pain and severe blood loss.

All patients requiring specialist emergency care are admitted to NSECH directly or from one of the 'base' hospitals at Wansbeck, North Tyneside and Hexham. Planned surgery which is considered to be high-risk is also carried out at NSECH, surrounded by relevant experts and support services such as critical care which may be needed in an emergency.

Patients were discharged to home or to one of the 'base' hospitals for further rehabilitation, care and treatment if they no longer needed emergency treatment. The transfer of patients between NSECH and the 'base' hospitals was still being configured at the time of inspection and staff were working flexibly to accommodate patient needs.

NSECH provided emergency surgery and orthopaedic trauma services, elective breast and reconstructive microsurgery, colorectal surgery, upper gastrointestinal, endocrine, bariatric (weight loss), urology and care of higher risk patients that may need critical care support as part of their recovery and treatment.

During this inspection we visited surgical Ward 1 (trauma and orthopaedics), Ward 3 (surgery) and the Surgical Assessment Unit, which was open 8am until 8pm at the time of inspection. We visited all 6 theatres on site and observed care given and surgical procedures undertaken.

We spoke with 22 patients and relatives and 26 members of staff. We observed care and treatment and looked at 14 care records.

Surgery

Summary of findings

We rated surgical services as outstanding because:

The hospital provided a new model of elective and emergency care to its population and at the time of inspection NSECH had been open for 5 months. The provision of specialist emergency surgical care, with consultants on site 24/7, as well as consultants in a range of specialties working seven days a week was embedded across the trust and appeared to be working well. At the end of September 2015, the trust was meeting the NHS operational target of 92% of patients waiting less than 18 weeks for treatment. Six theatres were open at NSECH, seven days a week. There were innovative approaches to delivering patient care and evidence based practice based on national guidance and benchmarking was evident across the trust.

Strong governance structures were in place across surgery and there was a systematic approach to considering risk and quality management. Performance data and information was available and displayed at NSECH, albeit limited from the month of opening in June 2015. The trust team had been consistent in its approach to communication, and having good systems and processes in place to protect patients and maintain their safety. Staff we spoke with in surgery at NSECH understood the process for reporting and investigating incidents and there was a good reporting and feedback culture. There had been no serious incidents at NSECH and 150 reported incidents in surgery since June 2015, with very low incidence of minor patient harm being recorded at this site.

Senior managers had a clear vision and strategy for the division and identified actions for addressing issues within the division. We were told the service had a commitment to a people centred approach delivering high quality care with robust assurance and safeguarding and saw this in practice during the inspection. Staff told us they were encouraged to challenge existing practices, look for improvements and suggest ways to develop and introduce innovative practice. Staff reflected on the strong leadership and visibility of senior members of the trust board. This motivated staff and they felt that senior leadership reflected the vision and values that they shared with the organisation. Surgical staff we spoke with at NSECH and across all base sites understood the new model of care and consistently spoke of being proud to work for the trust.

The surgical wards were a modern design with majority single room accommodation. They were spacious and visibly clean. We observed new pharmacy technology and new systems for monitoring patient/nurse calls. Staffing levels were good at the time of inspection. Staffing had been reviewed since opening and an increase in both medical and nursing cover had been agreed. Senior and site level leadership was visible and accessible to staff at NSECH. Staff spoke very positively about their immediate line managers and senior leaders and a positive culture was evident during the inspection.

We observed patients being cared for with dignity, compassion and respect in all surgical wards and departments. The 22 patients we spoke with were very positive about the service and staff and surgical services in NSECH had received positive feedback scores and comments for the first few months of delivering services at this hospital site. There was a comprehensive approach used by the trust to capture the patient experience but information was limited at the time of inspection of NSECH.

Surgery

Are surgery services safe?

Good

We rated safe as good because:

The trust had good systems and processes in place to protect patients and maintain their safety. Staff understood the process for reporting and investigating incidents. Staff we spoke with told us that there was good reporting and feedback processes at NSECH. We observed performance data that was trust wide and site specific. Data specific to surgery performance at NSECH was limited at the time of inspection. It was clearly displayed in wards 1 and 3. Very low numbers of patient harm incidents had been recorded since June 2015.

The surgical ward environment was modern in design with good provision of single room accommodation. The wards and departments were spacious, visibly clean and well organised. We saw evidence of regular audit with regard to infection control and cleanliness.

Wards 1 and 3 displayed NHS patient safety thermometer data and very low numbers of patient harm incidence had been reported. .

Staffing levels and skill mix had been planned and implemented at NSECH, however since opening and following a review, appropriate steps were taken to increase both medical and nursing staffing to safe levels.

We observed Multidisciplinary (MDT) handovers and good communication between staff at NSECH. Systems and documentation for staff handover of patients being transferred to base sites was clear at the time of inspection. Staff told us that the use of a Situation, Background, Assessment and Recommendation communication tool (SBAR) had improved handovers.

Completion of patient documentation was good but we observed inconsistent completion of the yellow risk alert document at the front of medical notes which potentially caused delay in assessment of medical alerts for patients admitted directly in an emergency or transferred from other hospital sites.

We observed the 'Five Steps to Safer Surgery' and completion of the World Health Organisation (WHO) checklist was consistently good at NSECH. The trust reported 100% compliance with completion of the checklist in 2014/2015.

Mandatory training was well attended at NSECH and staff we spoke with told us that appraisals and mandatory training had been a priority since the opening of the hospital, as many staff were newly appointed or had been redeployed from other hospitals in the trust. The trust prioritised its safeguarding strategy and work was on-going to ensure all staff are aware of their responsibilities in safeguarding vulnerable adults and children. Overall training targets had been achieved and action plans were in place to meet compliance targets for April 2016.

Incidents

- The Northumbria Specialist Emergency Care Hospital (NSECH) recorded no serious incidents since opening in June 2015. Staff had a good reporting culture and 150 incidents were recorded between June 2015 and October 2015, of which 128 caused no harm to the patient.
- Staff at NSECH understood and fulfilled their responsibilities to raise concerns and report incidents and near misses. Staff were fully supported and attended regular meetings where feedback and learning was encouraged.
- Staff told us how they reported incidents through the electronic system. Learning was shared through meetings, communication books and team briefings. We saw evidence of this approach displayed in staff and patient areas.
- Staff explained the arrangements for clinical governance meetings, including monthly ward meetings on Wards 1 and 3, SAU and theatres.
- Senior Matrons had an overview of every incident, complaint and concern and operated a good system of response and feedback to patients and staff. Staff understood their responsibilities in reporting and learning from events.
- The trust had a mortality and morbidity case review meeting. Due to changes in job plans and team locations meetings had been reorganised and rescheduled. Interim measures were in place to review

mortality and concerns in the absence of formal meetings during this period of change. We were told that the new meeting structure was now in place in surgery.
- Staff on Wards 1 and 3 and Surgical Admissions had attended training in 'Duty of Candour' although they could not share any experience or shared learning at the time of inspection.

Safety thermometer

- Wards 1 and 3 displayed NHS patient safety thermometerdata. This tool was used to measure, monitor and analyse patient 'harm free' care. We observed no incidence of pressure ulcers (PU), and venous thromboembolism (VTE). There had been one urinary catheter associated infection on Ward 3 and two reported patient falls. There was one reported patient fall in ward 1.
- Wards 1 and 3 had a consistent approach to display and share information and data. This was easy to understand and assured people using the service that the ward was improving practice based on experience and information.
- This information was displayed in ward entrances and staff had knowledge of the displayed information and ward performance.
- Information for the past year was displayed for monthly incidence of hospital acquired pressure ulcers, patient falls, urine infections associated with catheter insertion and the prevention of blood clots (VTE) in those patients assessed as being at risk.
- This showed 94% of patients received harm free careand88% of eligible patients had a VTE assessment and 81% ofthese received preventative prophylaxis treatment.
- Wards 1 recorded no new blood clots and two pressure ulcers (grade 2, July 2015 and grade 3, September 2015). Ward 3 recorded no new blood clots and pressure ulcers since June 2015. Since the opening of the hospital in June 2015 ward 3 had one reported preventable urine infection (August 2015).

Cleanliness, infection control and hygiene

- Thetrust has an infection surveillance programme and an infection control team. Policies were available as paper copies, with review dates, and on thetrust intranet. Monthly reports are generated and reported for clostridium difficile infection (C difficile), and Methicillin resistant Staphylococcus Aureus. (MRSA).
- Thetrust reported no incidences of MRSA and 30 cases of C difficile in the previous year, which met the trust target. One case of C difficile had been reported in surgical areas at NSECH in October 2015.
- We saw that the standard of environmental cleanliness was good across the wards inspected.
- Infection control and hand hygiene signage was consistently good and we observed signage for isolation of patients in single rooms that was clear. Each spacious single room has its own private bathroom. The wards have two spacious bays with four beds to each bay but provided mostly single room accommodation.
- Incidence of infection and cleaning audits were displayed clearly to visitors at the entrance to Wards 1 and 3. These showed 100% compliance with clean commodes, hand hygiene, cannula and catheter audits.
- We observed staff washing their hands and all patients we spoke with told us that this was done without exception. Hand gel was available at the point of care and staff used personal protective equipment (PPE) compliant with policy.
- We observed clean equipment throughout surgical areas and staff completed cleaning records and domestic cleaning schedules, and used a tape system which identified clean equipment.
- Wards had appropriately equipped treatment rooms to use solely for aseptic technique and dressing changes. Nursing staff reported treatment rooms had been reinstated as part of the strategy to improve surgical site infection rates. Nurse assessment of aseptic technique competence took place annually.
- The Surgical Site Infection Surveillance Team (SSI) operated a helpline for patients and a system of patient follow-up at two and 30 days post discharge. The team had evidence of improvement, reduction in patient complaints and the impact on reducing wound infection rates in surgery.
- Staff told us about the Sepsis Six care bundle, and information was displayed on performance boards. This initiative had been implemented across the trust as a key priority reducing sepsis related deaths by 30% over the previous two years by improving timely recognition and treatment.

- Clinical and domestic waste disposal and signage was good.Staff were observed disposing of clinical waste appropriately. Linen storage, segregation of soiled linen in sluice rooms and the disposal of sharps followed trust policy.
- Ward managers reported that the domestic team had been outsourced at NSECH but were accessible and good practice was evident. Staff rotated to cover the ward, performance from the team was reported to be good and the ward was clean.

Environment and equipment

- Wards 1, 3,surgicalassessmentunit andtheatres had the advantages of spacious, new build healthcare facilities. Departments appeared bright and well organised.Staff and patients spoke positively about the facilities and environment at NSECH.
- Wards at NSECH all had the same design and large floor plan. Additional storeroom capacity had been identified by converting some office rooms into storage areas.
- The standard of fixtures and fittings in ward kitchens was of an excellent standard; staff told us this had improved the service to patients. We saw a range of food choice, meals and snacks, safe storage and an additional supply of crockery and cutlery that met the needs of patients with specific needs such as dementia.
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- A system was in place to identify patients who required nutritional support to the catering staff. Details of dietary needs for individual patients were clearly identified on displays in the kitchen.
- Ward staff had attended medical device equipment training. However, the self-assessment competency component to the module was not completed to the 85% target in all staff groups in all surgical departments across the trust. These figures would include staff who had been redeployed to NSECH from other hospital sites. Medical device training was being addressed as a priority by ward managers.
- We inspected resuscitation trolleys and suction equipment on both wards and found all appropriately tested, clean, stocked and checked weekly as determined by policy. An emergency Sepsis Six trolley was also checked and found to be clean and stocked. These had been newly introduced to Ward 1 and 3.
- We witnessed three occasions where staff could not give the right directions to visitors who could not find the appropriate ward due to unclear signage.

Medicines

- In Ward 1, Ward 3, surgical assessment unit and theatres, medicines were stored and locked away in line with policy. Clinical treatment rooms had locked keypads for staff access.
- An electronic dispensing system had been commissioned for NSECH. This dispenses medication and identified the registered nurse by fingerprint technology. This provided an audit trail of information and tracks dispensed doses and improves inventory control.
- Medicine prescription records for individual patients were clearly written and medicines were prescribed and administered in line withtrust policy and procedures, reducing the risk of errors.
- Medication rounds were conducted with good practice principles and wards had dedicated support from pharmacy.
- Drug fridges were locked, within the locked clinical room. Fridge temperatures were recorded daily at ward level by nursing staff.
- We reviewed nine Patient Group Directions' (PGD's) used by nursing staff in Wards 1 and 3 and the Surgical Assessment Unit. Five were no longer in date and these were immediately removed and replaced with the current versions available online. Staff signed the updated PGDs and confirmed compliance.
- Storage for intravenous therapy and single use equipment had been rationalised as part of the Well Organised Ward (WOW) project. Senior nursing staff said this had improved practice and availability of essential equipment.

Records

- We looked at 14 sets of medical records at NSECH in wards 1 and 3, the surgical assessment unit and theatres. We saw they were mostly complete, legible and organised consistently but showed variable compliance with staff completing yellow alert forms in records.
- The risk register for surgery identified there were inconsistencies in staff completing alert forms filed at the front of medical records.
- The alert forms provided prompts and the opportunity for staff to record allergies, involvement in medical trials, infection alerts and other associated risks to patients on admission to hospital.

- On wards, patient medical notes were stored in lockable trolleys. Not all notes were in the locked section of the trolley and patient care charts were kept at the bedside for ease of access to staff. We did not observe a breach in confidentiality during inspection but patients and visitors could have accessed notes.
- Daily entries of care and treatment plans were clearly documented by the team. Care plans and charts we reviewed had completed patient assessment, observation charts and evaluations with a small number of acceptable omissions for new admissions.
- We reviewed handover sheets used by ward staff and the Treatment Escalation Plan (TEP) documentation which was effective in communication and decision making for those patients at risk of deterioration.
- We saw thorough completion of observation and monitoring charts at the bedside including the national early warning score (NEWS) observation chart.
- We saw good examples of complete preoperative checklists and consent documentation in patients notes.
- Trust data showed 100% compliance with the World Health Organisation (WHO) safer surgery checklist ('Safe surgery saved lives') between April and July 2015. We observed the WHO checklist used appropriately in theatres at NSECH.

Safeguarding

- Thetrust hada clear safeguarding strategy and a monthly safeguarding board meeting. Minutes and action plans were clear and these meetings are well attended by senior staff from across thetrust. Local safeguarding leads had been appointed. This meeting provided a forum for staff to discuss safeguarding concerns and share learning across the trust.
- Staff we spoke with had attended training and an on-going programme of sessions was available for staff to attend. Thetrust reported in September 2015 that 63% staff had attended safeguarding training and 66% had attended Deprivation of Liberty training, with more staff booked to complete in December 2015. Surgery had an action plan in place to support achieving its compliance targets for safeguarding training, with particular emphasis on the poorly attended level two training.
- Training plans and schedules for staff attendance were well organised by nursing staff and displayed in ward offices.
- An information file was available at ward level with guides, advice and details of contact leads to support staff in safeguarding decision making.

Mandatory training

- Surgery had an action plan in place to achieve compliance with mandatory training targets by April 2016. A compliance target was set at 85% for most modules. Attendance was further broken down into staff group, ward or department.
- Senior staff we spoke with in surgery at NSECH had prioritised staff appraisal and training. They told us that this was done to support newly appointed staff and those that had been redeployed from Wansbeck, North Tyneside or Hexham hospitals. Senior nursing staff had an organised and consistent approach to delivering the mandatory training programme.
- The trust overall compliance with mandatory training attendance in 2014/2015 was 91%. Specific trust data reflected training completed by staff subsequently redeployed to NSECH from other sites within the trust. Across all departments in Surgery, 88% compliance was calculated for 1827 staff.
- Staff told us they accessed mandatory training in a number of ways, such as online modules and eLearning, workbooks and key trainer delivered sessions. Staff said they were supported with professional development through education.
- Staff said they had a good induction and preceptorship programme when joining the trust and attended local sessions and those provided at a trust level.
- Ward Managers on Wards 1 and 3 told us that they had completed appraisals for the new team members. They recognised redeployed staff and newly appointed staff would all need objectives and support and this had been a priority after opening the wards in June 2015.
- We spoke with 26 staff and they told us they were up to date with mandatory training, the access to the training system online was good and they felt supported to attend training and mandatory update sessions.

Assessing and responding to patient risk

- Patients requiring emergency or high risk surgery were admitted to NSECH directly or transferred from one of the 'base' hospitals at Wansbeck, North Tyneside and Hexham. Support services such as critical care had been located at NSECH and consultants were available at all times.

Surgery

- The strategy and processes for recognition and treatment of the deteriorating patient in surgery were embedded. Staff across hospital sites gave examples where escalating a sick patient and transferring them safely to NSECH had worked well.
- Care planning based on patients assessed risk was good. We saw evidence of risk assessment for nutrition with the Malnutrition Universal Screening Tool (MUST) and this helped staff identify patient nutritional needs. Pain scores and diaries for patients were available.
- Staff knew how to highlight and escalate key risks that could affect patient safety, such as staffing and patient assessment and screening.
- Ward Managers, Matrons and Operational Site Managers in surgical services were available and visible and involved in supporting staff and addressing issues.
- Risk assessments, handover processes and safety briefs were observed and we saw all staff worked and communicated well as a team. We observed the 'risk approach' handover sheets used by ward staff on a daily basis and a Treatment Escalation Plan (TEP) was effective in decision making for those patients at risk of deteriorating across the hospital sites.
- Patients at risk of falls were identified and assessed on admission and an individualised plan of care was put in place. We saw planned care delivered, for example:one to one nurse patient ratio;close observation;safety rails on beds;falls stockings;stickers to identify risk on display boards;andthenurse call systembeing in reach.
- There was a system for recognition of the deteriorating patient. We observed 14 patient charts and 100% had a complete National Early Warning Score (NEWS).
- The nurse call bell system in Wards 1 and 3 and SAU had a central function for collection of response times to specific bed areas. Ward managers analysed this information to reduce specific risk to patients. This was an example of innovative technology being used to improve patient care at the NSECH site.
- There were no falls with fractures reported at this site. Thetrust planned further work to improve risk assessment, care and prevention of patient falls in order to reduce incidence of avoidable patient harm.
- Trust data showed 100% compliance with the World Health Organisation (WHO) safer surgery checklist ('Safe surgery saved lives') between April and July 2015. This is a tool for clinical teams to improve the safety of surgery by reducing deaths and complications.
- We observed the checklist being used appropriately in theatres at NSECH and saw completed preoperative checklists and consent documentation in patients notes.
- Advanced nurse practitioner (ANP) cover was available at all times and ANP's felt supported by their medical and nursing colleagues and the wider team. Good communication and teamwork existed.

Nursing staffing

- The National Institute for Health and Care Excellence (NICE) states that assessing the nursing needs of individual patients is paramount when making decisions about safe nursing staff requirements for adult inpatient wards in acute hospitals.
- The Director of Nursing for Northumbria had implemented a Safer Nursing Care Tool (SNCT) to assess the staffing requirements across wards. Decisions were made around staffing ratio for the whole trust based on the work completed.
- A roll out of Stage Two of this programme was planned for September 2015; we did not see results of Stage Two. Senior staff were involved in the initial process and it was recommended that staffing ratio should be one Registered Nurse (RN) to eight patients during day shifts and one Registered Nurse to ten patients on night shifts. Nursing Assistant (NA) ratios were not recommended.
- Numbers of staff on duty was displayed clearly at ward entrances. In Wards 1 and 3 andsurgicalassessmentunit, actual staffing levels were less than planned staffing levels on some shifts. Staff explained this was safe for patients as surgical activity and patient acuity had been assessed. We noted that there were a number of empty beds across the wards on the days of inspection.
- Ward matrons told us that shortfalls in nursing cover were managed day to day with regular senior nurse team meetings and cross-site conference calls as a business unit working together to meet demands in ward activity. The team did share that they had experienced concerns around safe staffing levels and that they made difficult decisions around moving staff across site to cover shortfalls in wards and theatres.
- We were told at the time of inspection that there were four Registered Nurse vacancies on ward 1 and bank nursing three-month contracts were in place to cover as an interim to permanent recruitment.

Surgery

- Staff told us registered nurses and nursing assistants from other hospital sites regularly covered the nursing shortfall at NSECH. Staff recognised that this was to ensure patient safety.
- Staff had been given redeployment choices as part of the redesign of services. Staff we spoke were happy with the arrangements and felt individual nurses and teams were enthusiastic and motivated about working atNSECH.
- Staff were motivated and enthusiastic and one ward sister told us of her development from an apprentice role and how she had aspirations to achieve the trust's'clinical service team of the year'award for the ward.
- A junior nursing assistant had been recruited to the new role of nutritional nurse. This post was introduced to improve recovery for orthopaedic surgery patients by prioritising and enhancing their nutrition as part of the 'HipQuip' trust project, a hip fracture quality improvement programme.
- Staff told us they felt valued, appreciated and listened to by colleagues and senior staff. Staff described the teamwork as one of the best things about working for thetrust.
- Staff told us of plans for developing the apprentice nursing role and of close links with Northumbria University. The care certificate initiative was being introduced for nursing assistants.

Surgical staffing

- Out of hours cover from senior medical staff was provided by NSECH. This included access to all day consultant review for patient care when required. The systems and policies in place for escalation of a deteriorating patient and any subsequent retrieval and transfer to NSECH were seen to be working well.
- Consultant Job Plans were altered to reduce travel so that most only work on a single site on any given day.
- Surgical lists were managed at 'base' hospital sites (Wansbeck, Hexham and North Tyneside) for elective surgery and also at NSECH for emergency and high risk elective surgery.
- Full day lists had been introduced to avoid wasted travel between sites and consultants covered the on call rota at NSECH one week in seven.
- Consultants and junior doctors were available for handovers, ward rounds and MDTs. Staff had good relationships with senior surgical doctors and consultants.
- The development of Advanced Nurse Practitioners for continuous cover of surgical wards at the hospital was embedded and working well in all specialities,for example, bariatric services and breast care.

Major incident awareness and training

- The trust had major incident and business continuity plans in place that included protocols that included deferring elective activity to prioritise unscheduled emergency procedures.
- No major incidents had been declared at NSECH. We observed major incident policy folders in ward managers'offices and these would be available to staff in the event of escalation.

Are surgery services effective?

Outstanding ☆

We rated effective as outstanding because:

Seven day services were provided at the NSECH site. The trust met all 10 national standards for 7 day working with 24/7 access to Consultant care and diagnostic services.

The Northumbria Specialist Emergency Care Hospital (NSECH) opened in June 2015. There were limitations on the collection and analysis of data and performance measures that were site specific. At the time of inspection for example, NSECH was not yet included in national audit data (e.g. standardised relative risk readmission rates). However, surgical teams had transferred surgical work to NSECH and it was accepted that outcomes from trust wide data applied to this activity. We saw an example of innovation where PROMs data within the National Joint Registry was used to change implant brand for hip and knee replacement surgery resulting in significant improvements in health gains.

Patients were treated based on national guidance and surgery took part in all the national clinical audits that they were eligible. All patients reported their pain management needs had been met. Care of patients nutrition and hydration were being met as part of the surgical care pathway. A junior nursing assistant had been recruited to

the new role of nutritional nurse on Ward 1. This post was being introduced to improve recovery for orthopaedic surgery patients by prioritising and enhancing their nutrition as part of the 'HipQuip' trust project, a hip fracture quality improvement programme.

All measures surveyed in the General Medical Council (GMC) national training scheme survey 2015 were within expected levels and did not identify any risks Clinical staff were supported to deliver effective care and treatment through a consistent appraisal and revalidation process. Appraisal rates were above the trust target. Protocols had been developed for the effective handover of patients to the newly opened Northumbria Hospital when needed.

At the time of inspection staff could access information in a timely way at NSECH. Consent to treatment was in line with the trust policy and Department of Health guidelines. Policies and procedures, which staff we spoke with understood, were in place in relation to the Mental Capacity Act (MCA) and Deprivation of Liberty Safeguards (DoLS).

We observed care that was coordinated and discharge and transfer planning took account of patient's individual needs. Patients were discharged at an appropriate time and when all necessary care arrangements are in place, handover processes were good between hospital sites.

Evidence-based care and treatment

- Patients were treated based on national guidance from the National Institute of Health and Care Excellence (NICE), the Association of Anaesthetics, Great Britain and Ireland and the Royal College of Surgeons.
- Enhanced recovery pathways were used for patients. The role of the primary nurse had been introduced to escort the patient through the care pathways and follow up each patient ensuring continuing care, including preoperative assessments, perioperative admission and postoperative discharge and follow up.
- Local policies were written in line with national guidelines and updated every two years or if national guidance changed. For example, there were local guidelines for pre-operative assessments and these were in line with best practice.
- The surgery division took part in all the national clinical audits that they were eligible. The division had a formal clinical audit programme where national guidance was audited and local priorities for audit were identified.
- We saw an example of innovation where PROMs data within the National Joint Registry was used to change implant brand for hip and knee replacement surgery resulting in significant improvements in health gains.

Pain relief

- Patients were regularly asked about their pain levels, particularly immediately after surgery, and this was recorded on a pain scoring tool that was used to assess patients' pain levels. All patients reported their pain management needs had been met.
- There was a pain assessment scale within the National (Northumbria) Early Warning Score (NEWS) chart used throughout the hospital. NEWS audits were in place and supported through feedback from the Friends and Family Test and directly from patients. These showed 100% of NEWS charts had been correctly recorded and responded within surgery (August 2015).
- Each ward had identified a pain link nurse and pre-planned pain relief was administered for patients on recovery pathways. All patients we spoke with reported their pain management needs had been met.
- As part of the 'shared purpose' initiative, one objective was to train staff in the identification of pain in patients with dementia. At the time of our inspection, this training had recently been rolled out and had achieved a 20% training rate.
- The development of a 'block room' for the administration of local anaesthetic to 'block' the nerve enabled operations to be done awake or with mild sedation. This resulted in 98% of patients not feeling sick or nauseous and 89% of patients experiencing no pain after their procedure.

Nutrition and hydration

- Protected patient mealtimes were complied with. Patients reported their meals to be very good, with a hot breakfast, good choice and it was clear that staff prioritised nutrition for surgical patients offering snacks and individualised choice for patients before and after surgical procedures.
- Records we observed showed that patients were advised of their time of preoperative fasting and this was specific to their individual care plan and treatment.

Surgery

- Patients were screened using the Malnutrition Universal Screening Tool (MUST). Where necessary patients at risk of malnutrition were referred to the dietitian. We did not have access to nutritional audit at the time of inspection.
- We reviewed 14 records and saw nurses completed food charts for patients who were vulnerable or require nutritional supplements and support was provided by the dietetic department. A trust wide nutrition audit an average of 96% of patients had received a nutritional assessment within 24 hours of admission (July and August 2015). A specific audit for NSECH was not yet available.
- We were told of a 'nutritional nurse' initiative being introduced across the trust as part of enhanced recovery and shared purpose goals. Improvements in practice were explained as promoting recovery and the patient experience.
- We spoke with catering staff who told us that the new catering facilities had improved the way they work and the service to patients. We saw a range of food choice, meals and snacks, safe storage and an additional supply of crockery and cutlery that met the needs of patients with dementia. Staff had a good understanding of the nutritional needs of bariatric patients in their care. The pureed meal choice had been adapted to look more attractive to patients through liaison with catering and reviewing best practice. This was a good example of individualised care.
- We spoke with a junior nursing assistant who had been recruited to the new role of nutritional nurse on Ward 1. This post was being introduced to improve recovery for orthopaedic surgery patients by prioritising and enhancing their nutrition as part of the 'HipQuip' trust project, a hip fracture quality improvement programme

Patient outcomes

- The Northumbria Specialist Emergency Care Hospital (NSECH) opened in June 2015. It was not yet included in national audit data (e.g. standardised relative risk readmission rates) as a result. However, surgical teams had transferred surgical work to NSECH and it was accepted that outcomes from trust wide data applied to this activity.
- Following the opening of the NSECH, theatre utilisation at the hospital varied between 91% and 100%.
- The Patient Reported Outcome Measures (PROMs) in the North East and North Cumbria Observatory report (September 2015) showed the trust had significantly better performance compared to the national average in the 'Oxford Hip Score' and also the 'Oxford Knee Score'.
- The National Hip Fracture Audit (2014) showed time to surgery at North Tyneside was better than the national average. Surgery was performed on day of admission or day after admission (NICE QS16 Standard 5) in 88% of cases. The hospital was ranked ninth in England, Wales & Northern Ireland.
- The trust had lower than the standardised relative readmission rates (2014) England average (100) for elective surgical patients for upper gastrointestinal surgery (76) and colorectal surgery (77); the standardised relative readmission rate for elective trauma and orthopaedics patients was higher than the England average at 112.
- Guidelines for oncoplastic breast reduction and guidelines for best practice in reducing surgical site infections had been developed. This resulted in a complication rate of 14% ((lower than the National Mastectomy and Breast Reconstruction Audit (NMBRA) of 18%)) and a wound infection rate of 11% (lower than the National Mastectomy and Breast Reconstruction Audit (NMBRA) of 25%).
- The National Bowel Cancer Audit (December, 2015) showed better than England average results for patients with complete pre-treatment staging (99%, England average 84%), patients seen by a clinical nurse specialist (96%, England average 93%) and length of hospital stay greater than five days (66%, England average 69%).
- Adjusted mortality rates at 90 days were better than the England average at the trust (2.9, England average 3.9), and slightly worse at two years (24, England average 22).
- Infection rates in surgery specific to the NSECH site were not available at the time of inspection.

Competent staff

- Staff appraisals were undertaken annually and all staff groups had achieved the trust target of 85% for staff appraisals. The majority of staff groups at NSECH had achieved 100%.
- There were also informal one to one meetings for staff should they request these. Monthly governance and staff meetings were taking place and the meeting structure had been in place from the opening of the NSECH site.

- Junior doctors told us they attended teaching sessions and participated in clinical audits. They told us they had good ward-based teaching and were well supported by the ward team and could approach their seniors if they had concerns.
- All measures surveyed in the General Medical Council (GMC) national training scheme survey 2015 were within expected levels and did not identify any risks. Revalidation and clinician outcomes were assessed and monitored by the Deanery.
- Staff were advised of the Nursing and Midwifery Council revalidation process through the trust intranet. New nursing staff had completed the trust induction programme and completed learning logs with a designated supervisor or mentor.
- Staff told us that the appraisal process was helpful and allowed them to discuss developmental objectives. These were agreed between staff and managers.

Multidisciplinary working

- Daily consultant led ward rounds, including weekends, involved the multidisciplinary team.
- Nursing documentation was kept at the end of the bed and centrally within the wards and was completed appropriately. Daily handovers were carried out with members of the multidisciplinary team and referrals were made to the dietitian, diabetes nurse, or speech and language team when needed.
- Therapists worked closely with the nursing teams on the ward where appropriate. Ward staff told us they had good access to physiotherapists and occupational therapists.
- There was pharmacy input on the wards during weekdays and weekends and dedicated pharmacy provision for each ward was planned.
- Staff explained discharge planning and weekend discharges requiring support were identified at pre-assessment so that appropriate equipment and support could be arranged.
- Staff told us that the use of a Situation, Background, Assessment and Recommendation communication tool (SBAR) had improved handovers.

Seven-day services

- The trust provided seven day services for all emergency attendances and admissions at NSECH. The hospital met all ten national standards for seven day working.
- A comprehensive transfer plan was in place for deteriorating patients to access emergency care at NSECH seven days a week and this was seen to be working well.
- Seven day rotas for consultant working was introduced in the trust in 2004. The development of the Northumbria new emergency model of care was led by the trust's clinical and executive teams to improve care and outcomes for patients.
- Consultants were available at all hours on call and attended daily ward rounds over seven days to review new admissions and provide emergency patient care.
- There was excellent access to a full range of diagnostic services across seven days to deliver high quality and efficient care to patients.

Access to information

- Risk assessments, care plans and test results were completed at appropriate times during a patient's care and treatment and we saw these were available to staff enabling effective care and treatment.
- We reviewed discharge arrangements for patients and noted planning started as soon as possible for patients. We saw discharge letters were completed appropriately and shared relevant information with a patient's general practitioner.
- There were appropriate and effective systems in place to ensure patient information was co-ordinated between systems and accessible to staff across hospital sites. Staff told us that a system was in place to ensure effective communication of information when transferring a patient to a base hospital.
- As part of the 'shared purpose' initiative, staff had access to up to date information on ward performance against objectives displayed at the entrance to the ward. Ward staff were still in the process of adjusting to the new environment at NSECH. It was reported that work was ongoing to ensure patients and visitors had good access to the information they needed at ward level.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- The trust had policies in place to inform and guide practice around the Deprivation of Liberty Safeguards (DoLS) and the Mental Capacity Act (MCA). Information

and guidance was provided to staff on terminology, issues surrounding capacity when taking patient consent and identifying trust leads for the escalation of issues.

- Staff we spoke with at NSECH were confident in identifying issues in regard to mental capacity and knew how to escalate concerns in accordance with trust guidance.
- Mental capacity assessments were undertaken by the Consultant responsible for the patient's care and Deprivation of Liberty Safeguards (DoLS) were referred to the trusts safeguarding team.
- Consent, Mental Capacity Act (MCA) and Deprivation of Liberty Safeguards (DoLS) training was delivered as part of staff induction.
- A trust audit on surgical consent (June 2014) showed 100% compliance with the person taking consent being capable of performing the procedure in question, the procedure explained to the patient, and any relevant risks and side effects being explained (22 records). There was 55% compliance with alternate treatments being discussed (including no treatment), and 27% compliance of patients being provided with additional information (such as leaflets).
- The audit was discussed and an action plan developed at the trust wide Surgical Integrated Governance Group. Staff had been reminded of the importance of good recording and documentation, including practice around gaining and recording consent, such as the provision of additional information as appropriate and discussions around alternative treatments, if relevant.
- We looked at 14 records and all patients had consented in line with the trust policy and Department of Health guidelines. All records we reviewed contained appropriate consent from patients and patients described to us that staff took their consent before providing care.

Are surgery services caring?

Outstanding ☆

We rated caring as outstanding because:

The services in NSECH received positive feedback scores and comments from a comprehensive approach used by the trust to capture the patient experience.

We observed patients being cared for with dignity, compassion and respect in all the surgical wards and departments we inspected. Patients we spoke with knew the name of their nurse and other members of the healthcare team. We saw patients spoken to in a professional and prompt manner, with staff introducing themselves by name, using an approach advocated by the 'Hello my name is…' campaign.

All patients we spoke with reported without exception that staff were caring, friendly and professional. Care plans highlighted the assessment of patients emotional, spiritual and mental health needs.

We spoke with 22 patients and 26 staff in ward 1, ward 3 and the surgical assessment unit.

Compassionate care

- The hospital in-patient survey (October 2015) on wards 1 and 3 showed 100% of patients were treated with dignity and respect, 98% of patients said they were involved in their care and 100% of patients said they were treated with kindness and compassion. Results from the survey had been consistently high for the months since the opening of NSECH.
- We observed staff treating patients with kindness and respect. Staff took time to introduce themselves to patients and give explanations for the treatment and care provided.
- We spoke to 22 patients and they told us that staff were kind and caring, with patients stating that: "they would recommend the hospital to family and friends". We observed staff being friendly and professional.
- The NHS Friends and Family Test (FFT) (based on trust wide figures for accident and emergency) in September 2015 showed 95% of patients would recommend emergency care at NSECH to friends and family if they needed similar care and treatment. Similar results had been achieved in July (93%) and August (91%).
- We spoke to 26 staff and it was clear that the demonstration of a caring approach was a high priority. Staff spoke to patients as individuals and demonstrated knowledge of their care and treatment. We observed examples in practice of kindness and professionalism in all staff interactions with patients and colleagues, without exception.
- Data from the '2 minutes of your time' patient survey resulted in both Wards 1 and 3 scoring 9.6 (out of a possible 10) for patients who would be highly likely or

likely to recommend the ward (October 2015). Data from this survey had been consistently high (9.7 to 9.9) since the opening of NSECH and was prominently displayed at entrances to wards.
- Patients told us staff responded promptly to the call bell system.
- Patients commented that they had been treated: '…very well, promptly and by staff who were caring and treated them well', and '…although staff are busy, they always have time for a chat, couldn't be better' and '…the service was professional at all times'.

Understanding and involvement of patients and those close to them

- Patients and relatives felt involved in their care and the regular ward rounds with consultants gave patients the opportunity to ask questions and have their surgery and treatment explained to them.
- Patients were given information in a way they could understand and were knowledgeable about treatment, progress and their discharge plan. One patient reported that: "the staff gave information about what procedure I was going to have. It was explained in detail and I understood everything".
- Patients told us family and relatives were informed and involved in care planning and spoke of good arrangements for discharge home.

Emotional support

- Patients reported that staff spent time with them and staff recognised the importance of time to care and support patients emotional needs.
- Care plans highlighted the assessment of patients emotional, spiritual and mental health needs. These care plans were complete in case notes observed on Ward 1 and 3.
- The Surgical Site Infection Surveillance Team (SSI team) offered a follow up service to all postoperative patients. Patients received a follow up phone call at two and 30 days post discharge from hospital. Specialist nursing teams also offered follow up for patients post discharge and across site when patients were transferred for rehabilitation and further recovery.
- Patients were given a contact card and information and could ring the 'surgical helpline' to get advice and support. An experienced member of the SSI team could be contacted Monday-Friday and outside of these hours patients could call the ward and nurses would offer advice about a range of issues, including wound pain or signs of infection, medications or general and emotional support and advice. This service had reduced patient complaints.
- We were given information about support groups for patients. These included stoma care support groups, pain management groups and open access to clinical nurse specialist helplines for surgical patients. The base sites had established support for patients and these were accessible for NSECH patients.

Are surgery services responsive?

Outstanding ☆

We rated responsive as outstanding because:

Surgical services at NSECH were part of its wider hospital network, and established the new emergency model of care in the trust. The services have been designed with public consultation and involvement to provide care and choice to the local community. This model of care allows patients to access elective care at Wansbeck, Hexham and North Tyneside General Hospital and ensured emergency support and services were also available 24/7 at NSECH.

All staff were aware of the need for flexibility towards surgical services provided at NSECH. Emergency and high-risk surgery was provided at NSECH but was subject to constant review by senior managers within the division. Some high-risk surgery (for example, bariatric surgery) was planned to be returned to base sites following review and assessment of risk and safety issues. Patients told us they understood and accepted the need for the centralisation of emergency services.

Specialist emergency surgical care, with consultants on site and available all day as well as consultants in a range of specialties working seven days a week was evident at NSECH.

The trust had an escalation and surge policy and procedure to deal with busy times. Capacity bed meetings were held to monitor bed availability across hospital sites, review planned discharges and assess bed availability throughout the trust on a daily basis. This was working well at the time of our inspection.

Surgery

The number of operations cancelled by the service was consistently below the England average over the past nine quarters. Of those cancelled between April 2014 and June 2015, six people were not treated within 28 days, which is lower than the national average. At the end of September 2015, the trust was meeting the NHS operational target of 92% of patients waiting less than 18 weeks for treatment.

Six theatres were open at NSECH, seven days a week and theatre utilisation was high since opening.

There is a proactive approach to understanding the individual needs of patients attending the hospital and pathways of care for patients requiring complex and multi-disciplinary involvement are innovative and embedded in practice in surgery across the trust. During the inspection at NSECH and across the trust we saw consistent examples of patients individual needs and preferences being central to the planning of services and care.

The commitment to post procedure follow up after patients are discharged home from hospital is excellent at the trust and we saw this at NSECH. There is a dedicated surgical helpline team, an additional process to contact patients by telephone the day following discharge to gather information about any immediate concerns the patient may have and provide advice and guidance. Specialist nurses, who can also liaise with other members of the MDT are available for advice and support. Ward staff were available to give advice and support to patients and some of the benefits of this approach have been reduced complaints and readmissions to hospital.

The service was responsive to the needs of patients living with dementia and learning disabilities. Senior nursing staff we spoke with told us that work was planned to adapt the new environment and they had collaborated with the local Lead for Learning Disabilities and the Alzheimer's society for advice. Link nurses who provided advice and support with caring for patients with learning disabilities and dementia had been identified.

Complaints processes were good in surgery at NSECH. Complaints and concerns were reviewed at monthly meetings where any training needs were identified and learning could be shared as appropriate.

Service planning and delivery to meet the needs of local people

- NSECH opened in 16 June 2015, providing specialist emergency care for seriously ill and injured patients from across Northumberland and North Tyneside. The hospital had been designed to provide specialist emergency care, with emergency consultants on site 24 hours a day, seven days a week, as well as consultants in a range of specialties working seven days a week.
- The change to the provision of emergency and high risk surgical services centred at NSECH ensured patients received the right care and treatment, support services, nursing and clinical staff at the appropriate time and location.
- The hospital treated serious emergencies and all patients requiring specialist emergency care were admitted to NSECH directly or from one of the 'base' hospitals at Wansbeck, North Tyneside and Hexham. Planned surgery considered high-risk was carried out at NSECH.
- Patients were discharged from NSECH after surgery to home or transferred to one of the 'base' hospitals for further rehabilitation, care and treatment when they no longer needed emergency or specialist care.
- This model of care was five months old at the time our inspection. However, the model had begun to embed within the service and there was a clear understanding amongst staff and patients of how the new system of care operated within the trust. We did not receive adverse comments about the centralisation of emergency services at NSECH. There was recognition by patients that this led to a better supported and safer service.
- While the change to the delivery of surgical services was managed flexibly at the time of inspection, staff told us they were fully engaged in this process. Staff were proud that during this period of change patient outcomes had been maintained and bettered.
- Fast track joint replacement relied on an anaesthetic spinal block before surgery. Patient feedback was collected on their experience with the spinal block procedure to determine if this was what patients would prefer. This had shown that 97% of patients surveyed preferred the spinal block to general anaesthetic, for surgery and to avoid a longer hospital stay.
- The development of guidelines from the findings from the National Mastectomy and Breast Reconstruction Audit (NMBRA) has improved and promoted best practice and positive patient outcomes for oncoplastic breast reconstruction surgery, around the quality of

patient experience, length of stay and lower complication and infection rates. An MDT approach was taken in developing and implementing best practice across the trust.

- Enhanced recovery pathways had been developed and were continually being reviewed. The trust had developed these pathways before the opening of NSECH. Staff were familiar with these pathways and these and had continued following opening.
- The trust has developed a dedicated bone health clinic managed and co-located with a breast cancer service. Patients undergo a DXA scan and then are given an assessment of non-cancer fracture risk. Management plans, including lifestyle advice, patient education, anti-fracture therapy, nutritional supplements and falls risk assessment are instigated. Plans for review of medication compliance and monitoring treatment response are established.

Access and flow

- The trust had 33,909 surgical spells between January 2014 and December 2014. In surgery services elective, day case and emergency activity for Wansbeck, North Tyneside and Hexham hospitals was reported. Overall surgical spells were average for NHS trusts. Data was not available at the time of inspection to breakdown surgical activity at NSECH.
- Six theatres were operational at the Northumbria, all classified for emergency out of hours surgery, inducing obstetrics and gynaecology, spinal surgery and bariatric surgery for high risk patients or those who may require intensive care support following surgery.
- A pre-assessment appointment was made with the patient before their surgery date and any issues concerning discharge planning or other patient needs were discussed at this stage. Patients requiring assistance from social services upon discharge were identified at pre-assessment and plans were continuously reviewed during the discharge planning process.
- At the end of November 2015, the trust was meeting the NHS operational target of 92% of patients waiting less than 18 weeks for treatment, achieving 93%.
- RTTs had steadily improved since the opening of NSECH and were met within general surgery (94%), urology (96%), plastic surgery (93%) and oral surgery (96%).
- Trauma and orthopaedics was the only area where this target was not met although there had also been improvement from 85% (September 2015) to 87% (November 2015) and 92% of patients were waiting less than 21 weeks.
- The primary reason for delayed transfer of care at the trust was patient or family choice. This was the reason for delay given in 32% of cases, against an England average of 13%.
- The trust used an enhanced recovery programme to assist in patients recovering from orthopaedic surgery and included the mobilisation of patients on day zero after hip and knee replacement surgery. The MDT worked closely to support recovery and patients were routinely discharged with reduced length of stay.
- A dedicated team contacted patients by telephone following discharge to gather information about any immediate concerns the patient may have and provide advice and guidance. If they identified any concerns during the call, staff invited the patient to return to the hospital for assistance, which was reported to reduce unnecessary readmission
- The model of care was to discharge post operative patients to home or to one of the base hospitals if they needed further care, and this will affect lengths of stay for patients at trust sites including NSECH. The breakdown of this information was not available at the time of inspection.
- The average lengths of stay for patients undergoing non-elective general surgery, non-elective colorectal surgery, non-elective orthopaedic surgery and breast surgery at NSECH were all consistently below the lengths of stay at other hospitals within the trust (June 2015 to October 2015).
- The average lengths of stay for patients were all consistently below England averages. The average length of stay for elective patients was below the England average for breast surgery (0.8 days, England average 1.6 days), colorectal surgery (2.5 days, England average 6.0 days) and upper gastro intestinal surgery (1.6 days, England average 4.3 days).
- Average length of stay for non-elective patients was below the England average for general surgery (1.7 days, England average 4.3 days), colorectal surgery (2.5 days, England average 4.2 days) and orthopaedics (2.4 days, England average 8.5 days).
- The hospital had an escalation and surge policy and procedure to deal with busy times. Capacity bed

meetings and cross-site working was working well to monitor bed availability, review planned discharges and assess bed availability throughout the trust on a daily basis.

Meeting people's individual needs

- During the inspection at NSECH and across the trust we saw consistent examples of patients individual needs and preferences being central to the planning of services and care.
- A system of pre-assessment for patients was well established and in addition patients could choose to watch DVD information about their procedure provided before surgery.
- Patients and their families received information in a way they could understand and were knowledgeable about treatment, progress and their discharge plan.
- Senior nursing staff were visible on the day of inspection and they reported that the Ward Manager and Matron were available for patients and their relatives to speak to on a daily basis. It was made clear to patients and visitors to the wards who was on duty as this was displayed at the ward entrance.
- The service was responsive to the needs of patients living with dementia and learning disabilities. Senior nursing staff we spoke with told us that work was planned to adapt the new environment and they had collaborated with the local Lead for Learning Disabilities and the Alzheimer's society for advice. Link nurses who provided advice and support with caring for patients with learning disabilities and dementia had been identified.
- A link nurse system identified staff who had additional training and could provide advice and support in caring for patients with learning disabilities and dementia.
- We saw the use of the 'This is Me' document for a patient who had Parkinson's and was having 1:1 nurse to patient care. We saw suitable information leaflets were available in pictorial and easy read formats and described what to expect when undergoing surgery and postoperative care. These were available in languages other than English on request. Wards had access to interpreters both in person and on the telephone.Requests for interpreter services were also identified at the pre-assessment meeting.
- We saw that the care and rehabilitation of patients following surgery was particularly effective through the provision of on-going physiotherapy and occupational therapy services.
- We were told by senior nurses that there was access to an independent mental capacity advocate (IMCA) for when best interest decision meetings were required and the trust had policies in place covering the 'Mental Capacity Act (2005) and Deprivation of Liberty Safeguards'.
- We observed effective access and facilities for wheelchair users and disabled bathrooms and toilet access. Inspectors noted that the signage and corridors at NSECH had tactile numbers and floor announcements for people with visual impairment.
- There was a system in place for open and individualised visiting for relatives and friends of patients. Staff said that the increase in single room accommodation allowed for a greater degree of privacy and facilitated open visiting.
- The facilities and equipment to support bariatric patient care in surgery at NSECH met the needs of patients. We noted spacious and dedicated single rooms, private wet room shower facilities with specialist seating and beds and a fixed patient hoist system to support mobilisation.

Learning from complaints and concerns

- Complaints were handled in line with trust policy that provided guidance on the complaint process, including the nominated investigative lead and timescales for responses. The number of written complaints received by the trust had reduced to 457 (2014/15) from a high of 528 in 2012/13.
- Patients or relatives making an informal complaint were able to speak to individual members of staff or the ward manager and staff were able to explain this process.
- Complaints processes were good in surgery at NSECH. Complaints and concerns were discussed and reviewed at monthly staff meetings where any training needs were and learning was identified and learning could be shared as appropriate.
- The Matron for surgery held a central paper copy of all complaints in surgery and reported that the processes were thorough. We were given a summary and example of three very different patient complaints, associated action plans and were assured that trust policy was

followed and lessons learnt. Staff were able to describe complaint escalation procedures, the role of the Patient Advice and Liaison Service (PALS) and the mechanisms for making a formal complaint.

- If patients or their relatives needed help or assistance with making a complaint the Independent Complaints Advocacy Services (ICAS) contact details were visible in the ward and throughout the hospital.
- We saw leaflets available throughout the hospital informing patients and relatives about this process.
- Complaints and concerns were discussed and reviewed at monthly staff meetings where training needs and learning was identified as appropriate. Conflict resolution training had been identified as a means to deal with complaints at a local level and was included as part of mandatory training for some staff groups.

Are surgery services well-led?

Outstanding ☆

We rated well-led as outstanding because:

Senior managers had a clear vision and strategy for the division and identified actions for addressing issues within the division. The strategy of the service clearly identified the new model of emergency and high-risk surgery provided at NSECH and the relationship between NSECH and the base hospitals. The new model was under constant review to determine the most effective site to undertake different procedures depending upon risk and safety. The trust had engaged on a major change to services in the months before inspection and local communities had been engaged in the consultation and development of the strategy for the new model of care.

We were told the service had a commitment to a people centred approach delivering high quality care with robust assurance and safeguarding and saw this in practice during the inspection.

Staff told us they were encouraged to challenge existing practices, look for improvements and suggest ways to develop and introduce innovative practice. Staff reflected on the strong leadership and visibility of senior members of the trust board. This motivated staff and they felt that senior leadership reflected the vision and values that they shared with the organisation.

Strong governance structures were in place across the directorate and there was a systematic approach to considering risk and quality management. Senior and site level leadership was visible and accessible to staff. We saw constructive engagement with staff and managers at all levels, communicated in person to staff in one to one and team meetings and through the weekly e-bulletin, team briefs, the staff magazine and internal campaigns.

Leadership in the organisation inspired and motivated staff and they told us repeatedly that they were proud to work for Northumbria NHS Foundation Trust.

The hospital in-patient survey showed 100% of patients were treated with respect and dignity, 98% of patients were involved in their care and 100% of patients said 'good' doctors and nurses treated them. The trust is integral to its local community and holds engagement forums with its stakeholders in GP, voluntary and community groups.

Vision and strategy for this service

- We met with senior managers who had a clear vision and strategy for the division and identified actions for addressing issues within the division. The strategy for surgical services clearly identified the new model of emergency and high-risk surgery provided at NSECH and the relationship between NSECH and the base hospitals.
- The new model was under constant review to determine the most effective site to undertake different procedures depending upon risk and safety. We saw examples of the flexibility and ongoing adjustment within the strategy through the provision of high-risk bariatric surgery planned for return to the base hospitals following assurance that it was safe to do so.
- The vision and strategy had been communicated throughout the trust and staff at all levels contributed to its development. Staff were able to repeat this vision and discuss its meaning with us during individual interviews.
- The trust vision and strategy was displayed in wards and staff were able to articulate to us the trust's values and objectives across the surgical division.
- We were told the trust had a commitment to a people centred approach delivering high quality care with robust assurance and safeguarding and saw this in practice during the inspection.

- Staff told us they were encouraged to challenge existing practices, look for improvements and suggest ways to develop and introduce innovative practice.

Governance, risk management and quality measurement

- Joint clinical governance and directorate meetings were held each month. We saw agendas and minutes with evidence of good audit activity, learning from complaints and clinical risk management issues. We observed peer review data, and patient and public involvement was evident.
- A rolling agenda was discussed in these meetings that included infection control, alert notices, examples of good practice, compliance with national service frameworks, and research projects. Evidence of action plans and staff responsibilities was in minutes.
- The trust held monthly mortality and morbidity case review meetings that were well attended. Due to changes in job plans and team locations the meeting had been recently reorganised and rescheduled. Interim measures had been in place to review mortality and concerns in the absence of formal meetings during this period of change across the trust. We were told that the new meeting structure was now in place in surgery.
- The division's risk register was updated following these meetings and when needed. Risks were assigned to specific staff responsible for the monitoring of actions and the revision of the risk assessment as required. The register included risk ratings, action plans, and information on timescales in which issues were to be resolved.
- Reports identified risks throughout the directorate, actions taken to address risks and changes in performance. These monitored (amongst other indicators) MRSA and C.difficile rates, RTTs, pressure ulcer prevalence, complaints, never events, incidents and mortality ratios.
- We saw that action plans were monitored across the division and sub-groups were tasked with implementing them. The risk register was updated with any progress or new risks.
- We noted an example of an action plan relating to staffing levels which were monitored through daily operational conference calls, the submission of weekly worked numbers, fortnightly vacancy control reviews and monthly budget meetings to review identified vacancies.

eadership of service

- Staff said service leads and managers were available, visible within the division and approachable; leadership of the service was good, there was good staff morale and they felt supported at ward level. Clinical management meetings were held weekly and involved service leads and speciality managers. During inspection of NSECH this approach was observed and reported to us by all levels of staff.
- The trust had engaged on a major change to services in the months before inspection. Staff at all levels told us they had been fully engaged in this process and felt their views had been taken in to account. While the change to the delivery of surgical services was managed flexibly at the time of inspection, staff told us they were fully engaged in this process.
- Monthly surgical speciality meetings were held and discussed financial and clinical performance, patient safety and operational issues.
- Staff at NSECH spoke positively about the service they provided for patients and emphasised quality and patient experience is a priority and everyone's responsibility.
- Nursing staff stated that they were well supported by their managers. We were told they could access one-to-one meetings which were mostly informal, as well as more structured meetings and forums.
- Medical staff stated that they were supported by Consultants and confirmed they received feedback from governance and action planning meetings.
- Staff reflected on the strong leadership and visibility of senior members of the trust board and executive team. This motivated staff and staff felt that senior leadership reflected the vision and values that they shared with the organisation. Staff on wards knew the Chief Executive and senior members of the trust team. A positive relationship was evident.

Culture within the service

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

Surgery

- All staff we spoke with felt that they received appropriate support from management to allow them to perform their roles effectively. Staff reported an open and transparent culture on their individual wards and felt they were able to raise concerns.
- Ward managers were given dedicated management time. This allowed them to focus on management and administrative issues. Management staff told us that they had appropriate access to senior staff members. This included being able to access support and leadership courses to help them in leading their services.
- Staff spoke positively about the service they provided for patients. High quality compassionate patient care was seen as a priority. Patient and staff feedback at the trust consistently refers to provision of good care, positive experiences, and 'feeling valued'. A 'caring culture' was evident in NSECH and across the trust.
- Staff spoke of the 'Northumbria Way' in regard to purpose and innovations in care and in ensuring that they provided a high quality experience to patients.

Public engagement

- Local communities had been engaged in the consultation and development of the strategy for the new model of care. This had a positive effect upon the feedback received from patients and relatives received during the inspection at NSECH and also at the base hospitals.
- The trust used '15 step challenges' to engage the public in assessing the hospital environment. This helped the trust to gain an understanding of how patients and service users felt about the care provided.
- The hospital in-patient survey on wards 1 and 3 showed 100% of patients were treated with dignity and respect, 98% of patients said they were involved in their care and 100% of patients said they were treated with kindness and compassion.
- Results in October 2015 also showed 100% of patients said they were treated by 'good' doctors and nurses at NSECH.
- The Surgical Site Infection Surveillance Team (SSI) helpline had been developed to contact patients following discharge. The team identified further care needs of patients and had evidence of improvement, a reduction in patient complaints and increased patient satisfaction.
- The trust holds quarterly stakeholder engagement forums with voluntary and community groups and issues regular bulletins to stakeholders including GPs. Programmes have been developed across the county to focus on issues such as older people's health, gardening for people with dementia, supported walks, loneliness, warmer health promotion, living with dementia training and 'get in to golf'.

Staff engagement

- All 13 measures surveyed in the General Medical Council (GMC) national training scheme survey 2015 were within expected levels. The survey asked questions about the quality of education, supervision and support. The overall satisfaction score given was 87%, within the top ten hospitals in England.
- Data collected by the Health and Social Care Information Centre (HSCIC) showed that the sickness absence rates for the trust have been very similar to the England average during the period from January 2011 to January 2015.
- Results from the 2014 NHS Staff Survey showed that the trust performed well, with 26 positive findings, six findings within expected levels, and no negative findings. The trust was within the top 20% in England based on staff survey results.
- Staff reported they were in a period of adjustment with the introduction of the new model of working but did not report any negative impact on performance or patient safety. They said teams in NSECH had come together 'exceptionally well'.
- Staff had been involved and engaged with the development of the new model of emergency care and had undergone significant organisational change across the trust. Staff we spoke with at NSECH talked about the opportunities that the changes bring and did not report any negative impact on performance or patient safety. It was noted that staff had been well prepared for the change process and consequently had managed, or were managing any necessary adjustments in surgical services. We saw senior managers communicated to staff through the weekly e-bulletin, team briefs, the staff magazine and internal campaigns.
- Staff had been involved in deciding annual priorities, staff governors, health and wellbeing advocates, the

appointment of sustainability champions and staff road shows. Staff said they had been consulted and engaged in the redesign of services before and after the opening of NSECH.

Innovation, improvement and sustainability

- During the inspection it was clear that there was a culture that supported innovative practice and improvement. The new model of emergency care at NSECH and across the trust was evidence of that. We spoke with staff, who without exception recognised this as a valued part of working for the organisation.
- The trust had embedded a number of excellent innovative ways of working and improvements in practice that were improving quality of care and experience for patients. The following examples were noted at NSECH during our inspection.
- The trust used a 'fast track' hip and knee replacement pathway. This pathway allowed patients to undergo procedures under anaesthetic spinal block and sedation. Patients mobilise on day zero following surgery and are discharged home within one to two days on ward 1 and staff told us that they had embraced the day zero mobilisation programme.
- The development of guidelines from the findings from the National Mastectomy and Breast Reconstruction Audit (NMBRA) has improved and promoted best practice and positive patient outcomes for oncoplastic breast reconstruction surgery, around the quality of patient experience, length of stay and lower complication and infection rates.
- Surgical care of the bariatric patient was supported across the trust by a dedicated team including specialist nurses. The facilities and equipment to support bariatric patient care in surgery at NSECH was planned and exceptional. The care of the patients nutritional needs were met through best practice.
- The trust has developed a dedicated bone health clinic managed and co-located with a breast cancer service. Patients undergo a DXA scan and then are given an assessment of non-cancer fracture risk. Management plans, including lifestyle advice, patient education, anti-fracture therapy, nutritional supplements and falls risk assessment are instigated. Plans for review of medication compliance and monitoring treatment response are established.
- The commitment to post procedure follow up after patients are discharged home from hospital is excellent at the trust and we saw this at NSECH. There is a dedicated surgical helpline team, an additional process to contact patients by telephone the day following discharge to gather information about any immediate concerns the patient may have and provide advice and guidance.
- The recruitment of a nursing assistant to the new role of nutritional nurse on Ward 1 was being introduced across the trust. This post was in place to improve recovery for orthopaedic surgery patients by planning individualised care for nutrition and prioritising and enhancing food and fluid intake as part of the 'HipQuip' trust project, a hip fracture quality improvement programme. The team had been awarded a national BMJ safety award for improving outcomes of recovery in patients with fractured neck of femur.

Critical care

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

Information about the service

Northumbria Healthcare NHS Foundation Trust provided critical care services at Northumbria Specialist Emergency Care Hospital (NSECH). The medicine and emergency care directorate managed the service.

The critical care unit at NSECH opened on 15 June 2015. Prior to this the trust provided critical care services across two units, one at North Tyneside General Hospital and one at Wansbeck General Hospital. The unit at NSECH had eighteen beds arranged in two pods of nine beds. Fifty percent of the beds were single side rooms which meant the unit had capacity to isolate patients who had acquired infectious diseases as well as ensuring single sex accommodation. It was staffed to care for a maximum of nine level three patients (who require advanced respiratory support or a minimum of two organ support) and eight level two patients (who require pre-operative optimisation, extended post-operative care or single organ support).

Intensive care national audit and research centre (ICNARC) data showed that between 15 June and 30 September 2015 there were 365 admissions with an average age of 62 years. Seventy six percent of patients were non-surgical, 7% elective surgical and 17% emergency surgical. The average length of stay on the unit was four and a half days.

We spoke with five patients, 11 relatives and 36 members of staff. We observed staff deliver care and looked at eight patient records and medication charts. We observed nursing handovers and ward rounds. We reviewed staff records and trust policies. We also reviewed performance information from, and about, the trust. We received comments from patients and members of the public who attended our listening event and from other people who contacted us directly to tell us about their experiences.

Critical care

Summary of findings

We rated critical care as outstanding because:

People's individual needs were central to the planning and delivery of critical care services. The service involved patients and stakeholders in the new model of care and the build of the unit to ensure it provided an innovative approach to integrated person-centred care. The management team worked with leads in the trust to plan service delivery.

Governance and performance metrics were proactively reviewed. Governance arrangements enabled the effective identification of risks and monitored these risks and the progress of action plans. There was evidence that controls were in place to mitigate these risks.

An experienced and cohesive team managed the service. They demonstrated a clear understanding of the challenges of providing high quality, safe care. Continuous improvement was driven with the involvement of frontline staff that felt valued and who were engaged in service development. The leadership team motivated staff to succeed. It was clear that staff had confidence in the leadership at all levels and spoke highly of the culture within the unit. There were high levels of staff satisfaction.

All staff considered patients individual preferences and evidently went out of their way to exceed expectations to meet their wishes. Staff were motivated and inspired by leaders to deliver person centred, holistic care. One visitor told us the staff made them feel like their relative was the only patient on the unit and nothing was too much trouble. Staff had been nominated for awards for their compassionate care. Formal feedback from patients and relatives was continually positive about all aspects of their care.

Care was led 24 hours a day, seven days a week by a consultant in intensive care medicine and staffing was in line with Core Standards for Intensive Care (2013). Patient outcomes were the same as or better than the national average and care and treatment was planned and delivered in line with current evidence based guidance and standards. There was evidence of excellent joint and patient centred multidisciplinary team working. The culture of 'everyone had a voice' was embedded.

The service had a good track record in safety. There had been no never events or serious incidents reported. Between July and October the unit achieved 100% harm free care on three out of four months and it had been over 300 days since there had been an avoidable pressure ulcer.

Critical care

Are critical care services safe?

Good

We rated safe as good because:

The performance showed a good track record in safety. There had been no never events or serious incidents reported. Staff understood their responsibilities to raise concerns and report incidents. There was evidence that lessons were learnt and communicated to the multidisciplinary team.

The unit was clean, equipment was maintained and there were appropriate systems in place to ensure that medicines were handled safely and stored securely.

Medical and nurse staffing was in line with Core Standards for Intensive Care (2013). Care was led 24 hours a day, seven days a week by a consultant in intensive care medicine and the work pattern delivered continuity of care. The unit had a robust process in place to ensure that treatment escalation plans were in place and reviewed regularly.

However, the critical care outreach team were only available for 12 hours a day and a full service was not available if a member of the team was on leave. The nursing establishment did not allow for a second supernumerary registered nurse as recommended in the Core Standards for Intensive Care (2013).

Incidents

- There had been no never events and no serious incidents reported since the unit opened in June 2015.
- Twenty two incidents had been reported between June and July 2015, 77% of these were graded as no harm and 23% minor harm or damage. Themes of the incidents were skin and pressure damage, falls and safeguarding referrals.
- Incidents were reported on an electronic system. Staff we spoke to were aware of how to report an incident and we saw they received feedback through team meetings, the critical care safety issues newsletter and the daily safety huddle meeting.
- We saw evidence of actions that had happened following incidents, for example, only giving visitors information about a patient face to face and explaining medications to patients when they were being given.
- We saw evidence that the unit had introduced critical care morbidity and mortality meetings.
- The duty of candour is a regulatory duty that relates to openness and transparency and requires providers of health and social care services to notify patients (or other relevant persons) of certain 'notifiable safety incidents' and provide reasonable support to that person.
- The trust had updated its 'Being Open policy' to include the duty of candour regulation and the nursing and midwifery council (NMC) and general medical council (GMC) professional guidance.
- From September 2015 the trust induction included information on the duty of candour.
- Senior staff demonstrated an understanding of the duty of candour. They had not been involved in any specific incidents but were aware of the importance of open and honest care.

Safety thermometer

- The NHS Safety Thermometer is a national improvement tool for local measuring, monitoring and analysis of patient harms and 'harm free' care. This focuses on four avoidable harms: pressure ulcers, falls, urinary tract infections in patients with a catheter (CUTI), and blood clots or venous thromboembolism (VTE).
- The unit displayed safety thermometer information on the ward performance board.
- Data from July, August and October 2015 showed 100% harm free care. There was one new case of VTE in September 2015.
- In August 2015 the service reported 300 days free of avoidable pressure ulcers.

Cleanliness, infection control and hygiene

- All areas on the unit were clean and tidy. Infection control information was displayed to visitors prior to entering the unit.
- The unit had not had a unit acquired methicillin resistant staphylococcus aureus infection since it opened.

- The unit had one case of clostridium difficile in July 2015. The infection control team completed a root cause analysis in August 2015 and deemed this to be an unavoidable case. The lesson learnt was that there was a delay in specimen collection on the unit.
- Evidence provided by the trust showed 87% and 95% compliance on the unit with infection control accreditation in June and July 2015. The trust standard was 98%. The unit achieved 100% compliance with clean commodes, hand hygiene and cannula audits.
- We observed all staff were compliant with key trust infection control policies, for example, hand hygiene, personal protective equipment (PPE), and isolation.
- Training participation information provided by the trust prior to the inspection was for the two separate critical care units prior to the move to NSECH. The electronic training record we reviewed at NSECH during our inspection showed 69% compliance with infection control training. The trust target was to achieve 85% compliance by March 2016.
- The unit had facilities for respiratory isolation, and two cubicles had laminar airflow.

Environment and equipment

- From the outset leads of the service and clinical staff had been involved in the planning and design of the new unit.
- The unit was secure; access was by the ward clerk on the reception desk or an intercom.
- The unit provided mixed sex accommodation for critically ill patients within the Department of Health guidance. To maintain patients privacy the bed spaces were separated by curtains.
- The trust provided information on national cleaning specification audits up to July 2015. NSECH achieved 97% compliance overall. There were no individual results for the critical care unit.
- The environment and equipment was standardised. Each bed space was set up identically. For procedures, such as central venous catheter and chest drain insertions, staff set up standardised boxes.
- Equipment was visibly clean and was labelled with the date it had been cleaned.
- The oxygen ports on the transfer trolley were past their service date by over six months. We informed the matron of this. Within an hour it had been addressed, and the following day it was shared with staff during the safety huddle and added to the equipment checklist.
- All the other equipment we checked, for example, bedside equipment, consumables, and transfer equipment was checked regularly and within the service date.
- Staff checked the defibrillator daily. Records for this were complete.
- Most of the equipment was new apart from the beds which did not have the ability to weigh patients; however, they were on the trust replacement programme.

Medicines

- The unit had appropriate systems to ensure that medicines were handled safely and stored securely.
- The unit had an Omnicell medicine dispenser. This required fingerprint recognition to gain access and recorded stock electronically.
- There was hourly hospital transport of pharmacy stock from the central area. A taxi was used to transport stock required 'out of hours'.
- We reviewed eight medication administration records (MARs) seven of which were complete. One had no weight or indications for antibiotics recorded.
- One patient, who had an allergy recorded on their MAR, was wearing an allergy band.
- In August 2015 the unit achieved 100% in the antimicrobial prescribing care bundle audit. This included documentation about the indication for antibiotics.

Records

- Records were stored securely and all components of the record were in one place.
- We reviewed eight sets of records. They were all accurate, complete and in line with Core Standards for Intensive Care (2013) and professional GMC and NMC standards.
- Medical staff completed a daily critical care assessment checklist that met the National Institute of Health and Care Excellence (NICE) CG50 guidance (acutely ill adults in hospital; recognition and response to acute illness in adults in hospitals).
- Staff completed a discharge summary that went with the patient to the ward on discharge from the Intensive Treatment Unit (ITU).
- We did not review any documentation audits as none had been completed since the unit had opened.

However, staff told us of changes that had been made following audits in the past. For example, all staff had to sign and print their name after each entry in the patient record.

- Information governance training was included as part of the mandatory training programme. Training participation information provided by the trust prior to the inspection was for the two separate critical care units prior to the move to NSECH. The electronic training record we reviewed at NSECH during our inspection showed 60% compliance with this training. The trust target was to achieve 95% compliance by March 2016.

Safeguarding

- All staff we spoke to were clear about what may be seen as a safeguarding issue and how to escalate safeguarding concerns.
- A safeguarding file with policies, procedures and contact numbers was kept on the unit. Staff we spoke to knew how to access the trust's safeguarding policy and the safeguarding team.
- Training participation information provided by the trust prior to the inspection was for the two separate critical care units prior to the move to NSECH. The electronic training record we reviewed at NSECH during our inspection showed 83% compliance with safeguarding adults level one and 100% compliance with safeguarding adults level two. This was above the trust target of 85% for level one and 66% for level two.
- The electronic training record we reviewed at NSECH during our inspection showed 100% compliance with safeguarding children level one and 75% compliance with safeguarding children level two. The trust target was to achieve 85% compliance by March 2016.

Mandatory training

- Staff were responsible for booking their own mandatory training, and this was reviewed at their appraisal. All staff told us training was accessible and they were given study leave to attend or complete this.
- Mandatory training included moving and handling patients, and fire safety and resuscitation training. The trust target was to achieve 85% compliance by March 2016. Information submitted by the trust prior to the inspection showed on average 93% of all staff had completed moving and handling patients, 80% had completed fire safety and 84% had completed resuscitation training.

Assessing and responding to patient risk

- The trust used a recognised national early warning tool called NEWS which indicated when a patients condition may be deteriorating and they may require a higher level of care.
- The trust used a treatment escalation plan; this was complete in the eight records we reviewed on the unit.
- The critical care outreach team provided a service at NSECH from 08:00 to 20:00 seven days a week. They reviewed: patients that triggered a clinical response to a NEWS score; patients with a central venous catheter; and patients with a tracheostomy (an opening made through the neck into the trachea (windpipe) through which a patient can breathe) or laryngectomy (removal of the voice box to enable the patient to breathe). A full critical care outreach service was not available if a member of the team was on leave or sick.
- Information provided by the trust showed that, between 15 June and 31 October 2015, the critical care outreach team had received 407 referrals from the ward and followed up 319 patients from critical care at NSECH.
- The nurse in charge of the unit took the critical care outreach referrals overnight and liaised with the critical care medical team when required.
- There was no critical care outreach at the base sites. Staff followed a deteriorating patient formula and pathway. To remotely view a patient and for direct discussions to take place with the patient and staff on the base site about escalation of care, consultant intensivists used iPad technology. In the six months the unit had been open,all the transfer and retrieval protocols developed had been used safely in practice.
- The unit did not accept paediatric admissions. While waiting for the dedicated intensive care transport service for children in the north east of England, the anaesthetists would attend ED if required. So that staff were working in as familiar a environment as possible, the paediatric resuscitation room in ED mirrored the bed space on critical care.
- All the risk assessments were completed in the eight records we reviewed. These included moving and handling, nutrition, tissue viability and VTE.

- At the beginning of their shift we observed staff completing safety care bundle and high impact intervention checks.
- Staff had identified two patients on the unit as being at risk of falls. Risk assessments for these patients were complete and appropriate care plans in use. This showed that information was being recorded and communicated effectively.
- The electronic training record we reviewed at NSECH during our inspection showed 100% compliance with falls level one and two training and 100% compliance with blood safety training.

Nurse staffing

- Nurse staffing met the Core Standards for Intensive Care (2013) minimum requirements of a one to one nurse to patient ratio for level three patients and a one to two nurse to patient ratio for level two patients.
- The unit had an establishment of 12 WTE band seven staff, 13 WTE band six staff, 44 WTE band five registered nurses and 9 WTE health care assistants. The actual number of band six staff in post was 14 WTE and 53 WTE band 5. Four of the band six staff were advanced critical care practitioner (ACCP) trainees, and two of the band 7 staff were qualified ACCPs and 2.8 were critical care outreach staff.
- The unit displayed the planned and actual staffing figures. On two days of our inspection the actual number of staff on the unit was lower than the planned number of staff. We reviewed the monthly information on staffing levels available on the trust website. The fill rates on the unit for August and September for registered nurses was 92% in the day and 89% at night. The fill rate for care staff was 89% in the day and 84% at night. This meant that planned staffing levels were not consistently achieved, however, there was no evidence this had an impact on patient safety.
- The planned staffing figures included one supernumerary clinical co-ordinator. Based on the size of the unit, Core Standards for Intensive Care (2013) recommend an additional supernumerary registered nurse but the establishment did not allow for this.
- Staff were moved from the unit when there was capacity to cover vacancies on the ward. The nurse in charge kept a record of this; in the six months the hospital had been open, 137 staff from the unit had been moved to work on the wards.
- Sickness in the service was around 3.5%.
- The trust used an agency that supplied staff that were trained in critical care. Two regular staff from the agency worked on the unit.
- The unit employed bank staff who had previously worked on the unit. Staff from other hospitals had applied to work bank shifts at NSECH. We saw evidence of the speciality induction form and competencies the matron expected bank staff to complete.
- The use of bank and agency staff was not greater than recommendations in the Core Standards for Intensive Care (2013).
- We observed a day to night nursing handover. Clear, structured patient information was provided and any unit issues were discussed, for example, staff sickness, equipment or expected admissions. The nurse in charge allocated nurses to patients and considered continuity of care and the experience of the staff.
- We observed a 'pit stop' handover of a new admission to the unit. Staff had developed the style of handover in line with human factors training. A member of staff took the lead and delivered a structured handover. The consultant and nurse in charge were present and staff were allocated roles for the admission process.
- We observed two safety huddles. The safety huddle took place at the end of the ward round and shared information with the multidisciplinary team. We found the handovers and the safety huddle demonstrated a standardised approach of effective communication.

Medical staffing

- The unit met the requirements of the Core Standards for Intensive Care (2013) for medical staffing. Care was led 24 hours a day, seven days a week by a consultant in intensive care medicine and the work pattern delivered continuity of care. Every day Consultants led two multidisciplinary ward rounds.
- Thirteen intensivists covered the unit; 11 of these were anaesthetists and two were physicians.
- During the day two consultants, two ACCPs and one or two junior doctors were based on the unit. A consultant provided continuity Monday to Friday and Friday to Sunday. The second consultant provided 24 hour on-call cover and responded to all referrals to the unit.
- One junior doctor was based on the unit overnight who was supported by the on-call consultant intensivist and the anaesthetists.

- We observed three ward rounds, two in the day and one in the evening. The multidisciplinary team and patient were involved in the ward round which was structured and management plans were communicated effectively.

Other staffing

- A ward clerk, based at the unit's reception during visiting hours, worked on the unit from 08:00 to 20:00 seven days a week.
- A data co-ordinator was based on the unit to input data into the 'Wardwatcher' and intensive care national audit and research centre (ICNARC) databases.
- Pharmacists worked on a rota between the hospitals. The specialist critical care pharmacist was allocated to the unit as the rota allowed.
- A microbiologist visited the unit daily.
- As part of a pilot project running for three years, a rehabilitation assistant specifically for critical illness recovery had been in post. They worked with patients on the unit and those who had been discharged to the ward. The assistant was managed by the nurse in charge on the unit.

Major incident awareness and training

- Senior staff clearly explained their continuity and major incident plans. The actions described were in line with the trust's major incident plan.
- Staff knew how to access the major incident and continuity plans on the intranet and on the unit.

Are critical care services effective?

Good

We rated effective as good because:

Care and treatment was planned and delivered in line with current evidence based guidance, standards, best practice and legislation.

Patient outcomes were the same as or better than the national average. There was participation in national and local audits and evidence of actions that had been taken following the completion of audits.

The service supported all staff to develop their professional skills and experience. Seventy-six percent of nurses had completed a post registration critical care qualification. This was much higher than the minimum recommendation of 50%. We observed excellent joint and patient centred multidisciplinary team working.

Staff had an understanding of consent, the Mental Capacity Act (MCA) and deprivation of liberty safeguards (DoLs). Training compliance in MCA and DoLs was 100%.

However, the unit did not have a clinical nurse educator which did not meet the recommendations of Core Standards for Intensive Care (2013).

Evidence-based care and treatment

- The unit's policies, protocols and care bundles were based on guidance from NICE, the intensive care society and the faculty of intensive care medicine.
- The admission and discharge documentation was in line with NICE CG50 acutely ill patients in hospital.
- The falls care plan included recommendations from NICE CG161 assessment and prevention of falls in older people.
- The trust had a think infection, spot sepsis campaign. This campaign was based on the sepsis six interventions which have been shown to improve outcomes in septic patients. In the week prior to our inspection the unit had achieved 100% in the sepsis audit.
- The unit delivered care in line with NICE CG83 rehabilitation after critical illness. Prior to our inspection we reviewed a north of England critical care network audit of compliance with the guideline. Despite the gaps identified in the service at the trust we found patients received a high standard of rehabilitation during and following their critical care admission.
- The rehabilitation after critical illness team had led the implementation of patient diaries, delirium screening, and support on the ward following discharge from critical care and a follow-up clinic.
- We saw evidence in the patient record that staff assessed patients regularly for delirium. This was in line with NICE CG103 delirium: prevention, diagnosis and management.

Pain relief

- We reviewed patient records and observed staff assessing pain and giving support to patients requiring pain relief.
- The patients we spoke to told us that their pain was managed effectively and kept under control.

- The patient experience survey included a question on pain control; in July and August 2015 the unit achieved a score of 10 out of 10.
- We observed a palliative care patient being discharged from the unit who was under review of a specialist palliative care nurse. The review included pain management suggestions.

Nutrition and hydration

- Staff assessed patients nutritional and hydration needs and acted upon the findings.
- Staff clearly documented patients fluid and nutritional intake in the patient record.
- We observed documented evidence of regular input from dietitians and speech and language therapists.

Patient outcomes

- We reviewed the intensive care national audit and research centre (ICNARC) data for the period 15 June to 30 September 2015. The average standardised mortality ratio (SMR) was 0.73. The clinical lead explained the potential for the model of care at NSECH to artificially lower the SMR. The data co-ordinator and ICNARC lead monitored the SMR internally to ensure the actual SMR remained within an acceptable range.
- There had been 15 re-admissions from 15 June to 30 September 2015. This was four percent of all admissions.
- The unit participated in VAPRapid-2 which is a Newcastle University research trial looking at improving antibiotic stewardship.
- An audit board displayed information about the sepsis audit and a missed medicines audit. We reviewed an electronic copy of the spreadsheet of audit activity.
- The data co-ordinator carried out weekly data quality audits based on the ICNARC data. This included case reports on out of hours discharges, delayed discharges and re-admissions.
- Junior doctors were encouraged to complete audits. One example was the deteriorating patient audit. This had been completed following incidents where patients may not have been escalated to critical care promptly. An action was to repeat the audit following the reconfiguration of services and move to NSECH.
- We reviewed electronic copies of completed audits. An audit of delirium screening found 18% of patients were not assessed for delirium. The audit was planned to be repeated following the move to NSECH. An evaluation of the deteriorating patient pathway found there was a lack of appropriate treatment escalation plans and speciality consultant involvement. The records that we reviewed during our inspection all had completed treatment escalation plans.
- The critical care outreach team completed five NEWS audits a month. These showed good results across the trust.
- The physiotherapist completed an audit on mobilising patients out of bed. A protocol was developed to support staff. As a result of the audit additional equipment, such as chairs, were purchased. Results showed that 98% of appropriate patients were mobilised out of bed.
- The physiotherapist was completing an audit on physical outcomes using a national outcome measure, the 'Chelsea Critical Care Physical Assessment Tool'.
- The nursing and medical staff completed monthly audits on identified quality metrics.

Competent staff

- Senior nursing staff had allocated responsibilities. Team leaders were responsible for managing a group of staff. This included completing appraisals, medical devices training, team meetings and revalidation. Senior nurses who were not team leaders were responsible for education, including human factors training, the rota and equipment ordering.
- All medical and nursing staff we spoke to told us they had received an appraisal within the last 12 months. Appraisal records were stored electronically. The trust target was 85% of appraisals to be completed by 31 March 2016. The report date we viewed electronically during the inspection was 30 September 2015 and 23% of appraisals had been completed. Senior staff provided evidence that the figures were inaccurate, for example, completed appraisals of staff which were recorded electronically as incomplete.
- Seventy-six percent of nurses had completed a post registration critical care qualification. This was much higher than the minimum recommendation of 50%.
- We saw evidence that 89% of staff were up to date with medical devices training.
- The electronic training record we reviewed at NSECH during our inspection showed 100% of staff had completed an induction.

Critical care

- New members of nursing staff were allocated a mentor and had a supernumerary period of between six and eight weeks depending upon their previous experience.
- Nurses completed a competency package based on the national competency framework for adult critical care nurses.
- The unit did not have a clinical nurse educator; this did not meet the recommendations of Core Standards for Intensive Care (2013). The management team agreed that a clinical educator would benefit the unit. The senior nurse responsible for education and training was developing a skills grid for nurses in conjunction with the critical care network.
- Band five nurses were attending the trust leadership programme.
- Critical care specific courses including transfer training for nurses, clinical supervision groups and trust revalidation information was on display.
- The unit provided student nurse placements. Information about student allocation, induction and mentorship was on display. A student nurse told us they received good opportunities for learning on the unit.
- The critical care outreach team delivered training on recognition of the deteriorating patient.
- Medical staffs' appraisals were up to date and they reported no limitations to study leave and good access to continuing professional development.
- Junior medical staff told us they were well supported and received a lot of training. The deanery had agreed intensive care medicine trainees would rotate through the unit.
- The assistant specialising in rehabilitation after critical illness completed a foundation degree in NHS service improvement and six months of training with therapy staff.
- The ACCPs reported excellent support and training. Four trainees were completing a course at the University of Northumbria. The unit supported two qualified ACCPs to complete their prescribing course and an airway skills course.
- Senior staff were confident to manage performance issues in line with the trust policy and with support from human resources.

Multidisciplinary working

- Staff told us there was good teamwork and communication within the multidisciplinary team. We observed this on the unit and at the bedside during our inspection, particularly between the ACCPs and the nurses and medical staff.
- The eight records we reviewed had evidence of a consultant admission review and treatment plan.
- Members of the multidisciplinary team attended the safety huddle; staff told us this made them feel part of the team.
- Two physiotherapists were based on the unit. Nurses told us they had access to occupational therapy, speech and language therapy and tissue viability specialists when required. A dietitian and pharmacist visited the unit daily.
- The rehabilitation after critical illness assistant worked with therapists on the unit and provided ongoing therapy and support to patients on the ward after discharge.
- The unit held multidisciplinary meetings for patients with complex needs or to plan end of life care. There was excellent joint and patient centred working between the palliative care team, specialist nurse for organ donation, chaplains and the critical care team. Staff explained the guidelines they would follow to transfer a patient from critical care to home for end of life care.
- We observed evidence of discharge planning during the ward round. Each profession handed over patient information verbally to the relevant professional prior to the patient leaving the unit. For example, the critical care consultant telephoned the patients medical or surgical consultant, the junior doctor contacted the junior doctor on the ward and the nurse gave the ward nurse a handover.

Seven-day services

- X-ray and computerised tomography (CT) scanning was accessible 24 hours a day, seven days a week.
- Specialist critical care physiotherapists provided treatment Monday to Friday. Patients received physiotherapy treatment at the weekend and an on-call service was available overnight.
- Consultants completed a ward round twice a day at the weekend which was in line with recommendations from the Core Standards for Intensive Care (2013).

Access to information

Critical care

- A resource file of policies and procedures was kept in the hub office. This included information on tissue viability, learning disabilities, central venous catheters, blood transfusion and nutrition and dietetics.
- Staff were able to access blood results and x-rays using electronic results services.
- The patient administration system linked to Wardwatcher on all computers.
- Staff completed a discharge document for patients who were transferred to a ward in the trust. This was in line with NICE CG50 acutely ill patients in hospital. A standard critical care network out of hospital transfer form was completed for patients who were transferred to another trust.
- A ward clerk reported no difficulty accessing or filing patient notes.
- A patient board on the unit displayed information for staff. This included details of the nurse and consultant in charge and contact numbers for key and support staff. Coloured dots were used as patient alerts, for example, patients with sepsis or those with a difficult airway. There was no explanation about what the dots meant and not all staff were able to explain the patient alerts to the inspection team.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- Staff we spoke to demonstrated an understanding of consent, the Mental Capacity Act (MCA) and deprivation of liberty safeguards (DoLs).
- We observed staff obtained verbal consent from patients before carrying out an intervention when possible.
- Staff told us they would speak to the nurse in charge or a member of the medical team if they had concerns regarding a patients capacity. All staff knew how to access the MCA and DoLs flowchart and policies.
- The electronic training record we reviewed at NSECH during our inspection showed 100% compliance with MCA level one and two training and 100% compliance with DoLs training.
- Staff were aware of the restraint policy and could explain the process they would follow if mittens were needed to be used for patient safety.

Are critical care services caring?

Outstanding ☆

We rated the service as outstanding for caring because:

Staff considered patients individual preferences and evidently went out of their way to exceed expectations to meet their wishes. Staff were motivated and inspired by leaders to deliver person centred, holistic care. Individual examples of patient care supported this. A visitor told us the staff made them feel like their relative was the only patient on the unit and nothing was too much trouble.

Formal feedback from patients and relatives was continually positive about all aspects of their care.

All staff consistently communicated with both conscious and unconscious patients in a kind and compassionate way and treated them with dignity and respected their privacy.

All the patients and relatives we spoke to told us they had been kept informed of their treatment and progress and that they were involved in the decisions made by the medical team. They said communication on the unit was better than at other hospitals.

Nurses started a diary for patients in consultation with their relatives. Staff used an adapted “This is me” booklet for long term patients in which they included information from relatives and visitors about the patients personal preferences.

A member of staff had been nominated for multiple awards for their compassionate care.

Compassionate care

- The unit did not participate in the NHS Friends and Family Test because patients were infrequently discharged directly home.
- The patient experience team visited the unit and collected real time patient feedback. Staff knew how to access the results on the intranet. They gave examples of changes following the survey, for example, bins were replaced with quiet closing lids and ensuring the lights were dimmed at night.
- The unit displayed “your voice” inpatient survey results. In October 2015, patient experience scored ‘10 out of 10,’ for July to September the results ranged from 9.19 to 9.73.

Critical care

- We observed staff treated patients with dignity and respect for their privacy. During all interventions, staff drew curtains around patients and patients were kept covered with sheets and blankets.
- All staff communicated in a kind and compassionate way with both conscious and unconscious patients.
- We observed patient call bells were placed within reach and staff responded in a timely and respectful manner to patient requests.
- Staff considered patients individual preferences and evidently went out of their way to exceed expectations to meet their wishes. Examples included: taking long stay patients off of the unit to spend time with their pet or in the fresh air; or supporting end of life patients to get married in the hospital chapel and enabling patients to experience their final stages of their care outdoors or at home. Staff supported a patient to spend time watching sport on the unit with their friends; because the patient was unable to have a drink staff made a lager flavoured ice lolly.
- A member of staff had been nominated for multiple awards for their compassionate care: The NHS FAB stuff awards and patient champion of the year: North East. The team also came second in the patient experience national awards.

Understanding and involvement of patients and those close to them

- The unit displayed a welcome board at the entrance giving relatives information on details of the matron, visiting times and how to make an appointment with a doctor.
- All the patients and relatives we spoke to told us they had been kept informed of their treatment and progress and that they were involved in the decisions made by the medical team. They said communication on the unit was better than at other hospitals.
- One relative told us the staff made them feel like their relative was the only patient on the unit and nothing was too much trouble.
- All the relatives we spoke to told us staff were open and honest, and gave them regular updates with realistic expectations.
- Relatives told us, to suit their personal circumstances, staff made exceptions to visiting times.
- We saw evidence in the records where patients and their relatives had been involved in making decisions about their care and treatment.
- On the ward round we observed staff involving patients in their care.
- Staff knew the procedure for approaching relatives for organ donation when treatment was being withdrawn. Staff told us they received a good level of support from the organ donation specialist nurses.
- A member of the rehabilitation after critical illness team set up a patient support group, 'ICU Steps North of Tyne'. The group met six weekly and was patient led.

Emotional support

- Nurses started a diary for patients in consultation with their relatives. During the patients stay on the unit, staff and relatives made entries in the diary.
- During our inspection we observed a chaplain visit the unit. Staff welcomed them and they visited two patients.
- The unit worked closely with the end of life team. For relatives, staff took handprints from patients who were at the end of life. The unit did not transfer end of life patients to another ward if capacity allowed. The team received good feedback from a relative about the end of life care provided.
- Rehabilitation after critical illness staff completed the hospital anxiety and depression scale if they were concerned about a patients non-physical health.
- The unit did not have psychology input, but there was an informal arrangement where psychology input may be accessed if the patient was still in hospital. Otherwise staff made a referral through the patients GP.

Are critical care services responsive?

Outstanding ☆

We rated responsive as outstanding because:

People's individual needs were central to the planning and delivery of critical care services. The service involved patients and stakeholders in the new model of care and the build of the unit to ensure it provided an innovative approach to integrated person-centred care. The management team worked with leads in the trust to plan service delivery.

Critical care

Bed occupancy was between 59% and 65%. This was better than the level recommended by the Royal College of Anaesthetics. Since the unit opened in June 2015 there was no evidence that critical care capacity had impacted on elective surgery.

Staff had training on learning disabilities and dementia and felt able to deliver care to meet the needs of people in vulnerable circumstances or those with complex needs.

The unit had a well-equipped and comfortable visitors' waiting room and a separate quiet room for private conversations.

The rehabilitation after critical illness team delivered a follow up service that they had presented at a national conference. The team had set up a patient led support group ICU Steps North of Tyne.

We saw evidence of good processes to manage formal and informal complaints. The service received a low number of complaints. These were proactively reviewed and improvements were made as a result in the unit.

Service planning and delivery to meet the needs of local people

- The service proactively involved patients and stakeholders in the new model of care and the build of the unit.
- The service worked with leads in the trust to plan service delivery. We saw evidence of this in the minutes of the trust wide ICU clinical meetings.
- The service was actively involved in the regional critical care network. The anaesthetic school had recently visited the unit.
- Staff told us there was good access to specialist care at a local trust. Access to a weaning unit was difficult due to capacity and demand.
- Staff started a diary for all level three patients and patients with delirium. These patients were invited back to a follow-up clinic.
- Twice a month the rehabilitation after critical illness team held a follow-up clinic at NSECH. The team consisted of a consultant, a senior nurse and the rehabilitation after critical illness assistant. Therapists were not a formal part of the clinic but the team told us they would attend to review a specific patient issue if required.
- A visitors' waiting room was available outside the unit and was well equipped with a vending machine, hot drinks, lockers for valuables and a television. Staff could meet visitors in private by using the separate quiet room.
- Visitors told us they found the hospital easy to access on buses or by car; parking was available and reasonably priced.

Meeting people's individual needs

- Staff had adapted the "This is me" booklet and used it for long term patients in which they included information from relatives and visitors about a patients personal preferences.
- Staff told us they felt able to support patients with dementia and learning disabilities due to the nurse to patient ratio in critical care. On the electronic record we viewed we saw evidence that staff had received training on learning disabilities and dementia.
- Staff were aware of how to access the learning disabilities liaison nurse and had access to 24 hour, seven day a week, psychiatry services.
- Staff screened patients on admission for dementia as part of the commissioning for quality and innovation. To ensure this had been done, critical care staff added a prompt to the observation chart.
- The safeguarding resource folder in the hub office had information and policies on domestic abuse, substance misuse, forced marriage, human trafficking, multi-agency public protection arrangements and multi-agency risk assessments.
- Staff could access a bariatric chair and commode on site, while other equipment was hired from a specialist company.
- Translation services were available to patients whose first language was not English.

Access and flow

- The Royal College of Anaesthetics recommends that bed occupancy should be below 70%. Between June and September 2015 bed occupancy was between 59% and 65%.
- Since the unit opened in June 2015:
  - there was no evidence that critical care capacity had impacted on elective surgery;
  - there had been no patients ventilated outside of critical care;
  - there had been no non-clinical transfers out;

  - there had been no mixed sex accommodation breaches;
  - all patients had been admitted to the unit within four hours of referral. This was in line with recommendations from Core Standards for Intensive Care (2013).
- The trust provided validated ICNARC data from June to September 2015 which showed there had been 169 delayed discharges. The data co-ordinator and management team explained this data was not representative of the true delayed discharge figures due to the need to input the discharge information on the trust bed management system prior to the patient being fully ready for discharge. This was to ensure the information was received early enough by the bed management team to plan bed capacity.
- Staff explained out of hours discharges had previously been a problem. The unit's local standard was not to discharge after 8pm.
- The unit had access to a dedicated palliative care ambulance for home discharges. The trust used a private ambulance for internal hospital transfers.

Learning from complaints and concerns

- The unit displayed information on how to make a complaint on the welcome board and leaflets were available to patients and relatives.
- Between June and August 2015 the service had not received any complaints.
- We saw an example of a response to a complaint and evidence in meeting minutes that staff discussed complaints at team meetings and the trust wide ICU clinical meeting.
- One relative gave an example of where they made an informal complaint to a member of staff following an incident concerning their relative's dignity. Staff dealt with the informal complaint promptly, effectively and swiftly and the incident did not happen again.

Are critical care services well-led?

Outstanding ☆

We rated well-led as outstanding because:

The service was managed by an experienced and cohesive team who demonstrated a clear understanding of the challenges of providing high quality, safe care. Continuous improvement was driven with the involvement of frontline staff that felt valued and were engaged in service development. The leadership team motivated staff to succeed. It was clear that staff had confidence in the leadership at all levels and spoke highly of the culture within the unit. There were high levels of staff satisfaction.

Governance arrangements enabled the effective identification of risks and monitored these risks and the progress of action plans. Governance and performance metrics were proactively reviewed. There was evidence that controls were in place to mitigate these risks.

The management team accepted that the strategic focus had been on the change in model of care and a vision and strategy following the move to NSECH had not yet been formalised. However, the clinical lead explained a clear vision for the service that was innovative and considered sustainability of the service. Staff at all levels embraced the trust and service's vision and values.

The service used innovative approaches to engage patients and the public to plan and improve critical care services. The patient transition across critical care project was completed in response to patient feedback at the follow-up clinic.

Everyone on the unit was involved in the daily safety huddle and the culture of everyone had a voice, seemed embedded.

Vision and strategy for this service

- The management team accepted that the strategic focus had been on the change in model of care and a vision and strategy following the move to NSECH had not yet been formalised. The directorate annual business plan would be submitted in April 2016 and the service aimed to have a written strategy for critical care completed as part of this.
- However, the clinical lead was able to describe a clear vision for the service. This was to: analyse and act on findings from the ICNARC data and to use this to improve the service and to review the critical care outreach and rehabilitation after critical illness services following the change in model of care. The description included reference to the need to consider the sustainability of the service including retention, education and satisfaction of all staff as part of the vision, which included a shift in culture to bring staff education to the bedside.

- The management team had prepared business cases for service reviews prior to the move to NSECH but these needed refining following the change in the model of delivering care.

Governance, risk management and quality measurement

- The service held monthly multidisciplinary trust wide ITU clinical meetings that included governance. We reviewed minutes from these meetings and noted that serious incidents, policy reviews, open complaints and the risk register were some of the agenda items discussed.
- The consultants and senior nurses took responsibility for metrics that formed part of an internal quality account. These were proactively led by staff who audited, reviewed and used the results to drive improvement. The quality metrics were a standing agenda item at the monthly clinical meeting.
- The management team acknowledged the significant investment in critical care the trust had made. Financial constraints were considered in the planning of the new unit and the number of beds was reduced from a planned 19 to 18.
- Risks were categorised using a risk matrix and framework based on the likelihood of the risk occurring and the severity of impact. All risks entered on the trust risk management system were assigned a current and target risk rating. Controls were identified to mitigate the level of risk and progress notes were recorded. The unit's risk register identified the following key risks: meeting national critical care outreach standards; delivering rehabilitation after critical illness following the move to NSECH; anaesthetic secretarial support and failure of the Wardwatcher IT system. The risk register showed that controls were in place to mitigate these risks.
- The management team and senior staff were aware of the issues on the risk register and agreed they were representative of the risks they identified in the service.

Leadership of service

- Leadership of the service was excellent. The management team and senior staff were visible and approachable.
- It was clear from our conversations, and observations and data we reviewed, that staff had confidence in the leadership at all levels. Staff reported feeling very supported by their teams and managers. There were high levels of staff satisfaction.
- The NHS 2014 staff survey showed a score of 3.89 for staff being supported by their immediate managers. This was better than the national average score of 3.65.
- Matrons attended the monthly senior nurse forum chaired by the director of nursing. This was a monthly operational meeting that included audit and education.
- Senior staff had completed the trust's leadership programme. Senior nurses managed a team of nursing staff who worked their block of night shifts together. This was to facilitate team meetings, appraisals and supervision of the team.
- The management team were extremely positive about the service and very proud of the team who were passionate about patient safety.
- The senior team had planned the move to NSECH for over six years. Consultants and nursing staff had worked across both units and implemented standardisation of guidelines, equipment and care.
- The management team were aware of the impact on morale of staff moves to the ward. Senior staff continued to record the staff moves.

Culture within the service

- Staff had been involved and engaged with the development of the new unit and it was clear that the leadership team had prepared staff well for the change. Two teams of staff had been brought together by introducing cross-site working and work streams to standardise equipment and practices in preparation for the move to NSECH. All staff spoke of a seamless transition from the base sites to NSECH.
- Nursing staff morale was low due to being moved from the unit to cover vacancies on the ward. The management team were aware of the effect on morale and had taken action to mitigate the risk such as not moving critical care staff to the base sites. Further, rolling recruitment was underway to increase staffing on wards at NSECH.

Public engagement

- The unit participated in the two minutes of your time patient feedback. Results were displayed on the unit.

- Patient comments and thank you cards were on display in the visitors' waiting room.
- The management team involved patients in the planning of the new unit. For example, the initial plan, to maintain patient privacy and dignity, was for the unit to consist of all side rooms. Patients at the follow-up clinic fed back that they would feel isolated in side rooms. In response the unit was built with half the number of planned side rooms.
- The rehabilitation after critical illness service was set up after patients in the follow-up clinic identified a gap in the service. Patients reported they felt abandoned on discharge from the unit to the ward. The service was set up as a pilot initially.

Staff engagement

- The 2014 NHS staff survey showed a score of 3.93 for staff engagement. This was better than the national average score of 3.74.
- All staff told us the planning, preparation and the move to NSECH was excellent.
- Staff had access to team meeting minutes electronically on the shared drive and team leaders emailed them to staff. We saw evidence that clinical governance, policies, training and link nurse updates were discussed at team meetings. One member of staff gave an example that the introduction of delirium screening had been communicated through team meetings.
- The data co-ordinator fed back quality data at the safety huddle. It was also included in a newsletter and on the staff information board.
- A notice asking for ideas and suggestions from staff to improve the unit was in the staff room.
- The matron was part of the trust's '15 step challenge' team and brought ideas back to the unit. Staff, patients and volunteers developed this toolkit to capture what good quality care looked, felt and sounded like. Staff had participated on inspections on their previous units and gave examples of learning points. At the time of our inspection there had not been a 15 step challenge on the unit.

Innovation, improvement and sustainability

- The service completed an improving patient transition across critical care project. The introduction of rehabilitation after critical illness assistant was shown to improve patient experience following discharge from critical care.
- The rehabilitation after critical illness team presented how to set up and maintain the critical care follow up service at a national conference.
- The pit stop handover for all admissions to the unit was developed with human factors training using formula one pit-stop models, to facilitate a structured handover and improve patient safety.
- Staff presented the service's work on human factors at the trust's nurse conference.
- Following the centralisation of critical care services to NSECH, iPad technology was introduced to manage the needs of deteriorating patients, transfer and retrieval procedures in a multisite organisation.
- Everyone on the unit was involved in the daily safety huddle and the culture of everyone had a voice seemed embedded. Information was recorded in the safety huddle book and issues such as: capacity; staffing; medicines; sepsis; the NEWS quality improvement project and patient feedback was discussed.

Maternity and gynaecology

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

Information about the service

Inpatient maternity services were transferred to the Northumbria Specialist Emergency Care Hospital (NSECH) in June 2015 from the Wansbeck General Hospital and from the midwifery led unit at NTGH. The trust offered a range of maternity services for women and families based in NSECH.This included antenatal and postnatal inpatient care for women with low-risk pregnancies to specialist care for women who needed closer monitoring. There was also an emergency gynaecology service provided on the surgical assessment unit. Between June 2015 and September 2015 there were 827 births at NSECH.

We visited the birthing centre, antenatal and postnatal ward 16, obstetric theatre and recovery and the emergency gynaecology service at NSECH. All planned and routine gynaecology was undertaken on other sites within the trust. Gynaecological oncology services were provided by neighbouring trusts.

We spoke with seven women, two relatives and 53 staff, including midwives, midwifery support workers, doctors, consultants and senior managers. We observed care and treatment and looked at 11 care records. We also reviewed the trust's performance data.

Summary of findings

We rated maternity and gynaecology services as requires improvement because:

We found the infant abduction policy had not been tested since the move to the new unit, despite an incident reported by a member of the public who was able to leave and enter the unit unchallenged. On inspection we found placentas were stored appropriately, however, we found inappropriate non-clinical items stored in the placenta freezer. The storage of emergency drugs on the birthing centre and ward 16 were not in line with the trust's pharmacy risk assessment, and the service was not using tamper evident boxes in which to store drugs required in ward areas. We reviewed care records and found inconsistencies in the completion of which pathway women were following, in particular who was the lead professional in antenatal and labour notes (partogram). We also found notes had incomplete fluid balance charts. Due to the unexpected levels of activity the unit had experienced staffing numbers which were worse than the national recommendations. However, service leads had recognised this and plans were in place to recruit additional staff. There were systems for reporting, investigating and acting on adverse events. The service collected and reviewed information about standards and safety and shared it with staff.

Although the senior management team were aware of the challenges to the service and had a vision for the future, the formal clinical strategy for maternity or

gynaecology services which was contained within the surgical business unit annual plan was very generic in terms of outcomes and references to maternity and gynaecological services were minimal. This did not support identification of how the service was to achieve its priorities or support staff in understanding their role in achieving the services priorities. The risk register did not reflect the current concerns of the senior management team, and had no mention of the concerns raised about infant abduction. We found there were risk and governance processes in place; however, we were concerned with the levels of scrutiny provided by the directorate with regard to the clinical dashboard. Risks were reported and monitored and action taken to improve quality. The views of the public and stakeholders through participative engagement were actively sought, recognising the value and contributions they brought to the service. There was some evidence of innovative practice.

The service used evidence based guidelines to determine the care and treatment they provided. We reviewed the annual audit plan; however, staff we spoke with informed us that since the move to the new hospital they had not been involved in any audit activity apart from the regular local audit. We found staff had the correct skills, knowledge and experience to do their job. Training ensured medical and midwifery staff could carry out their roles effectively. Competencies and professional development were maintained through supervision. Women told us their pain was managed, also they were provided with choice. Women were offered support to feed their baby's, and hot food and drinks were available for mothers 24 hours a day. Patient outcomes were monitored using the maternity dashboard but not all patient outcomes were within expectations; however, we saw that investigations were underway in areas of concern.

Patients were valued as individuals, and we were provided with examples of this. Following an increasing number of complaints regarding staff attitude in 2014, the service had put in place compassion training for all staff. In the 2015 CQC maternity experience survey placed the service in the top 10 hospital trusts. We observed patient care in the ward environment and staff were seen to be supportive and respectful. Women received emotional support and were involved in their care.

The service had gone through a significant reconfiguration to a new model of care, which saw the amalgamation of delivery services previously based at Wansbeck and North Tyneside General Hospitals on the one NSECH site. Policies were in place to ensure that patients were seen at the right place at the right time. We found the service had begun to engage with service users to inform developments within the service. There was no pregnancy assessment unit on site; women were triaged on the birthing centre. Staff we spoke with informed us on occasion this had reduced the capacity on the birthing centre for labouring women and the number of staff able to look after them. Service leads informed us this was high on their list of priorities and were working on short and long term plans for the future. There were a number of specialist midwifery roles to support women, for example, a high risk midwife and diabetes midwife specialist. Women using the service could raise a concern and be confident that concerns and complaints would be investigated and responded to.

Maternity and gynaecology

Are maternity and gynaecology services safe?

Requires improvement

We rated safe as requires improvement because:

We were concerned about the risk of child abduction on Ward 16, as patients and visitors were able to leave the ward unseen, and unchecked. We found inconsistencies in infection control procedures, and the checking of equipment.

On inspection we found placentas were stored appropriately, however, we found inappropriate non-clinical items stored in the placenta freezer. We raised concerns with staff, and the items were removed immediately by senior staff.

We found the storage of emergency drugs on the birthing centre and ward 16 was not in line with the trust's pharmacy risk assessment. We were concerned about the storage of emergency drug boxes.The service used an electronic system to monitor the administration of medicines, patients were also able to self-medicate following a completed risk assessment.

We reviewed 11 records of women who had completed the pregnancy pathway and found inconsistencies in the completion of which pathway women were following in particular who was the lead professional in antenatal and labour notes (partogram). This may lead to high risk women not receiving an appropriate plan of care or review by medical staff

We also found that eight sets of notes had incomplete fluid balance charts.

Staffing levels were set and reviewed by the operational board using nationally recognised tools and guidance. Medical and midwifery staffing were worse than national recommendations for the number of babies delivered on the unit since it opened in June 2015. This had been recognised by the service and staffing had been reviewed and additional midwives were being recruited at the time of our inspection. This was prior to the NICE (2015) recommended review of every six months.

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

Postnatal records relating to women's care were detailed enough to identify individual needs and to inform staff of any risk and how they were to be managed, however, there was inconsistent compliance with handover documentation. There were clear safeguarding processes in place; staff knew their responsibilities in reporting and monitoring safeguarding concerns.

Incidents

- The trust had policies for reporting incidents, near misses and adverse events. All staff we spoke with said they were aware of the process to report incidents. We saw printed information in all clinical areas which detailed what incidents should be reported. Staff reported incidents on the trust's electronic incident-reporting system. Staff told us they received feedback about incidents they had reported, with details of the outcomes of any investigations. Junior doctors said they were not always provided with feedback from incidents and case reviews.
- Between June and October 2015, 161 incidents were reported. Five were reported as moderate harm and 46 reported as minor harm or damage and 109 were reported as no harm. There were no specific identifiable themes identified.
- We saw evidence of specific learning events and investigations posted in clinical areas for staff to review.
- The service reviewed all incidents within a multidisciplinary meeting which includes: a consultant obstetrician; Supervisor of Midwives; Anaesthetists; neonatal staff; governance coordinator; midwives; matron; junior medical staff; and theatre staff. Any incidents that need immediate attention are escalated to the: clinical director, head of midwifery, business unit director, deputy executive director, general manager, OSM and lead consultant for the labour ward, and governance lead. Incidentsare escalated or downgraded as required following joint discussion. If escalation is required, this is discussed with the medical director and director of nursing.
- The service used a weekly safety bulletin to inform staff of learning and changes to practice and keep staff

informed of the risks, which faced the directorate. We observed the bulletin was displayed in clinical areas; staff we spoke with informed us that the bulletin was discussed in handover and ward meetings.

- There were no Never Events reported for maternity and gynaecology in 2014/15.
- Perinatal mortality and morbidity were monitored through monthly perinatal meetings, which were attended by obstetric and neonatal staff and reported quarterly to the trust mortality and morbidity steering group chaired by the medical director. Minutes of meetings from March 2015 to May 2015 included examples of the steering group reviewing cases and recommending changes to clinical guidelines and practice as a result.
- The duty of candour is a regulatory duty that relates to openness and transparency and requires providers of health and social care services to notify patients (or other relevant persons) of certain 'notifiable safety incidents' and provide reasonable support to that person. Staff we spoke with were aware of the principles of duty of candour and all were able to provide examples of where it had been applied. We also found examples of where duty of candour had been applied in meeting minutes and incident report outcomes.

Safety thermometer

- Maternity had started using the national maternity safety thermometer. This allowed the maternity team to check on harm and record the proportion of mothers who had experienced harm-free care. The maternity safety thermometer measures harm from perineal and abdominal trauma, post-partum haemorrhage, infection, separation from baby and psychological safety. In addition, it identified those babies with an Apgar score (a method to quickly summarise the health of the new-born) of less than seven at five minutes and those babies who were admitted to a neonatal unit.
- The service participated in the pilot for the national maternity safety thermometer. Results showed for combined harm free care between November 2014 and October 2015 between 52% and 87% of women received harm free care, however this was not benchmarked against other trusts.

Cleanliness, infection control and hygiene

- There were no cases of hospital-acquired Methicillin-Resistant Staphylococcus Aureus (MRSA) or Clostridium difficile (C. difficile) in 2014/15.
- At the main entrance to the unit, visitors were encouraged to wash their hands with antibacterial foam. Areas we visited had antibacterial gel dispensers at the entrances. Appropriate signage was on display regarding hand washing for staff and visitors.
- Observations during the inspection confirmed that all staff wore appropriate personal protective equipment when required, and they adhered to 'bare below the elbow' guidance, in line with national good hygiene practice.
- Cleaning rotas were in place for domestic staff and these were complete. We observed staff cleaning clinical areas during our inspection.
- The CQC Survey of Women's Experience of Maternity Services (2015) showed the service scored 'about the same' as other trusts for cleanliness, infection control and hygiene.
- Data for September 2015 for hand hygiene assessments showed 100% of midwives and medical staff on delivery suite and maternity ward were compliant.
- Failsafe systems were in place to identify women for Hepatitis B and HIV at booking to ensure relevant patients were managed on the correct care pathways. Data between 2014/2015 showed 100% of women had been screened for HIV and Hepatitis B.
- On inspection we found placentas were stored appropriately, however, we found inappropriate non-clinical items stored in the placenta freezer. We raised concerns with staff, and the items were removed immediately by senior staff.

Environment and equipment

- The new birthing centre had two pods each holding seven delivery rooms. Seven were allocated to midwifery led care and triage, and seven were high risk delivery rooms.
- A hybrid model of care was observed where women were not in dedicated low or high risk rooms but were in a delivery room where care could change from low risk to high risk as labour progressed. Staff we spoke with informed us that low risk women who began to labour in the midwifery led rooms, were able to continue their labour in the same room and were not transferred to a high risk room if complications were identified.

- Each room was en-suite and all had disabled access.
- Ward 16 had three pods.Two had seven individual rooms and one had six, which meant that the ward had 20 individual en-suite rooms, which meant that partners were able to stay.
- There was adequate equipment on the wards to ensure safe care – specifically, cardiotocography (CTG) and resuscitation equipment. Staff confirmed they had sufficient equipment to meet patient needs.
- The service had three resuscitaires one in each of the pods on the birthing centre and one on ward 16. There were nine portable resuscitaires which were to support women and babies achieve delayed cord clamping.This is a process by which the umbilical cord is not cut for at least one minute following birth to allow the baby to receive additional blood which improves outcomes.
- All safety testingchecks were completed. Staff also completed a self-assessment to identify their competence, which identified any medical devices training needs.
- There were two birthing pools in the unit. One located in the midwifery and high risk areas. These rooms also had equipment to support active birth such as birth balls and stools. We were assured staff tested evacuation from the pool, however this had not been done in the Birthing Centre since the relocation.Staff were unable to give an exact evacuation time however we were informed it was seconds.
- All delivery rooms had piped ENTONOX® (nitrous oxide and oxygen) and other gases. The birthing centre had a fetal blood analyser, located in the treatment room. We reviewed quality control records.
- The fetal blood analyser quality control records are maintained and are accurate. The cartridge replacement is carried out in line with manufacturing recommendations.
- The service had a room which would be used for women who experience still-birth. This room was in the high risk area of the birthing centre, which meant that women and their families were not separated and would be able to hear babies and labouring women. This room was called the Willow room; however, the room was appointed the same as all other delivery rooms. During our inspection the room had a resuscitative and CTG monitor, however portable items were removed or added as required. Appropriate equipment staff needed when caring for a women undergoing pregnancy loss was stored in a designated cupboard adjacent to the birthing centre. Staff informed us that prior to the move from Wansbeck, there was a specific room for families experiencing fetal loss.
- During our inspection we reviewed stock and store cupboards and found stock control and management to be effective.
- We found that daily checks on equipment were sporadic for example; the birthing centre lead did not have assurance that all rooms had been checked daily.We found that daily checks on resuscitaires were not always carried out and there were no procedures in place to alert leads when checks had not taken place. During our inspection, the birthing centre implemented a room checking proforma.
- During our announced inspection we found that checks on the emergency trolley on both the birthing centre and ward 16 were not consistent and daily checks were missed.We highlighted this concern with staff.Staff we spoke with informed us that there was confusion over which checking book to use. During our unannounced inspection we found that there was still confusion in which checking book was to be used, however, we raised this with staff and the duplicate books/checking documents were removed, while we were on the unit.
- There was one dedicated emergency obstetric theatre and one elective obstetric theatre based within the theatre suite; both enabled quick access from the birth centre, through alarmed doors which were accessible through a card swipe system.
- The neonatal unit was situated just outside the delivery suite doors. Staff we spoke with informed us that advanced neonatal nurse practitioners were able to attend emergencies quickly.

Medicines

- Medicines were stored using an Omnicell system.This system dispenses medication and the registered nurse is identified by fingerprint technology. This provides an audit trail of information and tracks dispensed doses. Staff we spoke with had been trained to use the system and it was working well.
- We were concerned with the storage of emergency drugs on the birthing centre and ward 16. We highlighted these concerns with staff. During our unannounced inspection, we found these issues had

not been resolved.We highlighted these concerns with the head of midwifery (HOM) and were provided with assurance this had been dealt with by the time we left the hospital site.

- Emergency drugs stored in the birthing centre and ward 16 did not have a tamper evident system in place when it was impractical for them to be locked away.This was against the recommendations in the Duthie report (2005). For example, drugs used for PPH were stored loosely on the trolley and drugs for eclampsia were stored in a plastic box which opened easily.
- The emergency drugs were stored within view of the nursing station but this area may not have a constant staff presence.
- 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. 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 showed controlled drugs were checked in line with hospital policy.
- All patient group directives PGDs were in date, however, we found that not all staff had signed as competent to use them. During our unannounced inspection, we found the service had taken action as we found that the number of staff who had signed the PGDs had increased.

Records

- The service was in the process of transition between paper records and electronic records. At the time of inspection antenatal records were completed electronically, however, delivery and postnatal records in hospital are electronic records with the exception of the partogram which was paper.
- We reviewed 11 records of women who had completed and been discharged from the maternity service and found inconsistencies in the completion of which pathway women were following in particular who was the lead professional in antenatal and labour notes (partogram). This may lead to high risk women not receiving an appropriate plan of care or review by medical staff. We also found that eight sets of notes had incomplete fluid balance charts. We also found that on reviewing situation, background, assessment and recommendation (SBAR) handover, two midwives did not sign forms on hand over, and in eight records were not completed appropriately. The SBAR communication tool allows effective communication between health professionals in each clinical area during handover of care. We spoke with staff who identified that this was consistently a problem.
- The service kept medical records securely in line with the data protection policy.
- We found good compliance with venous thromboembolism (VTE) risk assessments and also completion and escalation with maternity early warning score (MEOWS) if the score was above the trigger.
- Women carried their own records throughout their pregnancy and postnatal period of care. The unit used the North East Personal Child Health (NEPCHR) 'red book'.This was given to women following the new-born examination.
- The service used approved documentation for the process of ensuring that all appropriate maternal screening tests were offered, undertaken and reported on during the antenatal period.
- We reviewed an annual supervisor of midwives (SOM) audit of record keeping dated October 2014. A review of 25 patient records identified improvements were required in four areas, these were:
  - Basic record keeping.
  - Antenatal records.
  - Labour records.
  - Postnatal care.
- We reviewed the November 2015 SOM record-keeping audit which reviewed 27 health records and found improvements had been made; however, some areas had reduced in performance, for example, clients details on all pages had reduced from 100% compliance in 2014 to 85% compliance in 2015. Evidence of birth plan discussion had reduced from 100% to 73%. If CTG was used in labour hourly fresh eyes documentation had reduced from 70% to 50%. The postnatal checklist completed by midwife and evidence of health visitor handover had both reduced from 100% to 67%. The audit showed actions taken immediately by the SOM during review, however there was no detailed action

plan, although there were recommendations arounddiscussion documentation compliance in the annual SOM review and also the SOM mandatory training sessions.

Safeguarding

- There were effective processes for safeguarding mothers and babies. The service had a dedicated, midwife responsible for safeguarding children, following a serious case review in June 2014.
- The safeguarding plan sits in the back up medical notes and the care plan was based in the electronic notes, which meant staff had access to plans if the paper records were unavailable.
- Staff demonstrated a good understanding of the need to safeguard vulnerable people. Staff understood their responsibilities in identifying and reporting any concerns.
- The safeguarding lead told us all midwives received annual safeguarding training and community midwives also had face to face supervision at least every six months.Hospital based staff attended group supervision.
- Records showed 71% of nursing and midwifery registered staff had completed level three children's safeguarding training; this was against a trust target of 85%. Action plans were in place to ensure the service would meet the target by March 2015.
- Records showed 73% of staff had completed safeguarding adults level one training against a trust target of 85%. Action plans were in place to ensure the service would meet the target by March 2015.
- The child abduction policy had not been tested on ward 16 since the move to NSECH. Access to the ward was by a video call system. To exit the ward patients and visitors could press a button to leave; however, due to the curvature of the corridor the doors were not visible by staff at the desk offering the opportunity for entering the ward unseen and unchallenged. We noted that the doors took a long time to close. There was no baby tagging system in place.We found that this was a significant risk and raised this issue with service leads. We reviewed incident data which noted a member of the public had entered the Birthing centre and ward 16 unchallenged and had called the police who in turn notified the trust security.During our discussion with senior staff there was no mention of this incident. During our unannounced inspection, we were assured that action had been taken to have a buzz in buzz out system. A meeting was due to take place two days following our visit where the divisional board was going to sign off the new security arrangements and it would be added to the risk register.
- We asked staff how they assessed and reported concerns around female genital mutilation (FGM). The World Health Organisation (WHO) defines FGM as procedures that include the partial or total removal of the external female genital organs for cultural or other non-therapeutic reasons. Senior clinical staff told us there had been training about FGM the previous year, which raised awareness. A guideline was in place to support staff in the identification of those at risk of FGM and management. Since September 2014, it has been mandatory for all acute trusts to provide a monthly report to the Department of Health on the number of patients who have had FGM or who have a family history of FGM. In addition, where FGM was identified in NHS patients, it was mandatory to record this in the patients health record; there was a clear process in place to facilitate this reporting requirement.
- Results from the documentation audit showed compliance with documentation in relation to domestic violence required improvement and plans were in place to improve this.

Mandatory training

- The multidisciplinary team attend the two-day obstetric PROMPT training, which included emergency drills, adult and neonatal resuscitation, infant feeding, record keeping and risk management awareness. Staff we spoke with informed us that mandatory training was monitored by SOM and ward leads.
- We reviewed data, which showed mixed mandatory training rates between 11% for safeguarding adults level two against a trust target of 66%. We found that 48% had a mentorship qualification, 68% had completed basic life support training, 87% of staff had completed aspects of the essence of care training, against a trust target of 85%. Training was scheduled until March 2016 and staff were allocated to attend, therefore, all staff would receive mandatory training as required.

Assessing and responding to patient risk

- Midwifery staff identified women showing signs of early deterioration by using an early warning assessment tool known as the Modified Early Obstetric Warning System

(MEOWS) to assess their health and wellbeing. This assessment tool enabled staff to identify and respond with additional medical support if necessary. We reviewed 11 records and saw all contained completed MEOWS tools.

- Arrangements were in place to ensure checks before, during and after surgical procedures in line with best practice principles. This included completion in theatres of a trust wide World Health Organisation (WHO) surgical safety checklist. The service did not use the maternity specific WHO checklist, and staff we spoke with were not aware of this document.
- Evidence showed for the period April 2015 to June 2015 100% of WHO checklist in the notes. 96% of the checklists were fully completed.
- The unit used the 'fresh eyes' approach, a system which required two members of staff to review electronic fetal heart rate tracings, 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 (ROCG) guidance (Safer Childbirth: Minimum Standards for the Organisation and Delivery of Care in Labour) with a ratio of 1:19 across both community and hospital staff against the recommended 1:28. However, site-specific data provided by the service identified a 1:36 ratio based on 3000 births a year at NSECH.
- The service used Birthrate Plus® to establish staffing numbers, staffing at NSECH was being reviewed and nine additional midwives were going through the recruitment process. We were told births at the new NSECH site had exceed expectations as more women were choosing to deliver at the birth centre than anticipated.
- We found staffing levels were displayed on wards. We reviewed staff "off duty" and found a correlation between planned versus actual staffing numbers. Also in the off duty was a staffing list detailing where the staff were based on each shift.This enabled the service to flex staff between ward 16 and the birthing centre should the demands on the service increase.
- Women told us they had received continuity of care and one-to-one support from a midwife during labour. The trust reported the percentage of women given one-to-one support from a midwife was good.
- The service used bank midwives from their own staffing establishment should shifts require cover.The total hours worked was monitored by management to ensure staff were not working too many hours, which could affect patient safety.
- Midwifery handover occurred twice a day at the end of each shift. There was an overview of the patients on the unit or ward and then a handover at the bedside as required.

Medical staffing

- The medical staffing mix for the maternity and gynaecology service across the trust was better than the England average, with 38% consultant grade staff compared to the England average of 35%. Middle grade staff, that is doctors with at least three years as a senior house officer or at a higher grade, was 0% at the trust and the England average was 8%. The trust had higher than the England average for registrar level staff, which formed 58% of the staff, against an England average of 50%. Junior doctors, those in foundation years one or two, made up 4% of staff, with the England average at 7%.
- The delivery suite had consultant cover 84 hours each week. This was in line with the Royal College of Obstetrics and Gynaecology (ROCG) recommendations for the number of births.
- The consultant obstetricians provided acute daytime obstetric care on the birthing centre 08.00 – 20.00 and participated in out-of-hours work when they were on call for the obstetrics and gynaecology unit.
- Multidisciplinary ward/board rounds took place at 08.45amfor all women and review of critical care women as their condition dictated.The birthing centre coordinator also took part in the medical handovers.
- Anaesthetic cover was available for epidural and emergency procedures 24 hours a day. At the time of inspection the service did not audit the length of time it took for an anaesthetist to respond to request for epidural.

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.

Maternity and gynaecology

- There were clear escalation processes to activate plans during a major incident or internal critical incident such as shortfalls in staffing levels or bed shortages.
- Midwives and medical staff undertook training in obstetric and neonatal emergencies at least annually.
- The trust had major incident action cards to support the emergency planning and preparedness policy. Staff understood their roles and responsibilities.

Are maternity and gynaecology services effective?

Good

We rated effective as good because:

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

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

Women reported having their pain effectively managed and there were choices for managing pain. An anaesthetist was on duty to administer epidurals. Women were offed support to feed their baby's, and hot food and drinks were available for mothers 24 hours a day.

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

Evidence-based care and treatment

- Due to the timing of our inspection and the reconfiguration of services at NSECH there is no national audit data available for this site.
- Medical and clinical staff reported having access to guidance, policies and procedures on the hospital intranet.
- From our observations and through discussion with staff, care was in line with the National Institute for Health and Care Excellence (NICE) Quality Standard 22. This quality standard covers the antenatal care of all pregnant women up to 42 weeks of pregnancy, in all settings that provide routine antenatal care, including primary, community and hospital-based care.
- The care of women who planned for or needed a caesarean section was seen to be managed in line with NICE Quality Standard 32.
- There was evidence to indicate NICE Quality Standard 37 guidance was being met. This included the care and support that every woman, their baby and as appropriate, their partner and family should expect to receive during the postnatal period. There were arrangements in place that recognised women and babies with additional care needs and referred them to specialist services. For example, there was an on-site special care baby unit (SCBU).
- Staff were consulted on guidelines and procedures, which were regularly reviewed and amended to reflect changes in practice. Policies and procedures were available on the trust's intranet and were approved by the clinical governance group. The policies we reviewed (post-partum haemorrhage, multiple births, pre-eclampsia and raised blood pressure) were all in-date and in line with best practice. We found the hypertension policy was approved in November 2015 but did not reflect the care practices at NSECH and still referenced maternity care provided at Wansbeck General Hospital. We raised this concern with service leads; at our unannounced visit this had been changed.
- We found the care of women using the services were in line with Royal College of Obstetrics and Gynaecology (RCOG) guidelines (including 'Safer childbirth: minimum standards for the organisation and delivery of care in labour'). These standards set out guidance about the organisation, safe staffing levels, staff roles, and education, training and professional development.
- NHS Litigation Authority Clinical Negligence Scheme for trusts (CNST), maternity clinical risk management standards was assessed in 2010 and awarded level three. In order to gain compliance at level three the organisation was required to pass at least 40 of these criteria, with a minimum of seven criteria being passed in each individual standard such as high risk conditions, postnatal and new-born care, clinical care, organisation and communication.
- The unit was implementing the NHS funded Saving Babies in North England (SaBiNE) which was a care

bundle for still birth prevention, through improved antenatal recognition of fetal growth restriction. At the time of inspection, there was an identified SaBiNE midwifery and consultant lead.

Pain relief

- Women received detailed information of the pain relief options available to them, this included Entonox piped directly into the delivery rooms, active labour and birth pool and pharmacological pain relief options, for example, such as pethidine. Regional analgesia epidural was only available at NSECH.
- The service provided a 24-hour anaesthetic and epidural service. The trust did not undertake pain relief audits or collect this data, however, the 2014 patient survey found that 94% of women received the pain relief they wanted in labour.
- The service reported that it promoted hypnobirthing as an alternative method of pain relief and we were told two midwives within the service were trained in this technique. Women were signposted to support in the local community.

Nutrition and hydration

- There were two infant feeding coordinators; their role included training staff, supporting breastfeeding mothers on the postnatal ward and the community.
- Breastfeeding initiation rates for deliveries that took place in the trust for April 2015 to June 2015 were reported as 61%, which was above the trust target of 60%. Data showed that 51% of babies were still breastfed at discharge from the hospital and 37% of babies were still breastfed at discharge from maternity care.
- The trust was implementing United Nations Children's Fund (UNICEF) Baby Friendly Initiative standards. The unit had achieved stage two of the accreditation process, however, were unsuccessful when the service was assessed for stage three of the accreditation process.
- Women had 24 hour access to hot meals on the postnatal ward. One woman told us she had a full cooked meal at 03.00am. The choice of meals took account of individual preferences, including religious and cultural requirements. Women we spoke with said the quality of food was good.

Patient outcomes

- There were no risks identified in maternal readmissions, emergency caesarean section rates, elective caesarean sections, neonatal readmissions or puerperal sepsis and other puerperal infections (Source: HES 2014/15; Intelligence Monitoring Report May 2015).
- Emergency caesarean section rates were 12%, which was better than with the England average of 15%. For elective sections, the service achieved 9% which was better than the England average of 11% (Source: HES 2014/15; Intelligence Monitoring Report May 2015). Between June and September 2015 the service reported a caesarean section rate of 27.3%.This exceeded the target set by the service and an instrumental vaginal delivery rate of 7.8%.This was below the service's target.
- The service achieved a normal vaginal delivery rate of 68%, which was better than the national average of 60%. Between June and September 2015 the service reported a normal vaginal delivery rate of 67%.
- Between June and September 2015 the induction of labour rate was 30%.This exceeded the target.
- The National Neonatal Audit Programme (NNAP) includes two questions that would apply to the maternity area. The report for 2013 indicated the location achieved 100% compliance with temperature taking of babies born at less than 28 weeks and 6 days. The unit scored 80% for the percentage of mothers being given a dose of antenatal steroid when they delivered a baby between 24 plus 0 and 34 plus 6 weeks gestation.This was worse than the NNAP standard of 85%.
- Trust data showed the antepartum stillbirth rate over 24 weeks between April 2014 and March 2015 as nine. This is equal to the number in the previous financial year. The service dashboard showed there was six stillbirths at term; however, this did not take into account still born babies born between 24 and 37 weeks gestation.
- Trust data for April 2014 to March 2015, showed there were two neonatal deaths, and between June and September 2015 there were three reported neonatal deaths.
- The unexpected admission rate to the Special Care baby unit was 2.7% between June and September 2015.This was RAG rated amber.
- The number of 3rd and 4th degree tears had exceeded expected limits at 3% of deliveries between June and September 2015.

Maternity and gynaecology

- Between June and September 2015 0.8% of women had a blood loss measured at 2 litres or above, additionally 0.4% of women experienced a life threatening blood loss of 3 litres or more.
- There were four unplanned maternal admissions to the intensive care unit (ITU) between June and September 2015.
- There were four women readmitted within 42 days of delivery with sepsis, between June and September 2015.
- The service reported 3155 women were screened for HIV coverage for 2014 to 2015.This met the service key performance indicator; during the same time, there was a 100% referral rate for women identified to have Hepatitis B.
- During 2014 to 2015, the services reported an average of 2% of avoidable repeated newborn blood spot tests which was in line with national targets.
- The service had implemented the baby clear initiative to reduce maternal smoking in pregnancy, and between April 2015 and August 2015 the non-smoking rate was reported as 83% which was better than the trust target of 78%.

Competent staff

- The head of midwifery, matron and managers, allocated staff to training and identified through appraisals the need for additional training over and above mandatory training, and monitored staff training monthly. The appraisal rate was 96% for 2014/2015. All staff we spoke with informed us their appraisal was up to date.
- We were told the PROMPT training programme for obstetrics ran over a two-year cycle, which ensured a comprehensive training programme. Subjects included, antenatal and newborn screening, and public health initiatives. The training programme also included skills drills in subjects such as cord prolapse (including at home) and breech delivery, shoulder dystocia, eclampsia and obstetric haemorrhage.
- Newly qualified band 5 midwifery staff had a period of 'preceptorship', where they received additional support and went through a programme of competencies. Staff reported the level of support and training was "good."
- Healthcare support workers attend PROMPT training to support the delivery of services and examples of subjects included the care of deteriorating patients and MEOWS, maternal observations, skills drills, breech births, eclampsia and neonatal life support.
- Revalidation was part of appraisal process for medical staff. Staff we spoke with reported no difficulty in getting an appraisal done.
- All midwives had a named supervisor of midwives (SOM). Staff we spoke with told us they had access to and support from an on call SOM 24 hours a day. The ratio of SOM to midwives was one to 11 which was in line with recommendations. The 2014/15 local supervisory authority (LSA) report identified that SOMs needed to negotiate enough protected time to undertake statutory work, and also consider new models for supervision.
- The results of the General Medical Council National Training Scheme Survey 2015 showed educational and clinical supervision, induction and adequate experience for junior doctors was within expectations for this trust. The survey did show that work load was higher than in other trusts.
- Junior doctors attended protected weekly teaching sessions. They told us they had good ward-based teaching and were supported by speciality trainees, however informed us there was little involvement from consultant colleagues. We reviewed information from health education north east who was concerned with the level of supervision junior doctors were receiving during an inspection of the service in July 2015. The service was due to be re-inspected in early 2016.

Multidisciplinary working

- There was good multidisciplinary working. All staff, including those in different teams and services, were involved in assessing, planning and delivering women's care and treatment. The service participated in regional and local multidisciplinary team networks in areas such as fetal medicine.
- We observed communications with GPs summarising antenatal, intrapartum and postnatal care in medical records.
- Staff confirmed there were systems in place to request support from other specialties such as physicians, consultant microbiologists and pharmacy.
- Midwives at the hospital and in the community worked closely with GPs and social care services while dealing with safeguarding concerns or child protection risks.
- Staff confirmed they could access advice and guidance from specialist nurses/midwives, as well as other allied health professionals.

- Patients and staff we spoke with provided examples of multidisciplinary working in practice, for example working with multiple allied health professionals, medical and surgical specialities to support women during pregnancy and childbirth.

Seven-day services

- An obstetric theatre team was staffed and always available. A team was also on call out of hours.
- There was medical staff presence on the birthing centre 24 hours a day, with consultant presence 12 hours a day.
- Urgent ultrasound facilities were available 24 hours a day seven days a week through the on-call medical team.
- The early pregnancy service at NESCH was held Monday to Friday 08.30 – 17.00 with 4 appointment slots morning and afternoon.

Access to information

- Women who used the maternity services had access to informative literature. We saw examples on display, such as whooping cough in pregnancy, smoking cessation, pathway through labour and optimal infant nutrition.
- Copies of the delivery summary were sent to the GP and health visitor to inform them of the outcome of the birth episode.
- The maternity unit had its own version of the trust corporate branding. The unit also had its own dedicated area on the trust website. Pregnant women and their families could access this site and take a virtual tour of the birthing centre, to help inform their choice of birth location.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- Women confirmed they had enough information to help in making decisions and choices about their care and the delivery of their babies.
- Consent forms for women who had undergone caesarean sections detailed the risk and benefits of the procedure and were in line with Department of Health consent to treatment guidelines.
- Staff had a good understanding of mental capacity and described the process of caring for women who may lack capacity. 92% of staff had completed MCA level 1 training.

Are maternity and gynaecology services caring?

Good

We rated caring as good because:

We found patients, and their families were valued as individuals, and we were provided with examples of this. Following a number of complaints receivedin 2014 at Wansbeck, the service had put in place compassion training for all staff.

We had mixed feedback from patients and their families about the care they experienced during different pregnancies.

We observed patient care in the ward environment and antenatal clinics; staff were supportive and were adaptable to the situation presented to them. Women received emotional support and were involved in their care.

Compassionate care

- Following a number of complaints received in 2014 at Wansbeck, the service introduced a programme of compassion training. Staff informed us that originally they felt it was unnecessary, however, following the training all staff said they found it extremely valuable.
- Results from the Maternity Service Survey 2015, showed the service scored better than other hospitals in five of the 19 questions about labour/birth. For antenatal and postnatal care, the service scored the same as other trusts.
- Most women spoke positively about their treatment by clinical staff and the standard of care they had received. They felt well supported and cared for by staff, and their care was delivered in a professional way. Comments included: “Kept informed at all stages of my labour”.
- However, some women informed us that they felt isolated in the ward environment; however, it was beneficial that partners could stay.
- Results of the NHS Friends and Family Test showed that between July and September 2015 an average 98% of women would recommend their birth experience; this was better than the England average at 97%. Staff

proactively promoted patient experience projects, including the NHS Friends and Family Test, which included a feedback card and envelope system to improve the response rate.
- The service also undertook regular real time patient experience surveys,the results of which were posted in each clinical area in the birthing centre and ward 16. All results were positive and staff were proud of this. Data showed the '2 minutes of your time' patient survey resulted on the birthing centre and Wards 16 scoring 9.8 (out of a possible 10) for patients who would be highly likely or likely to recommend the ward (October 2015). Data from this survey was prominently displayed at entrance to both areas.
- We observed positive interactions of staff with women and their partners. Staff were calm and compassionate and knocked and waited at the patient door before being invited in. We observed signs on doors when women were receiving treatment from the physio and breastfeeding support.

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. However, women we spoke with were not aware of which pathway (midwifery led or consultant led care) they were following during delivery.
- We noted the rate of home births was low (below 1%), Records showed staff discussed birth options at booking and during the antenatal period. Supervisors of midwivesand the consultant team, were also involved in agreeing plans of care for women making choices outside of trust guidance, focusing on supporting women's choices of birth while ensuring they were making fully informed decisions.

Emotional support

- Bereavement policies and procedures were in place to support parents in cases of stillbirth or neonatal death; two midwives who were allocated one day a week between them supported this. People's emotional and social needs were highly valued by staff; staff were actively working with key partners to improve care for bereaved families. The bereavement facility was a delivery room with a different name however was not separate from the birthing centre. Prior to the move to NSECH the service had a dedicated bereavement room which had tea and coffee making facilities and non-clinical furnishings. Staff we spoke with informed us that the bereavement service had taken a step back. However, we were informed there had been no negative feedback from service users.
- Standard operating procedures were in place for the sensitive disposal of fetal/placental tissue, following early pregnancy loss.
- Women who had experienced a previous traumatic birth or struggled to adjust following termination of pregnancy or early pregnancy loss were supported by the Health Psychology Service; the outcomes of this service were reported as good. This was a well-established service and patients self-referred or were assessed and referred by staff. Patients were contacted promptly, appropriately assessed and redirected offering early engagement and reassurance to this patient group.

Are maternity and gynaecology services responsive?

Good

We rated the responsive domain as good because:

The service had gone through a significant reconfiguration to a new model of care, which saw the amalgamation of delivery services previously based at Wansbeck and North Tyneside General Hospitals on the one NSECH site. We found robust policies in place to ensure that patients were seen at the right place and at the right time.

The service had begun to engage with service users to inform developments within the service.

There was no pregnancy assessment unit on site; women were triaged on the birthing centre. Staff we spoke with informed us on occasion this had reduced the capacity on the birthing centre for labouring women and the number of staff able to look after them. Service leads told usthis was high on their list of priorities and were working on short and long term plans for the future.

Maternity and gynaecology

The service had a number of specialist midwifery roles to support women, for example, a high risk midwife and diabetes midwife specialist.

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

Service planning and delivery to meet the needs of local people

- The service had undergone a significant restructure following the commencing of the new model of care in June 2015 at NESCH. This meant that all high risk intrapartum care was carried out at the new hospital site.
- We were informed by service leads there were good relationships with local commissioners and this was said to be strengthened during the reconfiguration of the service.
- The service had begun to engage with service users and had held one meeting of the Maternity Service User Forum in September 2015.It was planned that this group would meet quarterly and the next meeting was set for January 2016. Due to this forum being in its infancy at the time of our inspection there were no outcomes as yet.

Access and flow

- Bed occupancy between June and October 2015 was between 43% and 69%, on ward 16 and between 34% and 54% for the birthing centre.
- There was no pregnancy assessment unit (PAU) at NESECH; however, the birthing centre did have 2-3 delivery rooms that were allocated to assessment. Staff we spoke with informed us on occasion this had reduced the capacity on the birthing centre for labouring women and the number of staff able to look after them.
- The CQC survey of women's experiences of maternity services for 2015 received information related to access and flow. With respect to the question 'If you needed attention while you were in hospital after the birth, were you able to get a member of staff to help you within a reasonable time?' the trust scored 8.4, which was ranked among the best performing trusts.
- Senior staff we spoke with advised us the service had not closed to admissions or deliveries. If there were pressures on the service, low risk women were diverted to the midwifery led units. We were told that a labouring woman had been diverted to the Hillcrest Maternity Unit; however, the staff were not aware until she arrived.
- The service used the midwifery red flag criteria as outlined in the NICE staffing paper (February 2015) to monitor delays in women being seen within 30 minutes of arrival. It also monitored delays of the commencement of treatment over an hour. This is reported monthly to the Obstetrics and Gynaecology Operational and Surgical Board. A consultant is on site for at least 12 hours each day or could be available in less than 30 minutes should the need for consultant review occur.

Meeting people's individual needs

- There were arrangements to support individuals with complex needs, with access to clinical specialists and medical expertise, for example, arrangements were put in place to support a woman with complex health and social care needs. There was a network of midwives and consultants with special interests in teenage pregnancy, high risk pregnancy, diabetes and bereavement. The teen pregnancy midwife was based within the Family Nurse Partnership, however, due to commissioning arrangements, this service was only available to young parents in North Tyneside. There was a service provided by the local authority for Northumberland, however, this did not have midwifery support.
- Midwifery staff described their role in supporting individuals who had learning disabilities. The emphasis was around ensuring the individuals concerned understood the provision of maternity care. Next of kin and carers were involved and, where necessary, social services, to ensure the best outcomes for parents and child.
- Staff could explain how the translation service was accessed and used.
- Midwives said they encouraged 'normalisation' about women's experiences, providing a good environment, as relaxed as possible. This included high-risk women who were able to labour in water.
- Women who were in early labour could be sent home depending on their distance travelled to the unit or could mobilise on the ward. Evidence-based guidance showed that women who were reviewed in a designated

area away from the delivery suite experienced shorter labour and less medical interventions (Evidence Based Guidelines for Midwifery-Led Care in Labour Latent Phase, Royal College of Midwives, 2010).
- There was advanced neonatal nurse practitioners and trained midwives examination of the newborn within 72 hours of birth, using the NIPE smart tool. At the time of writing this report we did not have data specific to NSECH; we had requested this from the trust.
- There were processes in place to ensure the process of disposal of pregnancy remains was handled sensitively. Women were provided with a choice of how they would like to dispose of pregnancy remains. This included cremation or being enabled to take them home.

Learning from complaints and concerns

- Complaints and concerns were included on a performance dashboard and monitored monthly at the obstetrics and gynaecology governance group.
- Both formal and informal complaints were treated with the same seriousness by the service. Staff offered to meet the complainant when complaints were received; the PALS team supported this.
- Between June 2015 and September 2015, the service received five complaints. We reviewed a selection of cases and the outcomes of which were appropriate, with duty of candour appropriately applied in all cases. Themes of these complaints included communication, clinical care, and waiting for resources.
- We were provided with examples of learning from complaints from all staff we spoke with. For example, a number of complaints had been received in 2014 at Wansbeck.This was escalated to the chief executive and the management team implemented a programme of compassion training for all staff including the management team and consultant body. The real time patient experience survey and 2015 CQC patient experience reflected the improvements made by staff and the outcomes of the compassion training.

Are maternity and gynaecology services well-led?

Requires improvement

We rated well-led as requires improvement because:

Although the senior management team were aware of the challenges to the service and had a vision for the future, the formal clinical strategy for maternity or gynaecology services which was contained within the surgical business unit annual plan was very generic in terms of outcomes and references to maternity and gynaecological services were minimal. This did not support identification of how the service was to achieve its priorities or support staff in understanding their role in achieving the services priorities. The risk register did not reflect the current concerns of the senior management team.

There were risk and governance processes in place; however, we were concerned with the levels of scrutiny provided by the directorate with regard to the clinical dashboard.

The service had not benchmarked themselves effectively against the recommendations of the Kirkup Report (2015).

The views of the public and stakeholders through participative engagement were actively sought, recognising the value and contributions they brought to the service. There was some evidence of innovative practice.

Vision and strategy for this service

- The senior management, midwives and consultants were all committed to their patients, staff and unit. The vision of the unit was to provide the best outcome for women through promoting normality and high quality care and to become the “provider of choice”.
- Although the senior management team were aware of the challenges to the service and had a vision for the future, the formal clinical strategy for maternity or gynaecology services which was contained within the surgical business unit annual plan was very generic in terms of outcomes and references to maternity and gynaecological services were minimal. This did not support identification of how the service was to achieve its priorities or support staff in understanding their role in achieving the services priorities.
- A business case had been put forward to progress the development of a PAU at NSECH, and we were informed this needed to happen as soon as possible. In the long term there were plans in place to locate the early pregnancy assessment service at NSECH and provide this service seven days a week; however, there was no specific time scale for this.

- Most staff were aware of the trust's vision and were committed to embedding the improvements both in maternity and gynaecology services and as part of the trust as a whole.

Governance, risk management and quality measurement

- The maternity risk management strategy set out guidance for the reporting and monitoring of risk. It detailed the roles and responsibilities of staff at all levels to ensure poor quality care was reported and improved and areas of good practice highlighted. The risk management strategy had not been reviewed to reflect the current service provision as it did not highlight the care provided at NSECH.
- The maternity incident review group was chaired by the consultant on call or by the obstetric delivery suite lead and reviewed clinical incidents. This group collated a summary of incidents which then escalated concerns to the obstetrics and gynaecology governance group (OandGGG) chaired by the head of midwifery (HOM). The aim of the group was to look at any areas for concern in practice and to identify trends and determine what actions should be taken to avoid a similar incident in the future. Joint learning and good practice was cascaded to the staff trustwide using the safety brief and quarterly newsletter and also one to one meetings where required.
- A clinical governance coordinator reviewed and responded to risks on a daily basis. A quarterly report was produced from: incidents, data from the birth register and key performance measures, that were monitored on the maternity services dashboard each month.
- Learning was encouraged through further discussion at local meetings and memorandums and also one-to-one meetings where required.
- The service used the maternity dashboard recommended by the RCOG. The dashboard was a clinical performance and governance scorecard and helped to identify patient safety issues in advance. We found the dashboard contained inaccuracies, for example the number of instrumental, operative and vaginal births did not equate to 100%.This meant we were concerned with the accuracy and monitoring of the dashboard at all levels within the service.
- A maternity risk register contained 27 risks in total. It was updated on a monthly basis at the obstetrics and gynaecology operational management board meeting (OandGOMB). Risks included cost pressure, maternity IT systems, and latex sensitivity. We saw that the top three risks were shared with staff weekly in the safety bulletin. All staff we spoke with were able to inform us of these risks.
- There were systems and processes in place linking the statutory supervision of midwives to the local clinical governance and risk management strategy. Issues of risk and governance were discussed by the SOM team at their supervisors meetings.
- There was no alignment between the risk register and the senior team worry list. Through discussion with the senior team there was concerns about staffing levels at NSECH, as the demand had exceeded expectations. The senior team also stated high on their list of priorities was the relocation of pregnancy assessment services at NSECH. Neither of these concerns were documented on the directorate risk register. We also found that concerns the service has raised about the exit door on ward 16 were absent from the register.
- Governance documents identified the roles of the SoMs and the Local Supervising Authority. SoMs 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 regulations relating to 'duty of candour' and were able to inform us of information which was posted on wards and departments.
- We received two Kirkup (2015) gap analyses from the service.The first was data prior to the publication of the report and the second was data following. However, the service only assessed itself against the recommendation applicable to the wider NHS and not against the recommendations made for the individual service named in the report.

Leadership of service

- The maternity and gynaecology service was part of the Surgical Business Unit.
- The structure that leads the maternity and gynaecology service is as follows: business unit director; deputy executive director; clinical director; general manager; head of midwifery; operational service manager (OSM); clinical Lead Midwife/matron; Acting Clinical lead

midwife/matron and a matron for gynaecology. The day to day management of the unit is provided by the clinical lead midwife/matron who links in with the team leaders, HOM, OSM and general manager.

- Across the service, there was a matron for gynaecology and one for maternity and an interim matron for community; however, due to the geographical spread the service required additional matron posts. We were informed two substantive matron posts had been advertised, one for the midwifery led units and one for community. It was expected that interviews would take place in December 2015.
- Staff said they received good support from managers and were able to escalate and discuss concerns. They felt the HOM was visible and approachable and were aware of members of the senior management team.

Culture within the service

- We observed a strong team of midwives, who worked alongside medical staff. The midwifery staff told us that the trust was a 'good place to work'.
- Medical staff we spoke with told us they sometimes had to push to be involved in a woman's care when her labour was not progressing normally.
- We reviewed evidence from health education north east.This highlighted on going issues around the relationships between midwives and medical staff.The trust received a pink flag for undermining and bullying comments made against trainees.
- We saw commitment to patient care and treatment. Staff said they provided a safe service in maternity and this was confirmed by medical and anaesthetic staff we spoke with.
- Managers operated an 'open door policy' for staff to raise any issues or concerns which staff felt confident would be acted on.
- Staff sickness levels in maternity between June 2015 and August 2015 was 5%.This equated to 2.06% for the birthing centre and 8% for ward 16, however, the overall sickness absence rate for Obstetrics and Gynaecology was 25%, against a trust target of 3.5%. Some of these related to long -term sickness.

Public engagement

- The service was beginning to take account of the views of women and their families through the maternity services user forum, a multidisciplinary forum where comments and experiences from women could be used to improve standards of maternity care. This forum had only met once at the time of inspection, and therefore there were no outcomes from this forum.
- The service also used the real time patient survey to engage with patients and their families.We reviewed results from this survey and they were positive. The maternity service undertook a quarterly maternity patient pathway survey and benchmarked itself against the CQC national standards. The trust told us it obtains a good response rate in excess of 30% return and this covers the entire maternity pathway and it uses the findings to further develop its service and improve patient experience.

Staff engagement

- There were no directorate specific results in the 2014 NHS staff survey results for staff engagement. The national survey showed on a scale of 1-5, with 5 being highly engaged and 1 being poorly engaged, the trust scored 3.93. This score placed the trust in the highest 20% of trusts compared to similar trusts.
- We spoke with staff and in all areas staff were very engaged and felt involved in service development especially during the consultation periods prior to the relocation of maternity services at the Wansbeck General Hospital to NSECH.

Innovation, improvement and sustainability

- The service had the support of a small health psychology team. This team supported women who had experienced a previous traumatic birth or struggled to adjust following termination of pregnancy or early pregnancy loss. The outcomes of the service were reported as good.
- The service implemented a series of workshops to equip staff with the necessary skills to enable them to deliver compassionate care by utilising appropriate communication skills and strategies with patients and families. The health psychology team delivered this, following a review of the 2015 CQC patient experience survey the trust has ranked within the top 10% for patient experience. This meant that the compassion training was improving patients experience of care and interactions with staff.
- The services had introduced routine delayed cord clamping for all deliveries. This had reduced the number

of babies requiring initial resuscitation and subsequent admission to SCBU. The unit purchased mobile Life Start resuscitation equipment to facilitate this practice at the bedside and during caesarean section.

- Further, the trust informed us that there have been the following service improvements:
  - monthly multidisciplinary practice development meetings to review practice innovations. This group is currently reviewing Home Induction of labour, the use of tele-health to support women who have high risk pregnancies at home which will facilitate home monitoring of diabetes in pregnancy and pregnancy induced hypertension. The trust believes this will be of benefit to the ladies living in its rural areas.
  - implementation of the midwifery Red flag events as outlined in the NICE safe Midwifery staffing for maternity settings. The trust says it has adopted the criteria and have devised a recording tool which allows it to monitor the red flags on a shift by shift basis and linked this in with its escalation policy to enhance safe patient care. The information is monitored monthly and discussed at the internal Governance and operational boards and the trust says it has been instrumental in identifying additional staffing resource requirements.
  - weekly NSECH staff meetings to provide ongoing support for staff to address any concerns from working in a new environment and to facilitate effective team working following the integration of the two teams. This group also reviews clinical practice and implements any changes required.
  - bi-monthly student midwife forums to provide support and engagement between senior staff which includes: the head of midwifery, matrons and supervisor of midwives, educationalists and university colleagues. This provides feedback of their experiences within the trust and they can share ideas and new initiatives which may be implemented within the unit. This forum also includes preparation for employment within the trust.
  - a junior medical staff forum which enables engagement between senior medical colleagues and the student cohort.
  - a digitised maternity community record. This electronic record enables women to carry their own hand held notes while the information captured is uploaded into the hospital system effecting safe and timely sharing of care critical clinical information between the hospital and community teams. This has enabled patient records to be visible at all points of contact and as a safety tool this has proved invaluable in ensuring continuity of patient care plans across all disciplines.
  - implementation of the enhanced recovery pathway for women having an elective Caesarean section. Enhanced recovery is a modern, evidence-based approach that helps women recover more quickly after having Caesarean section. This will reduce morbidity and improve patient satisfaction.
  - an in house training programme for midwives in examination of the newborn. This includes hospital and community midwives. The trust have recently implemented the NIPE smart IT programme to standardise and monitor data collection.
  - participation in the NSPCC Coping with Crying pilot to reduce non accidental injuries by informing parents about coping strategies they can adopt, when dealing with a crying child. This has now been rolled out and adopted within the trust's services.
  - implementation of the Baby Clear initiative to reduce smoking in pregnancy as part of the still birth care pathway. The trust says it was one of the first in the region to roll this out.
  - bi-annual away days for staff to update with current midwifery issues and practice changes. These days enable staff to take time out, encourage debate and reflection on current practice issues and influence practice developments.
  - a rolling programme for midwives and Gynaecology nurses to undertake additional training to become sonographers.
  - introduction of Myosure outpatient treatment of endometrial polyps.

Services for children and young people

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

Information about the service

When the Northumbria Specialist Emergency Care Hospital (NSECH) opened in June 2015, the service for children and young people transferred here from other hospitals within the trust.

Services for children and young people were provided at two main locations within NSECH. The Special Care Baby Unit and the Short Stay Paediatric Assessment Unit. The Special Care Baby Unit had relocated from Wansbeck General Hospital to NSECH and staff from Ward 10 at North Tyneside General Hospital and the Children's Unit at Wansbeck had moved across to the Short Stay Paediatric Assessment Unit when it opened in June.

The Special Care Baby Unit (SCBU) provided level one care for infants born less than 30 weeks gestation and weighing less than 1.5 Kg birth weight. The unit offered 24 hour care to babies with significant weight loss, jaundice or feeding problems. It provided phototherapy for babies with jaundice and looked after babies with neonatal abstinence syndrome. It also provided transitional care for Mums and their babies allowing them to remain together with additional support before going home.

The Short Stay Paediatric Assessment Unit (the Children's Unit) provided emergency and short stay (24 hour) care for children aged sixteen and under. This was a consultant led service where children could be assessed, investigated, observed and treated within 24 hours. Day surgery was also provided for children and young people at NSECH and staff from the Children's Unit supported a day surgery service once a week at North Tyneside General Hospital.

During this inspection, we visited both of these units and observed care being delivered. We spoke with 14 children and parents, and 25 staff including doctors, nurses, health care assistants, therapists, nursery nurses, ward managers and administrative assistants. We looked at the records of 21 patients and attended a number of focus groups. Before the inspection, we reviewed performance information from, and about the trust.

For clarity in this report, we have referred to the Short Stay Paediatric Assessment Unit as the Children's Unit.

Services for children and young people

Summary of findings

We rated services for children and young people at NSECH as outstanding because:

Access to Children's Unit and 24 hour care was excellent with patients reporting they were seen by relevant staff and treated quickly. The performance for children being seen and either discharged or admitted within 4 hours in the Children's unit was 99%.

A triage assessment tool was in place to identify clinical acuity and fast track children when necessary. There were robust arrangements for the transfer of babies and children needing a higher level of care. Other organisations and the local community had been involved in the planning and delivery of this service. There was a proactive approach to understanding the needs of children and young people to ensure that care was delivered to meet their needs. The new facilities were excellent, met national standards and the needs of children and young people.

There was a clear vision for this service with strong leadership. The management team were very positive about their services and very proud of their staff. They sought to make continual improvements and were passionate about and strived to deliver high quality patient care. Staff told us that managers were both visible, approachable and open to new ideas. Robust and effective governance arrangements were in place to protect patients from harm. Governance arrangements and the risk register were proactively reviewed. There was a high level of staff engagement and excellent team working. Staff felt proud of the services they delivered to patients and there was a culture of continual improvement. There were inventive ways of engaging the public and service users in order to improve the patient experience. The service supported and encouraged innovation.

Staff provided compassionate care and treated children and parents with kindness and respect. We heard consistent praise from children and parents who told us they felt well informed and involved in decisions about their care. Both the Children's Unit and the Special Care Baby Unit (SCBU) scored highly in patient surveys. In the Special Care Baby Unit, we saw that staff gave special attention to siblings to help them feel included. They also gave parents a call 48 hours after discharge to offer advice and support. Emotional support was good with the availability of specialist bereavement midwives in SCBU and easy access to in-reach mental health services in the Children's Unit.

There were arrangements in place to protect patients from abuse and avoidable harm. There was a positive culture of reporting and learning from incidents. The clinical environment and equipment was clean and staff observed good infection control practices. Medicines, including controlled drugs were stored securely and dispensed safely. Safeguarding systems were robust in protecting children and young people from harm. Staffing levels were safe although further work was being undertaken to ensure staffing levels in the Children's Unit could meet future demand. There were effective measures in place to assess and respond to a child whose condition was deteriorating.

Services for children and young people were effective. Clinical practice was based on local and national standards and was regularly audited to ensure standards continually improved. There was involvement in regional networks to learn and share good practice. Staff were competent to deliver care. Additional training needs were being identified and training planned as the new service continued to develop. Policies and procedures were in place, up to date, and staff knew how to access them.

Services for children and young people

Are services for children and young people safe?

Good

We found services for children and young people to be good for safe because:

The clinical areas we visited were visibly clean and well organised. Staff washed their hands effectively and there were high scores in the weekly hand hygiene audits.

Equipment was clean and well maintained. Age appropriate resuscitation equipment was available and had been checked regularly, although some days this had not been documented on the Children's Unit.

Medicines were stored securely and dispensed safely as were controlled drugs.

There were robust safeguarding systems and training in place. Staff knew what to do and who to contact should they have a concern.

There was a positive culture of reporting and learning from incidents however, we found knowledge amongst some staff of duty of candour was not consistent.

Staffing levels were safe although further work was being undertaken to ensure staffing levels in the Children's Unit could meet future demand.

There was a good standard of record keeping and effective measures were in place to assess and respond to patient risk.

Incidents

- There had been no never events. Never events are incidents determined by the Department of Health (DoH) as serious, wholly preventable patient safety incidents that should not occur if the available preventative measures have been implemented correctly.
- Between July 2014 and July 2015, 188 incidents were reported in the child health business unit. Of these, 166 incidents were classed as no harm, 13 were minor harm, eight were moderate harm and one incident was reported as a death because of a patient safety incident.
- Staff we spoke to knew how to report incidents using an online electronic reporting system. Incident feedback was a standard agenda item for team meetings on both the Special Care Baby Unit (SCBU) and the Children's Unit. We looked at minutes of previous staff meetings and saw discussion and learning from incidents had taken place. Staff also received feedback on a one to one basis if this was required.
- We were told about a serious incident that SCBU had been involved with. The incident had been investigated thoroughly and the internal report had not been able to identify what could have been done better. The report had been sent to another unit for external review. This was an example of good practice with clinicians looking for opportunities to improve care and avoid future incidents with openness and transparency. Staff had informed the family of the investigation and shared findings, demonstrating the service were meeting the duty of candour.
- Staff told us about a weekly meeting, which included the operational service manager, nursing staff and consultants from both the Emergency Department and the Children's Unit. The purpose of this meeting was to improve communication, and discuss and learn from recent incidents. The model of care was still relatively new and the aim of the meeting was to improve quality and safety for patients.

Duty of candour

- The Duty of Candour is a regulatory duty that relates to openness and transparency and requires providers of health and social care services to notify patients (or other relevant persons) of 'certain notifiable safety incidents' and provide reasonable support to that person.
- Knowledge of duty of candour was not consistent across all staff across the service. Some staff understood what the duty of candour was and others did not know but once explained to them said they acted according to it. At trustwide level this process was well managed.

Cleanliness, infection control and hygiene

- The clinical areas in SCBU and the Children's Unit were very clean and well organised.
- The equipment we inspected on both units appeared clean and had a sticker attached with the date it was last cleaned.
- We observed domestic cleaning schedules on the back of the door of the milk room in the Children's Unit.

Domestic staff had completed and signed the schedule indicating they had cleaned the room the day before. Cleaning schedules were also in place for incubators, cots and toys in SCBU. There was a monthly audit of cleaning standards in SCBU. Scores for the previous two months were 97% and 99%. Domestic staff told us they were working hard to achieve 100%.

- Handwashing facilities were available and personal protective equipment and alcohol hand gel was available at the entrance to, and throughout both units we visited. A notice board on SCBU and the Children's Unit displayed results of weekly audits for hand hygiene and cannula care plans at 100%.
- We observed staff washing their hands effectively on both units however, at the day surgery service at North Tyneside we observed a member of staff failing to wash their hands between patient contacts.
- Information supplied by the trust showed that training compliance for infection prevention and control exceeded the trust target of 85% in both units.
- There had been no cases of Methicillin Resistant Staphylococcus Aureus (MRSA) on SCBU.
- Staff we saw observed the uniform code and displayed name badges clearly.
- Posters with 'follow the keep clean code' were displayed on the wall of both units.

Environment and equipment

- All areas within SCBU and the Children's Unit were well organised, uncluttered and clean.
- There was a mixture of old and new equipment in the Children's Unit. Some had been brought across from Ward 10 at Tyneside General Hospital as labels where still attached from the move.
- On two occasions, we saw staff on the Children's Unit leave the assessment room to collect a piece of equipment from another room. There appeared to be a shortage of some basic equipment in the assessment rooms.
- SCBU had put in a bid for breast pumps so that one would be available for Mums to use at each cot side. They had also ordered nine new pulse oximeters, which would be shared between the unit and maternity services.
- The ventilators on SCBU were quite old however staff told us that they were still in good working order. There was a service agreement in place to maintain them and a capital plan to replace them in two years.
- Age appropriate resuscitation equipment was available and there was evidence that this had been checked daily with the exception of four days in October on the Children's Unit. The resuscitaire on SCBU was checked twice a day.

Medicines

- There was no on site dispensary at NSECH. Both SCBU and the Children's Unit held minimum stock levels which had been agreed with the pharmacist. Pharmacy had closely monitored and adjusted the stock following the opening of the new units. Medicines required but not in stock were ordered from the pharmacy at North Tyneside General Hospital.
- Medicines were kept securely in a locked treatment room. Medicines were stored within automated dispensing cabinets, which used fingerprint recognition to gain access.
- The drugs fridge was fitted with an alarm that would sound if the fridge went out of its safe operating range. Staff knew to contact the pharmacist immediately when this happened in order to rectify the fault.
- Controlled drugs would only be released from the locked unit when checked out by two registered nurses. Both nurses then attended the patients bedside to ensure the safe administration of the drugs and both staff documented and signed to confirm this.
- Staff were required to complete yearly online training on the safe administration of medicines. The ward manager on the Children's Unit told us that when drug errors occurred they would be investigated and the members of staff responsible would have to complete competency based training to ensure they were safe.
- We observed a pharmacist validating medicines who told us that pharmacy did not input regularly into SCBU and the Children's' Unit.
- Patient Group Directions (PGDs) were in use on both SCBU and the Children's' Unit. PGDs are written instructions which allow specified healthcare professionals to supply or administer a particular medicine in the absence of a written prescription. We observed that these were signed and up to date and had been authorised correctly.

- We heard that there had been two medication near misses reported on the Children's Unit. This was discussed at the team meeting and staff were asked not to disturb colleagues when calculating medication dosages.
- We reviewed 14 prescription charts and found that all prescriptions had been signed and dated. Antibiotics had been prescribed to comply with guidelines and allergies documented. However, we found that on two occasions the weight of the child was not recorded on the drugs chart.

Records

- We looked at the records of 21 patients and found they were of a good standard. Most of the records we saw were clearly set out, legible, comprehensive, dated and signed. Records included diagnosis and management plans, patient observations and evidence of discussion with families.
- Records on SCBU were in paper form and only current records were kept on site. Old records were stored off site at Wansbeck General Hospital.
- All records were held confidentially and securely.
- SCBU did not have dedicated care plans; there was a limited plan on the top of the record chart.

Safeguarding

- All staff we interviewed demonstrated knowledge of what to do and who to contact should they need to raise a concern. Staff felt well supported in addressing safeguarding issues. They knew the name of the trust safeguarding lead and their named nurse. They could seek advice and support whenever they felt necessary. Everyone we spoke with was very positive about the safeguarding team.
- There was a safeguarding policy folder in all units and standardised safeguarding documents on the trust intranet. Policies and procedures included working with other multidisciplinary teams and external agencies. Staff reported that they had effective working relations with the local children's safeguarding team.
- All clinical staff were reported to be level three trained and received yearly updates. Information supplied by the trust supported this.
- Staff received one-to-one child protection supervision sessions from the safeguarding team at least every six months, in accordance withtrust policy.
- Safeguarding governance reporting arrangements were in place to ensure that safeguarding processes were monitored trust wide.
- The Children's Unit used a quality assessment tool to assess if injury was accidental or non-accidental. The tool recorded condition, witness, incident, location, time, escort, description (CWILTED).
- Both units had a safeguarding link nurse who received regular updates to share with staff on their unit.
- Security arrangements were in place to prevent child abduction on both units. The units were locked. Parents had to press a buzzer and were questioned before the door was opened. There was a visitors' book for visitors to sign in and out. Staff had received abduction training and a simulation of abduction had taken place at North Tyneside General Hospital.
- Staff had access to the Patient Administration Systems (PAS), which alerted staff to identify any child subject to a child protection plan, who was looked after, or where a Multi-Agency Risk Assessment Conference (MARAC) had occured.
- In the Children and Young People's Survey 2014, this trust performed about the same as other trusts in the question relating to feeling safe on the hospital ward (9.11 out of 10). This question was asked of parents and carers of 0 to 7 year olds.
- The trust performed better than other trusts regarding feeling safe in the hospital (9.79 out of 10).This question was asked of 8 to 15 year old children themselves.

Mandatory training

- Staff we spoke to were aware of the importance of completing their mandatory training. They said that training was accessible and they were given study leave to attend. Staff were responsible for ensuring this was up to date and it was reviewed at their annual appraisal.
- Data provided by the trust showed that mandatory and statutory training compliance was 90% for SCBU, which exceeded the trust target of 85%. The ward sister told us that staff could attend three days of training which covered all their mandatory requirements.
- Mandatory and statutory training compliance was 76% for the Children's Unit. We heard the unit manager reminding staff to ensure that their training was up to date.

- All nursing staff on SCBU were trained in Newborn Life Support (NLS). We were told the current nursing rota ensured there was at least one new-born life support (NLS) trained nurse in SCBU at all times.
- Information supplied by the trust showed that 85% of nurses on the Children's Unit had Accredited Paediatric Life Support (APLS) training. The unit was staffed 24 hours a day with an Advanced Paediatric Nurse Practitioner (APNP) or a nurse with APLS as a minimum.

Assessing and responding to patient risk

- The SCBU worked closely with a tertiary centre, The Royal Victoria Infirmary in Newcastle. Babies requiring a higher level of care were transferred following a consultant to consultant referral.
- The nurse consultant told us about the plan to introduce the Newborn Early Warning Trigger Tool (NEWTT) to SCBU in January 2016. The unit used transitional care charts approved through the trust governance process to detect deterioration. Observational charts were used for babies with withdrawal, hypoglycaemia, jaundice and babies born through meconium (faeces) stained amniotic fluid. Abnormal readings were escalated and the consultant had access to a dedicated phone line to a consultant in Newcastle.
- The Children's Unit used the Paediatric Early Warning Score (PEWS) to identify children whose condition was deteriorating and required early intervention. Observation charts were age banded and were identical to those used in Newcastle. Staff told us this was helpful when discussing a child's condition with consultants in Newcastle. PEWS compliance was audited monthly and results showed compliance was 100% every month since the unit opened in June.
- The Children's Unit was not designed as a ligature free environment. However, an environmental risk assessment was undertaken on an annual basis together with individual assessments when there was a child/young person at risk of self harm. Measures to protect the child were put in place such as enhanced observation including one to one care if required.

Nursing staffing

- SCBU was a nurse led unit managed by the ward sister and led clinically by a nurse consultant. Eight Advanced Neonatal Nurse Practitioners (ANNPs) worked between the unit and maternity. The ward sister said that sometimes there were staffing pressures to ensure an ANNP was on shift at all times especially if there was staff sickness.
- Staffing levels on SCBU met the requirements of The British Association of Perinatal Medicine (BAPM) for special care, with a nurse to infant ratio of 1:4. Planned and actual staffing levels were the same on the days we visited.
- At the time of our visit, occupancy levels on SCBU was low however, we saw that there was an escalation procedure in the event of an increase in demand leading to staff working below staffing levels as determined by British Association of Perinatal Medicine (BAPM).
- SCBU had three new nurses who were following a preceptorship programme. There was a planned process for succession planning in SCBU. We were told that there was a good career pathway for staff as SCBU liked to 'grow their own' by offering staff development opportunities to advance from nurse to neonatal nurse practitioner (NNP) to advanced neonatal nurse practitioner (ANNP). The ward sister said they encouraged their own staff to develop into this specialist role, as it was hard to recruit.
- The Children's Unit had a unit manager and was staffed by paediatric nurses and nursing assistants. Three nursey nurses and a play specialist also worked on the Unit. Advanced Paediatric Nurse Practitioners (APNP) worked on the unit and once suitably trained they joined the medical rota.
- We were told that the Paediatric Acuity and Nursing Dependency and Assessment (PANDA) tool was used to calculate safe staffing levels on the Children's' Unit. Prior to moving to the new hospital, managers had looked at the staffing structure in a similar unit in Salford. Royal College of Nursing (RCN) and Royal College of Paediatrics and Child Health (RCPHC) guidance had been taken into account in setting staffing levels and there were always a minimum of two registered nurses on inpatient and day case units at all times.
- A board on the wall of the Children's Unit displayed the planned and actual staffing levels. The planned nurse staffing was five registered nurses and two nursing assistants in the day and three registered nurses at night. On the days we visited, the actual staffing levels were below planned. The ward manager and the senior management team were aware of this and did not think it affected patient care, as the unit was not being fully

utilised. They told us that nursing staffing levels and shift patterns were being constantly reviewed as they monitored the demands of the new service. There was an escalation plan to follow if planned staffing levels were not met.

- Nursing rotas were phased to match patient flow, as more staff were needed on duty in the afternoon and early evening with this being the busiest period for the unit. There was an agreement in place for an ambulance to bypass the unit after 11pm therefore children were not normally brought in after that time.
- The Children's Unit had five newly registered nurses in post. Three were classed as supernumerary while they completed their induction. Three vacant posts were being advertised, two registered nurses and one nursing assistant. This represented a vacancy rate of 10% for nurses and 20% for nursing assistants. The ward manager told us that once these posts were recruited the unit would be fully staffed. The Children's Unit used bank staff but no agency staff to fill empty shifts.
- We observed nurse handovers on SCBU and the Children's Unit. Handovers occurred twice daily at 8am and 8pm. They both used Situation, Background, Assessment, Recommendation (SBAR) and we found them clear and effective. SCBU conducted their hand overs at the cot side.
- From the most recent information provided by the trust, sickness rates on the Children's Unit were 1.97% for registered nurses and 4.35% for nursing assistants. Sickness rates on SCBU were 6.13% for registered nurses and 1.12% for health care assistants.

Medical staffing

- The trust employed 27 doctors in Services for Children and Young People. There were slightly lower proportions of doctors at consultant and junior levels and more in the middle career/ registrar group than the England average.
- There were seven consultants on the Children's Unit. They worked on a 1:7 rota as 'consultant of the week' to provide senior decision-making and leadership on the unit. The consultant of the week was present on the unit seven days a week from 9am until 9pm, and between this period was on call from home. A middle grade doctor or an Advanced Paediatric Nurse Practitioner (APNP) was on duty 24 hours a day, seven days a week. The middle grade doctor provided cover for four nights and an APNP covered the remaining three nights (Friday, Saturday and Sunday). In addition, there were two junior doctors allocated to the unit.
- Staff told us that there were plans to recruit more APNPs to reduce the reliance on middle grade doctors. Senior managers said they had developed the APNP model as they were aware of recruitment issues for junior doctors.
- Medical handovers occurred twice daily at 8.30am and 8.30pm on the Children's Unit. We observed a medical handover, which used Situation, Background, Assessment, Recommendation (SBAR) system to describe each patient to the medical team. The handover used printed sheets which contained patients details was organised and thorough.
- SCBU was a nurse led unit. Paediatric consultants from the Children's Unit provided medical support to SCBU. They visited twice a week on Tuesdays and Fridays at 2pm to carry out ward rounds. Consultants would also attend on request of the nursing staff. We saw a copy of the agreed indications for calling the consultant to SCBU.

Major incident awareness and training

- Trust wide winter management plans were in place. A winter surge exercise had recently been carried out. The child health plan was linked to a regional plan as most inpatient beds for the region were in Newcastle and short stay units would discuss having step down patients during busy periods.
- An emergency preparedness file was available in the Advanced Neonatal Nurse Practitioners (ANNPs) office in SCBU.

Are services for children and young people effective?

Good

We found services for children and young people to be good for effective because:

Services for children and young people

There was evidence of audit at both local and national level and staff could tell us about their involvement. We saw examples where audit activity was used to assess compliance with the National Institute of Clinical Excellence (NICE) quality standards.

SCBU was part of the Northern Neonatal Network and representatives from the service attended meetings every three months to learn and share good practice.

Policies and guidelines were up to date and staff were able to access them on the intranet.

Pain relief was well managed but we did not see evidence of play and distraction being a core part of care.

Children and parents nutrition and hydration needs were met and facilities were available to support and encourage mothers of babies on SCBU to breastfeed.

Staff were competent to deliver care. Staff from the Children's Unit had received additional training in preparation for the move to the new hospital. Additional training needs were being identified and training planned as the new service developed.

Appraisal rates were high and staff had opportunities for further development.

We saw good examples of multi -disciplinary working.

Evidence-based care and treatment

- There was a comprehensive local clinical audit programme for children and young people. Staff we spoke to could tell us about their involvement in audit.
- Children's services participated in a number of national audits such as asthma, epilepsy and diabetes. Participation in the National Paediatric Asthma Audit was discussed at the ward meeting and at a medical handover we attended.
- We saw evidence of local audit activity to assess compliance with NICE quality standards. For example, one member of staff told us about an audit to review the clinical effectiveness of Movicol in the management of severe paediatric constipation.
- SCBU was part of the Northern Neonatal Network and representatives from the service attended meetings every three months to learn and share good practice. The Network formed as a formal group following recommendations from the Department of Health to ensure babies and their families' received the highest quality of care.
- BLISS recognises and rewards neonatal units across the country caring for premature and sick babies, where they deliver consistent high quality family-centred care. SCBU had applied for BLISS accreditation and was waiting to hear the outcome.
- Policies and guidelines were available on the intranet. We looked at the Resuscitation policy, and the Northumbria Neonatal Unit Guideline for Hypotension and Poor Perfusion, both policies were in date.
- There was a clear admission policy with criteria for the transfer of a sick new born to SCBU.

Pain relief

- A young person we spoke to on the Children's Unit told us that there had been no delays in receiving pain relief. The parent of another child informed us that pain relief had been given in a timely manner to her child.
- A play specialist worked on the Children's Unit. The role of the play specialist was to use play activities to help children cope with any pain, anxiety or fear they might experience being in hospital.
- We observed children being treated on the Children's Unit and did not see evidence of play and distraction being a core part of care. There were no toys available in the triage rooms with which to distract children.
- SCBU did not use a pain measurement tool. Babies were given sucrose prior to painful procedures.

Nutrition and hydration

- Meals were prepared by the ward hostess on the Children's Unit. Nursing staff ordered meals when special diets were required, and cooked in the ward kitchen.
- Children and parents we spoke to on the Children's Unit were happy with the food provided.
- There were facilities available to support and encourage mothers of babies on SCBU to breastfeed and a milk room was available for the safe storage of breast milk in the refrigerator and freezer.

Patient outcomes

- Hospital episode statistics data for this trust showed that for the period February 2014 to January 2015, the rate of multiple (two or more) emergency admissions within 12 months among children and young people for asthma in the 1 to 17 year old age range was 9.6% which was lower than the rate for England as a whole (17%).
- The trust achieved positive results in the Epilepsy 12 National Audit for March 2013 to June 2014 and performance in the National Paediatric Diabetes Audit for April 2013 – March 2014 was better than the England average. We saw action plans for both audits to make further improvements.
- SCBU took part in the National Neonatal Audit Programme (NNAP). The NNAP measures care based on data provided annually by all three levels of neonatal units across England and Wales. Results of the last audit published in October 2014 were poor however; this was attributed to a problem with the reporting system. An action plan to improve this was in place.
- The nurse consultant in SCBU told us about his involvement an audit of resuscitation they had been involved in which found that the implementation of delayed cord clamping had reduced the number of term infants receiving resuscitation from 14% to 4%. This was presented at a national conference.

Competent staff

- Information provided by the trust showed that appraisal rate for staff on the SCBU was 85%. The ward sister said that appraisals were taken very seriously and included discussion on the trust's values. The appraisal rate for the Children's Unit was 50%, however staff we spoke to had completed their appraisal or had a date planned.
- Staff received medical devices training every year. The ward sister on SCBU told us this was checked during staff appraisals and was recorded on the electronic staff record. Staff on the Children's Unit told us they had received medical devices training on the safe use of ventilators and monitors.
- SCBU supported student nurses and midwives on clinical placement. The Children's Unit had temporarily suspended student placements until staff felt ready to support students effectively in the new model of care.
- In preparation for moving to the new model of care at the Children's Unit, staff rotated into the Emergency Department at Wansbeck General Hospital.
- A consultant told us he had completed the Neonatal Life Support (NLS) training and spent a week observing at the Royal Victoria Infirmary in preparation for the change in his role.
- Newly qualified nurses were supported to complete a structured preceptorship programme which was delivered in conjunction with Northumbria University. Advanced Nurse Paediatric Practitioners (APNPs) delivered in house training to support this.
- There were seven Advanced Paediatric Nurse Practitioners (APNPs) on the Children's Unit who functioned at a level alongside junior doctors but undertook nursing activities if needed. They were involved in teaching nurses and medical students. We observed a teaching session with a final year medical student during our visit.
- At a staff meeting on the Children's Unit, we heard the ward manager reminding staff to ensure they have completed their revalidation and directed them to where they could find information to assist with this.
- Clinical supervision was discussed during a staff meeting on the Children's Unit. The Unit manager told staff that this would be starting soon and would be led by the supervisee.
- We were told that there had been some anxieties from nursing staff on the Children's Unit around resuscitation and that scenario-based training was planned to be delivered by the APNPs to address this.
- Nursing assistants and nursery nurses on the Children's Unit had plaster room training and were able to apply a plaster backslab. We had some concerns about the role of nursery nurses in recording patient observations. Although this was in their job description, the job role had changed to meet the service redesign but there was no updated job description to reflect this. However, we heard plans to develop competencies for non-qualified assistants discussed at the team meeting. Nursery nurses appeared to carry out the same duties as the nursing assistants on the Children's Unit and some told us that they did not always feel their skills were fully utilised.
- A doctor said he had received excellent training and induction and the consultants were accessible and supportive. Training was available and there was an

educational supervision programme in place. He was able to keep his electronic portfolio up to date and had completed the Advanced Paediatric Life Support (APLS) training.
- Staff could access services through the occupational health service and could be fast tracked to a musculoskeletal service if needed.

Multidisciplinary working

- The Children's Unit was integrated with the emergency department. The paediatric team worked closely with the staff from the emergency department and their nursing and medical rotas allowed for movement across both areas. However, staff said that this did not always happen due to work pressure.
- The Children's Unit also worked closely with critical care. The anaesthetist would attend if a child needed intubating and stabilising prior to transfer to Newcastle.
- Staff on both units gave positive examples of multidisciplinary team (MDT) working. They worked with other allied healthcare professionals such as dietitians, physiotherapists, and had access to tissue viability nurses. This was reflected in the clinical notes we looked at.
- Staff on SCBU made referrals to the breast-feeding team. They also had strong links with the community paediatric team who look after babies following discharge.

Seven-day services

- Both the children's Unit and SCBU provided services 24 hour, seven days a week.
- A consultant psychiatrist was available 24 hours a day, seven days a week and could be requested to see a patient on the Children's Unit if necessary.
- There was a consultant on site 24 hours a day, seven days a week in the Emergency Department, which adjoins the Children's Unit.
- X ray facilities for children were available 24 hours a day seven days a week in the Emergency Department.

Access to information

- There were no medical records available for a patient arriving at the Children's Unit for day surgery. The ward manager located the records and arranged for them to be transferred to the unit immediately. This was reported as an incident and we were told that this has happened before.
- There were issues putting patients onto the patient administration system at weekends on the Children's unit, as there was no administrative support. This led to a backlog of administration work on Monday mornings, which the doctors and advanced paediatric nurse practitioners had to complete. This resulted in a delay in sending out electronic discharge summaries to GPs and was not a good use of the clinician's time.

Consent

- The trust had a consent policy, which contained specific references to children and young people.
- The Gillick test helps clinicians to identify children aged under 16 who have the legal capacity to consent to medical examination and treatment. Staff told us they understood the Gilllick test and Fraser guidelines. They always considered whether young people had the intelligence, competence and understanding to appreciate what was involved in their treatment, to give consent themselves.
- We observed staff asking parents for verbal consent prior to giving their child treatment.

Are services for children and young people caring?

Outstanding ☆

We found services for children and young people to be outstanding for caring because:

Children and parents gave consistent praise for the care staff had given them. We observed staff delivering care in a person centred way, showing compassion to both children and their families. Privacy and dignity were respected.

Both the Children's Unit and the SCBU scored highly in patient surveys. Patient Feedback was consistently positive.

Children and parents told us that their treatment had been well explained and they felt very involved in decisions about their care. In SCBU, we saw that attention was given to make siblings feel included and special.

Emotional support was good with the availability of specialist bereavement midwives. Staff in SCBU gave parents a call 48 hours after discharge to offer advice and support.

Services for children and young people

In-reach mental health services were available to children in the Children's Unit.

Compassionate care

- We spoke to 14 children and parents on both units and there was consistent praise for the care staff had given them. They said staff were kind, caring and kept them well informed.
- We observed staff interacting with patients and parents in both the Children's Unit and SCBU and thought that they demonstrated a high level of care and compassion.
- Staff in SCBU told us that they placed a teardrop sticker on the notes of mothers who has previously experienced the loss of a baby.
- Screens in the form of a moving wall were available in SCBU to provide privacy to mothers while breast feeding their babies at the cot side.
- Results from the 'two minutes of your time' survey in SCBU for October 2015 showed a high level of satisfaction for the question 'were you treated with kindness and compassion' scoring 97%. The Children's Unit achieved a similar result with a score of 96%.
- Parent survey responses for SCBU in October showed that 10 out of 11 parents had given a rating of five out of five stars for the service they had received.
- Results from the National Friends and Family test were displayed on the notice board in SCBU. For the months of July, August and September scores were consistently high ranging from 93% to 99%. The Children's unit scored 97%.
- Average scores for the your voice in patient survey were consistently high for the Children's Unit, scoring 9.78 for July, 9.77 for August and 9.85 out of 10 for September.
- A parent had commented in the child and young people's survey that a doctor had helped the parent out even though he was on a break. The doctor had offered the parent a tub of saline for his contact lenses as he had not brought any spares with him and needed to stay overnight with his child.
- One mother told us about staff from SCBU bringing a photograph of her baby to her while she was in recovery. She was extremely happy with this. We thought this was an excellent example of good practice.

Understanding and involvement of patients and those close to them

- A notice board in SCBU showed scores for their 'two minutes of your time' survey for October 2015. In response to the question 'were you involved as much as you wanted to be in decisions about your treatment and care', 94% of respondents said yes.
- Parents we spoke to on SCBU said they were delighted at the inclusive care of their baby's sibling. One parent said that even though she was not able to stay with her baby, staff had kept her involved with all decisions from home.
- A parent passport was in use in SCBU to increase parental involvement in the care of their baby. The passport included a summary of information regarding their baby and a list of various aspects of care, for example, nappy care, or tube feeding. The passport summarised the parents confidence and competence in carrying out this care. Following discharge, it provided a record for other healthcare professionals to understand the continuing needs of the parents in caring for their baby.
- Children and parents we spoke to told us that their treatment had been explained to them and they understood everything. They felt very involved in decisions about their care.
- A chart on the wall of both units showed pictures of staff uniforms and job titles which was useful for children and parents to understand the roles of staff caring for them.

Emotional support

- Specialist bereavement midwives were available to give support to women and their families following the loss of a baby.
- The ward sister told us how they supported mothers and babies ready to leave SCBU. Once babies were 1.8-1.9Kg and feeding well on breast or bottle, they were moved to the mother and baby room for two nights. Parents had the opportunity to care for their baby prior to discharge in a supported environment. Studies have shown this reduces certain issues relating to anxiety.
- A system was in place on SCBU to support parents 48 hours after discharge. Staff would give parents a call to offer advice and support.
- The Intensive Care and Treatment Service (ICTS) was available for children who self-harm and provided an in-reach mental health service to the Children's Unit.

Services for children and young people

Are services for children and young people responsive?

Outstanding ☆

We found services for children and young people to be outstanding for responsive because:

Other organisations and the local community had been involved in the planning and delivery of this service. A children's service user group met regularly to suggest and develop ideas to improve local services. A group of young people were involved in research to facilitate effectively the successful transition of young people with complex health needs from childhood to adulthood services.

Access to Children's Unit and 24 hour care was excellent with patients reporting they were seen by relevant staff and treated quickly. The performance for children being seen and either discharged or admitted within 4 hours in the Children's Unit was 99%.

A triage assessment tool was in place to identify clinical acuity and fast track children when necessary. There were robust arrangements for the transfer of babies and children needing a higher level of care.

There was a proactive approach to understanding the needs of children and young people to ensure that care was delivered to meet their needs. The new facilities were excellent, met national standards and the needs of children and young people. There was a dedicated room for adolescents in the Children's Unit and interpretation services could be easily accessed. The trust had a policy for the transition of young people to adult services and a champion in each business unit to roll out the policy. Staff from SCBU visited parents in the birthing centre when a pre-term delivery was expected. There was a welcome pack for baby's parents on arrival to SCBU.

Information was available to patients on how to complain and staff tried to address complaints at ward level where possible. The Children's Unit had received no formal complaints since opening. If formal complaints were made, these would be discussed with staff and learning would be shared.

Service planning and delivery to meet the needs of local people

- Managers told us that had planning for the new model of care at NSECH had taken approximately 8 years and there had been close working and involvement with stakeholders and commissioners with this. There were good relationships between local commissioners and the trust and this had been strengthened during the service remodelling process.
- The Children's Unit hosted meetings every Tuesday for the Child Health Action Team (CHAT). CHAT was a children's service user group who met regularly to suggest and develop ideas to improve local services. We were told that members of CHAT had recently been involved in staff interviews and had developed a child friendly hospitals information book, which included blood investigations.

Access and flow

- A parent and child we spoke to told us the minor injuries unit had sent them to the Children's Unit. They had come straight through to the children's assessment area, triaged quickly and were seen by a doctor within an hour. They were happy with their experience. Other patients said they had not waited long to be seen.
- There were arrangements in place for the transfer of critically ill children to specialist centres by a stand-alone children's transport service called nectar. Staff told us that these arrangements worked well.
- The performance for children being seen and either discharged or admitted within 4 hours in the Children's unit was 99%.
- The normal length of stay on the Children's Unit was 24 hours and under. They said that on a few occasions a child had stayed on the unit longer because consultants were confident that with a slightly longer stay the child would be fit for discharge home. They thought this was better for the child and the parents rather than the disruption of transferring the child to another hospital for them to be discharged only a few hours later.
- Staff told us that occasionally there were delays in discharging children from the Children's Unit if medication was not available and needed ordering from the pharmacy at North Tyneside General Hospital.
- We observed patients being triaged in the Children's Unit and saw that a triage assessment tool was in place to identify clinical acuity and fast track children when

necessary. There appeared to be no one co-ordinating triage that had a total overview of the process. There was direct access to senior decision-making and support, which was good practice.

- We were told that occupancy rates for both units were low. Information provided by the trust confirmed this with the average occupancy rate since the Hospital opened being 21.5% for the Children's Unit and 34.9% for SCBU. This meant there were no issues accessing beds for babies or children when needed.
- The nurse consultant informed us that babies admitted onto SCBU who need a higher level of care were stabilised and could be cared for up to six hours prior to transfer to a tertiary centre. There was a separate transport service for neonates provided from Middlesbrough or Newcastle.
- The newborn hearing screening service was based on SCBU. We were told that all infants should be screened within four weeks and the trust had achieved an average of 99% babies screened within this period.
- For the period February 2014 to January 2015 the median length of stay was nil days for elective and non-elective patients in both age categories, under 1 year olds and 1-17 year olds, compared to the England average of one day for non-electives and nil days for electives.

Meeting people's individual needs

- The Children's Unit was co-located with the Emergency Department. There were 22 beds on the unit, 14 single rooms and two bays of four beds which were used for assessment. The unit had a triage room, three treatment rooms, one procedure room and access to the plaster room. There were also children's x ray facilities and a paediatric resuscitation room. There was a large waiting area specifically for children which had a range of toys and books available to entertain children while they waited to be seen. Staff told us that the wall of the waiting room would soon be decorated with a colourful mural to make it more welcoming to children. A play room was brightly decorated and well stocked with games and toys to suit a wide age range of children. There were plans to develop an outside play space.
- SCBU was a purpose built unit designed to meet the needs of the neonate and family. The unit consisted of 14 cots, two bays with four cots in and six cots in single rooms. The unit was located next to the maternity ward which facilitated ease of transition for Mums and babies between the two and movement of staff.
- We measured the space between the cots and found that it was over three metres. This complied with the British Perinatal Association guidelines. This enabled staff to navigate around each cot space with ease.
- The unit had two mother and baby rooms. One room had a reclining chair for partners to stop over if they wished. Parents were provided with meals and lockers were available for them to store their valuables.
- The trust had a dedicated learning disability lead. Staff told us that the lead visited wards to update staff on issues relating to learning disabilities. We were told that funding had been agreed for a trust wide learning disability nurse.
- The trust had a policy for the transition of young people to adult services and a champion in each business unit to roll out the policy. A group of young people called the United Progression (UP) group were involved in research to facilitate effectively the successful transition of young people with complex health needs from childhood to adulthood services.
- One room in the Children's Unit was dedicated for adolescents. It had an en-suite shower room, a settee and television however there were no age appropriate games available.
- A parents' room was available in the Children's Unit. The room contained a settee, chairs and drink making facilities. There was an en-suite bathroom with shower facilities. A notice board displayed transport information such as bus and metro timetables.
- Staff on the Children's Unit wore an additional name badge which was designed to be child friendly. The badges had pictures on which had been drawn by children.
- When young people presented at the Children's Unit under the influence of drugs or alcohol a notification was automatically generated to the Never Too Late (NTL) substance misuse team.
- We saw a variety of information leaflets were available in a display cabinet for patients/parents in the Children's Unit.
- Translation services were available face to face and using the pearl phone system. There was access to British Sign Language (BLS) interpreters and written information could be requested in larger print or braille.

- The SCBU planned pre- birth visits to parents in the birthing centre when a pre-term delivery was expected. Parents were given information about the unit and had the opportunity to ask questions.
- There was a welcome pack for baby's parents on arrival to SCBU.

Learning from complaints and concerns

- We saw posters on the walls of both units giving advice on how to contact the Patient Advice and Liaison Services (PALS) or the on-call manager if patients or parents wanted to complain. A leaflet was also available containing further details about how to contact PALS.
- The Children's Unit had received no formal complaints since opening. The ward manager said they would discuss complaints and compliments at the team meeting. Staff told us that they tried to resolve verbal complaints at ward level as quickly as possible.
- Complaints and compliments were discussed at the monthly team meeting on SCBU. Staff told us that learning from complaints was shared with them at their team meeting.

Are services for children and young people well-led?

Outstanding ☆

We found services for children and young people to be outstanding for well-led because:

There was a clear vision for this service with strong leadership. The management team were very positive about their services and very proud of their staff. They sought to make continual improvements and were passionate about and strived to deliver high quality patient care. Staff told us that managers were both visible, approachable and open to new ideas.

Robust and effective governance arrangements were in place to protect patients from harm. Governance arrangements and the risk register were proactively reviewed.

There was a high level of staff engagement and excellent team working. Regular weekly staff meetings were held to discuss governance, risk and service development. All grades of staff participated in these discussions. All staff had been included in every stage of planning for the new Children's Unit.

Staff felt proud of the services they delivered to patients and there was a culture of continual improvement.

There were inventive ways of engaging the public and service users in order to improve the patient experience.

The service supported and encouraged innovation.

Vision and strategy for this service

- The Child Health business unit had a clear vision for their services which linked in with the overall trust strategy to provide excellent, person centred patient care. They were in the process of reviewing the new model of care at NSECH and continuing to make improvements.
- Staff we spoke with had a clear understanding of the trust vision and values. Staff said during their appraisal the objectives they set were linked to the trust values and the overall objectives of their team.

Governance, risk management and quality measurement

- Staff on both units told us about the '15 steps challenge'. Teams of senior matrons organised unannounced visits across the trust and viewed areas from a patient perspective within '15 steps' of walking onto a ward. The trust board and frontline teams were given feedback on their first impressions. SCBU had recently had a 15 steps visit and were awaiting feedback.
- The unit manager of the Children's Unit attended weekly meetings with the operational service manager to discuss incidents and risks.
- The ward sister on SCBU and the unit manager of the Children's Unit attended monthly governance meetings. Minutes of the meetings were shared with staff.
- The governance committee discussed risks and decided what to escalate up to the directorate risk register. Governance arrangements and the risk register were proactively reviewed.
- Risk management was a standing item on the agenda for the SCBU monthly team meeting.
- The senior management team for the child health business unit were clear on what their highest risks were

and we saw this was reflected in the risk register. They had taken clear actions to reduce the level of risk and documented clearly plans to reduce or remove further risks.

Leadership of service

- The management team were very positive about their services and very proud of their staff. They sought to make continual improvements and were passionate about and strived to deliver high quality patient care.
- Staff told us that they often saw senior managers on the Children's Unit. They were able to speak to their general manager and operational manager regularly and found them very approachable. Managers would call in to let staff know they were the on-call duty manager.
- The ward sister on SCBU told us she was proud to manage her team and felt supported by her line managers.
- Several staff told us that the trust was open to ideas and always willing to listen and support them.
- Staff said that research and innovation was encouraged and supported by the senior management team.
- At the time of the inspection, there was no matron for the children health business unit however staff told us the post had been appointed to and the new matron would be starting at the end of November.

Culture within the service

- The nurse consultant for SCBU had worked for the organisation for approximately 18 years and said there was a stable workforce on the unit.
- Staff turnover rates were low on SCBU at 4% for registered nurses and 9% for registered nurses on the Children's Unit.
- We found a positive culture of staff development. Staff told us they had opportunities to develop in their roles and managers told us they are keen to grow the skills and knowledge of their staff.
- We saw good examples of strong team working and good relationships between staff at all levels.
- Staff told us that they felt valued and said they would not want to work anywhere else. They were proud of their team and their trust.

Public engagement

- We found a high level of engagement with service users and their families. There was a trust wide patient experience programme which used several methods to capture patient views.
- The trust collected patient feedback using the Your Voice inpatient survey. Patients were asked to give scores out of 10 for areas such as involvement in care, cleanliness and pain control. Feedback was displayed and used to improve services for patients.
- The trust had an exit survey in place called two minutes of your time. Patients were asked six key questions about the care they had received during their stay. We saw the results, which were extremely positive, displayed on notice boards in the areas we visited.
- A real time survey was carried out with the patient being interviewed face to face. Results from this survey were fed back to clinical teams within 24 hours.
- In SCBU, for the months of July, August and September the National Friends and Family test scores were consistently high ranging from 93% to 99%. The Children's unit scored 97%.

Staff engagement

- The ward sister for SCBU as well as other staff told us that they had been involved in the planning of the new unit and consulted at each stage of the design process. This had resulted in a smooth transition when the service moved over to the new hospital.
- A consultant told us that staff had been included in every stage of planning for the new Children's Unit.
- Another consultant told us that his role had changed since moving to the new unit. Despite receiving additional training prior to the move, he was finding some aspects of this change difficult.
- SCBU held staff meetings monthly. There was a set agenda to ensure important items such as risk management were covered. There was a section for any other business and staff could add items for discussion prior to the meeting. Staff also communicated with each other using short messages in the diary, notices on the notice board and by email.
- There were staff meetings every other Thursday on the Children's Unit to discuss service development. Consultants, medical registrars, the unit manager and advance paediatric nurse practitioners attended. Staff said that they worked well together as a team.

Services for children and young people

- We observed a nursing staff meeting on the Children's Unit and staff appeared very engaged. They showed interest and contributed to ideas and suggestions on how to improve services.
- Staff informed us that a monthly child health bulletin was circulated electronically to all staff working in the child health directorate. Staff also received an electronic copy of the trust team brief.
- Staff we spoke to said that they would recommend the services at this hospital to their own friends and family, as they believed they were good quality and safe.
- Most staff on the Children's Unit told us that they loved working in the new hospital providing care for patients under the new model. However, some said they were finding the transition difficult and thought about leaving.

Innovation, improvement and sustainability

- The new model of care in the Children's Unit was in its early stages. There was clear evidence that staff were engaged with the change and constantly reviewing and learning from issues as they arose in order to improve the patient experience.
- A nursery nurse was working with one of the community paediatricians to deliver care for children with constipation in their own homes. Advice and support were offered to families in a relaxed setting to promote a behavioural change. We were told that although this had worked well her current workload did not allow her to develop this service further. She hoped that once they had settled into the new hospital she would be able to continue this work.
- The trust was supporting a Consultant Clinical Psychologist in a longitudinal study to address the question of how health services could contribute most effectively to facilitating successful transition of young people with complex health needs from childhood to adulthood. The study involved young people from the conception of the research idea and throughout the course of the programme. Information from the study was fed into the National Institute for Care Excellence (NICE) as part of a consultation for draft guidelines on Transition from children's to adults' services.

End of life care

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

Information about the service

Northumbria Healthcare NHS Foundation Trust provided an integrated trust wide end of life care service. The service consists of three integrated acute hospital specialist palliative care liaison teams based at Northumbria Specialist Emergency Care Hospital (NSECH), North Tyneside General Hospital (NTGH) and Wansbeck General Hospital (WGH). The hospital liaison teams consisted of a band seven specialist palliative care nurse and two palliative care nurses (Band 5 and Band 6). Their role was to provide specialist support to each hospital site and to provide a rapid discharge service for patients wishing to be discharged to die in their preferred place of care. The rapid discharge service involved a member of the liaison team accompanying the patient home and handing over their care to colleagues in the community services. Also as part of the integrated end of life care service were two specialist palliative care community teams and two specialist palliative care units based at NTGH and WGH. Between January and December 2014 the trust had a total of 2,364 in-hospital deaths.

Northumbria Specialist Emergency Care Hospital (NSECH) is a purpose built hospital that opened on 16 June 2015, providing specialist emergency care and acute hospital admissions for patients across Northumberland and North Tyneside. 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 hospital liaison palliative care team. Where appropriate patients who required ongoing hospital admission were transferred from NSECH to specialist palliative care units or general hospital beds at either North Tyneside or Wansbeck hospitals. Specialist palliative care was provided as part of an integrated service across the hospital and community teams and the palliative care service sat within the trust's community and social care business unit. The hospital liaison palliative care team at NSECH consisted of three nurses, one band 7 specialist palliative care (SPC), a clinical nurse specialist (CNS) and one band 6 palliative care nurse. There was a band 5 vacant palliative care nursing post that the trust was recruiting to and an additional band 7 CNS post had been identified as necessary following a review of palliative care activity within the hospital since opening.

We saw that referrals to the integrated trust wide palliative care service totalled 2142 between April 2014 and March 2015 and that 70% of patients referred had a cancer diagnosis and 30% had non-malignant disease. Since opening in June 2015, 725 patients at NSECH had been seen by the hospital liaison palliative care team, of these 67% had a cancer diagnosis and 33% had non-malignant disease.

During our inspection we spoke with members of the hospital liaison palliative care team, the wider integrated palliative care team, mortuary staff, chaplaincy staff and ministers, medical staff, ward managers, nursing staff, health care assistants, allied healthcare professionals and student nurses. In total we spoke with 21 staff. We visited a number of wards and clinical areas across the hospital including surgery, respiratory, acute medicine, elderly care, stroke care, cardiology, critical care, the mortuary and the assessment unit and ambulatory care. We reviewed the records of seven patients at the end of life and reviewed 12

End of life care

Do Not Attempt Cardio Pulmonary Resuscitation (DNACPR) orders. We spoke with one patient and one relative and we reviewed audits, surveys and feedback reports specific to end of life care.

Summary of findings

Overall we rated end of life care at NSECH as outstanding because:

We found that the hospital was providing high quality end of life care services using innovative approaches and effective partnership working. There had been significant investment in palliative and end of life care services and the trust was responsive to addressing issues as they arose with flexibility in relation to staffing and resources. There was a clear vision, strategy and leadership at all levels of the organisation with a focus on good quality end of life care. Patients were cared for using a truly holistic approach and staff teams were committed to working collaboratively to meet individual needs. The structure of the hospital liaison service that had been developed in partnership with Marie Curie provided additional flexibility to enable specialist palliative care staff to provide support to patients at the end of life irrespective of the complexities of their condition. This was sometimes in the form of supporting a rapid discharge to the patients preferred place of care in the community and as such involved a very hands on approach to ensuring as straightforward a transition as possible with hospital staff accompanying the patient in order to handover to community staff.

We saw evidence of the use of national guidance and appropriate anticipatory prescribing of medicines at the end of life. Multidisciplinary working was apparent between different disciplines and across services within the hospital and the community. The hospital liaison palliative care team worked well alongside the acute teams at NSECH to provide palliative and end of life care specialist support at the earliest appropriate opportunity. There was an emphasis on working to increase the confidence and competence of ward based staff to ensure all patients had access to good quality end of life care. Patients and their families were involved in care and we saw a number of initiatives in use to record patient wishes including advance care plans, emergency healthcare plans and treatment escalation plans.

There was consistent evidence that staff were motivated to go the extra mile. Spiritual care was seen to be important with initiatives having been developed in

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supporting staff in the assessment of spiritual needs through training and the use of an internally designed assessment tool. Chaplaincy support saw multi-denominational ministers and faith leaders available for patients, relatives and staff.

The leadership, governance and culture were used to drive and improve the delivery of high quality person-centred care through collaboration and partnership working. The trust had clear leadership for end of life care services that was supported at the top of the organisation. There was a clear proactive approach to seeking out and embedding new and more sustainable models of care. Staff we spoke with consistently told us they felt that end of life care was a priority for the trust.

Are end of life care services safe?

Good

We rated safe in end of life care as good because:

Staff understood their responsibilities to raise concerns and to record safety incidents. We saw evidence of shared learning from incidents, sharing of information and appropriate anticipatory prescribing of medicines used at the end of life. There was good identification of patients at risk of deterioration and we saw evidence of the use of emergency health care plans in ensuring that all patients have a plan in place should their condition deteriorate.

Equipment was generally available for the care of patients at the end of life; however there had been some issues with maintaining stocks of syringe drivers on site. The Management of the service were addressing this as an issue with tracking and monitoring equipment rather than there being a shortage.Staff told us they had always been able to access syringe drivers from other sites when needed. Mandatory training was in place and adapted to specific roles, however, there were inconsistencies in terms of mandatory training completion among hospital liaison staff based at NSECH. There were plans in place to ensure that this training was completed before April 2016.

Incidents

- There had been no end of life care related never events reported in the last 12 months (a never event is a serious incident that is wholly preventable, as guidance or safety recommendations that provide strong systemic protective barriers are available at a national level and should have been implemented by all healthcare providers).
- Staff delivering end of life and specialist palliative care understood their responsibilities with regard to reporting incidents. Staff we spoke with told us that when an incident occurred it would be recorded on an electronic system for reporting incidents.
- Staff told us that if an incident was related to a patient at the end of life then the palliative care team would be involved in the investigation and subsequent learning as a result.

End of life care

- We viewed minutes of hospital liaison team meetings and saw that relevant incidents were discussed at these meetings.
- We viewed documentation relating to a medication incident and saw that the incident had been reported appropriately and that consideration had been given to environmental circumstances that influenced the error. Staff involved told us they had felt supported in reviewing the error and learning from it. We saw that the patient and family had been informed of the incident.
- Staff we spoke with had an awareness of their responsibilities in relation to duty of candour.

Environment and Equipment

- There was a 52 unit body store at NSECH. We viewed mortuary protocols and spoke with mortuary and portering staff about the transfer of the deceased. Staff told us that the equipment available for the transfer of the deceased was adequate and we saw that this included bariatric equipment.
- The body store fridges were temperature monitored and alarmed. We saw that if the alarm was triggered this would alert reception staff who would contact the mortuary staff.
- We observed the use of McKinley syringe drivers on the wards and saw that regular administration safety checks were being recorded.
- Palliative care staff told us they had experienced a problem with obtaining syringe drivers on site and we observed an incident where staff needed to access a driver from Wansbeck hospital when a patient had been identified as requiring one. Management of the palliative care service told us they were confident this was due to a tracking issue rather than a lack of supply and had implemented measures to track syringe drivers more closely and ensure they were returned to the hospital they originated from. Ward staff told us that syringe drivers were available when they needed them and were not aware of any situations where patients had to wait.
- Palliative care staff told us they did not have a dedicated work office at NSECH as it had not originally been anticipated they would be based there as much as they were. The impact of this was that they had limited storage space for specific end of life care tools such as stocks of the CDP (Care of the dying patient) document and comfort care packs for relatives. Palliative care service management told us an office space had been identified and they were working with staff to ensure this was fit for purpose.

Medicines

- Medicines were prescribed using guidance from the Northern England Strategic Clinical Networks. The guidance was available on the intranet and as part of the trusts Care of the Dying Patient (CDP) document. The guidance included different scenarios for a range of symptoms that could be experienced at the end of life.
- Medicines for use at the end of life, including those for use in a syringe driver, were readily available on the wards.
- There was no on site dispensary at NSECH and staff told us that while this did not impact patients directly it had resulted in them having to find alternative ways of obtaining anticipatory medicines for patients being discharged to their preferred place of death using the fast track route. Staff told us there had been no incidents of patients discharge being delayed although it had sometimes resulted in family members getting involved in obtaining medicines through community pharmacies.
- We saw that anticipatory end of life care medication was appropriately prescribed. Medical staff we spoke with said they felt confident in this practice and had attended training relating to anticipatory prescribing.

Records

- We saw that an inpatient admission record was used to record patient details, medical and nursing assessments and risk assessments, and care plans.
- Patients identified as being ill enough to die were cared for using the CDP guidance that had been developed by the Northern England Strategic Clinical Networks.
- We viewed the records of seven patients who were considered to be ill enough to die. In all cases we saw that assessment and care records were completed appropriately and accurately.
- We reviewed 12 Do Not Attempt Cardiopulmonary Resuscitation (DNACPR) forms. In all cases we saw that there was a clearly documented reason for the decision recorded with clinical information included. All decisions were dated and approved by a consultant. Discussions about DNACPR with patients and relatives were mostly recorded in sufficient detail within the

patients notes; however we saw one example of a decision not being discussed with the patient where the reason for this was not clearly recorded on the form or in theirnotes.
- Palliative care staff had access to the same electronic patient record system as community palliative and nursing staff although this was a new development that was not yet fully embedded. We saw that the system was being implemented in a phased way and included plans for specialist palliative care staff to have access to GP palliative care registers.

Safeguarding

- The trust had appropriate safeguarding systems in place with policies and procedures in place in relation to safeguarding adults and children.
- We viewed mandatory training records and saw that members of the palliative care team had attended training in Safeguarding children at level 1 or 2 and safeguarding adults. However, not all of the members of the team based at NSECH were up to date with this training.
- Staff we spoke with demonstrated a good understanding of their responsibilities in reporting safeguarding concerns. They were able to explain what constituted a safeguarding concern and the steps they were required to take.

Mandatory training

- We viewed training records and saw that members of the palliative care team had attended training in a number of mandatory areas. Examples included fire safety, safeguarding, mental capacity act, infection control, moving and handling and basic life support.
- We viewed mandatory training and saw that attendance amongst the hospital liaison team based at NSECH was 100% for basic life support, information governance and medical devices. However, we saw gaps in attendance for other training such as health and safety and infection control training. There were plans in place to ensure that this training was completed before April 2016.

Assessing and responding to patient risk

- We observed the use of general risk assessments on the wards, including those relating to the risk of falls, malnutrition and dehydration, the use of bed rails and the risk of pressure damage.
- The patients whose records we reviewed all had treatment escalation plans (TEPs) in place. A TEP provides the opportunity for patients, doctors and nurses to outline an overall plan of care. It gives guidelines on what treatments patients may receive should their condition get worse and enables quick escalation of care for those patients who need it, while avoiding unnecessary treatments for those who do not.
- The trust had in place the Northern England Strategic Clinical Networks guidance on caring for the dying patient. The guidance was in place for the care of patients whose condition had deteriorated and the clinical team believed that the patient was ill enough that they may die within hours or days. The guidance included the requirement for the senior clinician in charge of the patients care to review the patient and to make a plan for symptom management. Additional guidance included the need for a daily medical assessment and two hourly nursing assessments.

Nursing staffing

- The trust had worked in partnership with Marie Curie to develop an integrated model of palliative care nursing that included the use of hospital liaison teams. The liaison team at NSECH operated an establishment of 3WTE (whole time equivalent) palliative care nurses. Of these, one was a band 7 specialist palliative care nurse and the other two were palliative care nursing posts at band 6 and band 5. At the time of our inspection the band 5 post was vacant and in the process of being recruited to.
- In addition to the existing establishment a second band 7 specialist palliative care nursing post had been agreed and was in the process of being recruited to. The decision to fund this additional post had been in response to higher than expected numbers of referrals to the hospital liaison palliative care team since NSECH opened in June 2015.
- Specialist palliative care nurses were available from 9am – 5pm Monday to Friday. There was no on call specialist palliative nursing cover out of hours although staff had access to an out of hours advice line using a local hospice.
- Nursing staff on the wards told us they felt they had sufficient staffing to prioritise good quality end of life care when needed and that they had processes in place to escalate staffing concerns should they arise.

End of life care

- The specialist staff told us they had plans to develop end of life care champion roles for ward staff with a special interest in end of life care.

Medical staffing

- There were five palliative care consultants employed across the trust at the time of our inspection.
- There was seven day on call palliative care consultant cover.
- We saw that ward based doctors were supported to deliver end of life care by the specialist palliative care team and we observed the specialist palliative care nurses discussing prescribing guidelines with doctors on the wards.
- Medical staff we spoke with told us the specialist palliative care team were available for specialist advice as needed.

Major incident awareness and training

- We saw that business continuity plans relating to the body store/mortuary included arrangements for times of increased mortality rates, for example in the winter months, where capacity within the mortuary was increased to meet demand. The plans included the use of the mortuary and body stores across the trust.
- Major incident planning included the use of the chaplain in a support role and we saw that the on-call chaplain was included when a major incident occurs.

Are end of life care services effective?

Outstanding ☆

We rated effective in end of life care as outstanding because:

End of life care services were well resourced and we observed a truly holistic approach to the assessment, planning and delivery of care and treatment to patients. The palliative care model adopted at NSECH was one of early intervention where the specialist palliative care nurse would work alongside acute teams in areas such as accident and emergency and critical care to support the management of symptoms.

The continuing development of staff skills, competence and knowledge was recognised as being integral to ensuring high quality care and the trust had worked to develop a range of comprehensive training courses for staff at all levels.

Systems to manage and share information to deliver effective patient care were in place with a new electronic record system used by the SPCT across all hospital sites that was aligned with the system used by community teams and GPs.

Staff were proactively supported to acquire new skills and share best practice. The model of end of life care services working alongside acute services at NSECH and out into the community was an innovative and pioneering approach to care. Staff, teams and services were committed to working collaboratively and have found innovative and efficient ways to deliver more joined up care to people who use the service.

Evidence-based care and treatment

- The trust used the Northern England Strategic Clinical Networks guidance on caring for the dying patient and care planning document (CDP). The guidance included identifying patients at the end of life, holistic assessment, advance care planning, coordinated care, involvement of the patient and those close to them and the management of pain and other symptoms.
- The CDP document had been implemented to replace the Liverpool Care Pathway that had been discontinued in 2014.
- We saw that the CDP documentation had included national guidance from sources such as the Leadership Alliance for the Care of Dying People, the Department of Health End of Life care Strategy, and the National Institute of Clinical Excellence (NICE).
- The palliative care service had a local audit activity plan in place that included an audit of the appropriate use of emergency health care plans. They had also carried out audits of the care of the dying patient document throughout its implementation.

Pain relief

- Patients who were considered to be in the last days/ weeks of life were appropriately prescribed anticipatory medicines for the symptoms sometimes experienced at the end of life, including pain.

End of life care

- Staff told us there were adequate stocks of appropriate medicines for end of life care and that these were available as needed both during the day and out of hours.
- We found that patients received good pain relief. Patients and relatives told us that their pain was under control and we saw that pain relief was administered in a timely manner. We did not observe any patients in pain during our inspection.
- We viewed pain scales being used appropriately on the wards to assess patients pain and to evaluate the effectiveness of medication administered.
- Patients and relatives we spoke with told us that the nursing staff supported them well in managing their pain.

Nutrition and hydration

- The 'MUST' Nutritional Screening and Assessment Tool was used. Staff were aware that nutrition and hydration plans at the end of life were focused on quality of life issues.
- The CDP document included an assessment of a patients nutrition and hydration status and guidance that it is the patients choice to eat and drink, even if they have swallowing difficulties.
- We observed staff on the wards offering patients food and drinks and encouraging relatives to be involved in that part of a patients care as appropriate, including the administration of mouth care when a patient was no longer able to eat and drink.
- Palliative care staff worked closely with ward staff in the assessment of patient needs in relation to nutrition, hydration and mouth care.
- Staff we spoke with told us they were led by the patients wishes at the end of life with regard to nutrition and hydration. Staff gave us examples of where catering staff had worked with them to provide patients with food that they wanted and prepared food in a way that they could tolerate.

Patient outcomes

- The palliative care team had produced an action plan following participation in the 2013/14 National Care of the Dying Audit (NCDAH) where they had not achieved 4 out of 7 organisational key performance indicators. These areas covered: education, training and audit; Trust Board representation; protocols covering privacy, dignity and respect; and formal feedback processes regarding bereaved relatives views of care. We also saw that the trust had performed below the national average in clinical areas such as multidisciplinary recognition that the patient is dying and medicines prescribing for the five key symptoms during the dying phase.
- We saw that action had been taken to improve the areas identified. For example, there was now trust board representation, comprehensive training programmes, a CDP document that included aspects of privacy, dignity and respect, and that formal feedback processes had been developed regarding bereaved relatives views of care.
- While the NCDAH had been carried out prior to NSECH opening we saw that the learning from the audit across the trust had been incorporated into all end of life care activity, including activity at NSECH.
- The service ensured that there was timely identification of patients requiring end of life care on admission. Systems were in place where a patient admitted who was known to the palliative care team would generate an alert to the team. There was also an alert generated where a patient was started on the CDP document.
- The palliative care model adopted at NSECH was one of early intervention where the specialist palliative care nurse would work alongside acute teams in areas such as accident and emergency and critical care to support the management of symptoms. In particular we saw evidence of work in relation to specialist palliative care input for patients with non-malignant progressive disease such as heart failure or chronic obstructive pulmonary disease. This was reflected in an increase in the percentage of patients with a non-cancer diagnosis who were supported by the team. For example, since opening in June 2015 33% of referrals to the palliative care team at NSECH had a non-cancer diagnosis, compared to 30% across the trust between April 2014 and March 2015.

Competent staff

- The palliative care nursing team had completed advanced communication skills training or were scheduled to attend. The team received regular clinical supervision with a clinical psychologist every four to six weeks.
- Members of the specialist palliative care team had specialist training in palliative care including degree modules.

End of life care

- Consultants in palliative medicine had conducted research in a number of areas including the use of advance care planning at the end of life and exploring ethics of decision making and issues around sedation at the end of life.
- The specialist palliative care team provided a range of specialist training to general staff caring for patients at the end of life. This included a three day course on the effective management of palliative patients through a multidisciplinary approach. Specific subjects covered included spiritual care, communication skills, breaking bad news and symptom management.
- Specific training courses were designed around the needs of different staff groups, for example newly qualified nurses and health care assistants. Feedback from healthcare assistants included comments around the value of specific practical aspects of care such as mouth care, symptom control and supporting the spiritual and emotional needs of patients and their families.
- We viewed evaluation reports where 90% of attendees fed back that the course content was of an excellent standard.
- Junior doctors we spoke with told us they had attended end of life care training within the trust including communication training and breaking bad news.
- Middle grade doctors we spoke with told us they attended monthly training sessions and that these had included aspects of palliative and end of life care.
- Ward staff told us that the specialist nurses would support them in caring for patients at the end of life by working alongside them to ensure they were confident in the care they were delivering. Ward staff consistently told us that the specialist staff supported them in a way that helped them to develop the skills they needed to deliver good quality care. This involved the specialist nurses attending wards daily, attending a variety of multidisciplinary team meetings and working proactively to support general staff to identify patients at the end of life as early as possible.
- The manager of the hospital liaison palliative care team told us that the operating model they had adopted was deliberately designed so that specialist nurses were able to work alongside general staff to develop their competence using a hands on approach to supporting palliative and end of life care.
- Specialist palliative care staff told us a significant part of their role was to work alongside acute hospital teams and teach them about focusing on managing patients symptoms to ensure quality of life.
- Members of the palliative care team had attended training in advanced communication skills.

Multidisciplinary working

- Multi-disciplinary team (MDT) working was an integral part of the aims and objectives of the SPC team.
- SPC staff regularly attended other discipline's MDTs for example, heart failure and respiratory. Staff told us they worked closely with staff in other specialities. One example they gave related to working alongside cardiology specialists to use subcutaneous diuretics to support patients with heart failure at the end of life and help control their symptoms alongside existing methods of symptom management.
- We consistently saw examples of staff working closely across departments to deliver care. This included across community and acute services. We observed MDT working across chaplaincy, psychology, nursing, medicine, physiotherapy and occupational therapy services.
- The SPCT held a consultant led clinical review meeting at NSECH every week and the team attended a SPCT MDT meeting on a weekly basis across the trust. The MDT was attended by staff from a variety of disciplines including medicine, nursing, physiotherapy, social work, occupational therapy, psychology services and the chaplaincy.
- The trust had implemented a new electronic record system for use by the SPCT across all hospital sites that was aligned with the system used by community teams and GPs. This enabled staff to access patient records and communicate around patient care in real time with other disciplines. While the system was not yet fully embedded staff we spoke with told us it enabled them to keep up to date with the care patients were receiving from other teams in the community.
- The NSECH hospital liaison team told us they had quarterly meetings with the critical care team as this was an area where the hospital liaison team had been undertaking a good deal of work. We were told this enabled a more integrated approach where the palliative care staff felt a part of the wider critical care team and were more accessible as a result.

- Members of the palliative care team also attended meetings with ward managers and that there had been a focus on raising the teams profile in order to be more visible and accessible to ward staff. Ward staff we spoke with told us it felt to them like the palliative care staff were part of their team and as a result the palliative care nurses were able to work alongside them to deliver better care for their patients.

Seven-day services

- Inpatients at NSECH had access to specialist palliative care input seven days a week using a consultant on call rota. Adequate medical cover was available to provide a good level of service around the clock.
- Face to face specialist nursing input was available Monday to Friday. Telephone advice was available from the palliative care inpatient units at Wansbeck and North Tyneside general hospitals and a palliative care helpline based at a local hospice.
- The trust was working on an implementation plan to introduce a seven day rapid response service for palliative care. The primary aim was to introduce a community based service that would work between hospital and community provision to enable patients at the end of life to stay in their place of choice and access specialist input. Other aims included preventing avoidable admissions to acute care and assisting rapid discharges from acute care.
- At the time of our inspection there were no clearly identifiable plans to implement hospital based 7 day face to face specialist nursing services. However, staff consistently told us that they saw the rapid response programme working across both acute and community bases to meet the specialist needs of patients.
- The management of the specialist palliative care service told us that they had intentionally phased the introduction of new ways of working so as to manage the change more effectively. With this in mind they were focused on patient need in line with their strategy for improving end of life care in the community and patients preferred place of care.
- The first phase of the rapid response service was due to be implemented in January 2016.

Access to information

- The trust had implemented a single electronic patient record system across both acute and community palliative Care services to enable co-ordination and integration of care, eliminating six different record systems across the service and improving data collection. We saw that the system was available at NSECH although was not yet fully embedded. We saw that embedding the system was incorporated into the service's action plans and staff told us of plans to ensure the system was used consistently.
- The aim of the development of the electronic patient record for all patients under the palliative care service was so that communication of information was timely.
- Further aims of the system included the ability to measure quality patient outcomes so that these could be used to evaluate and improve the service consistently over time. Staff told us the system also allowed for staff to access GP palliative care registers and access information when patients accessed the service irrespective of the time of day.
- Treatment escalation plans, DNACPR and advance care plans were discussed openly with patients and their families from the time of admission to NSECH. We saw that plans were reviewed and amended in line with changes to the patients condition and circumstances and that information regarding ceilings of treatment and care was to hand.
- The CDP document provided a clear guide to clinical staff in the assessment and identification of patients needs. Information was recorded in a clear and timely way so that all staff had access to up to date clinical records when caring for and making decisions about patient care.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- The trust had a policy in place that detailed the procedures for obtaining consent. This included the process for obtaining consent, recording and responsibilities. The policy included advance directions, the use of independent mental capacity advocates (IMCAs) and the use of mental capacity assessments.
- Clinical staff we spoke with had a good understanding of mental capacity issues and were able to describe the process they followed to assess a patients capacity to make decisions or to be involved in decisions.
- We viewed the records of four patients who had been identified as lacking mental capacity to be involved in decisions about DNACPR. In three out of four cases there was a clear assessment of their mental capacity recorded.

End of life care

- Where patients did not have capacity to be involved in decisions we saw that decisions had been made in their best interest following discussions with family members.

Are end of life care services caring?

Outstanding ☆

We rated caring in end of life as outstanding because:

Staff were motivated to go the extra mile to meet patient needs. We observed a commitment to providing care that was of a consistently high standard and focused on meeting the emotional, spiritual and psychological needs of patients as well as their physical needs. There was a strong visible person-centred culture and staff were motivated and inspired to offer care that was kind and promoted people's dignity. Patients were cared for holistically and there was very strong evidence of spiritual and emotional support being recognised for its importance within the trust. This was apparent through the development of a tool to help staff better assess the spiritual needs of patients and elements of spiritual care being incorporated into end of life care training.

We heard about different situations where staff had accompanied patients home when being discharged to their preferred place of care at the end of life, providing additional support at a time when both patients and their families were likely to feel concerned about what to expect. Feedback included examples where staff had stayed beyond the end of their shift to ensure patients had the support they needed.

Compassionate care

- Part of the role of the hospital liaison team was to support patients and relatives around being cared for in their preferred place. We were given examples from a range of staff where the team had taken patients home in order to facilitate a smooth and supported transfer. This had included staff working beyond the end of their shift to provide continuity of care and ongoing support.
- During our inspection we saw that patients were treated with compassion, dignity and respect.
- Patients and relatives we spoke with told us they were extremely satisfied with the quality of care they received.
- Patient experience survey data was limited for NSECH at the time of our inspection due to the hospital only having been opened for a few months; however members of the palliative care team provided the service across hospital sites. Patient feedback data across the trust showed a high level of satisfaction in palliative care services. Data from 2 minutes of your time feedback showed that 100% of those surveyed stated they would recommend the service, were satisfied overall and were treated with dignity and respect.
- We were told that members of the specialist palliative care team, including consultants and nurses had supported a family in the community when the decision had been made to withdraw artificial ventilation from a patient being cared for at home. Staff had attended to be present in the patients home to provide specialist support at the end of life and continued to provide support over a period of days to meet the patients needs.
- We saw that care after death honoured people's spiritual and cultural wishes. Members of the chaplaincy team told us they were able to source expertise from the local community around different cultures and faiths and that there were staff within the trust that had specific knowledge in this area.
- We spoke with mortuary staff who told us they work closely with family members regarding care after death and all mortuary staff had attended bereavement training.
- Patients privacy and dignity was respected. For example, we saw specific initiatives such as additional screening having been built at the back of the body store to ensure that the privacy and dignity of patients, their relatives and other visitors was respected.

Understanding and involvement of patients and those close to them

- We observed staff caring for patients in a way that respected their individual choices and beliefs.
- We saw that treatment escalation, emergency healthcare plans and advance care plans were in place to support patients and those close to them in making decisions at the end of life.
- We spoke to staff and heard stories of different situations where patients and their relatives had been

involved in care. This ranged from supporting patients with meeting their hygiene needs on the wards, to supporting individual choices around going home to die.
- We observed interaction between families and staff and saw that staff worked hard to help people to understand what was happening and incorporate individual choices and preferences into the plan of care.
- Families were encouraged to participate in care and provide feedback through surveys.
- Patients preferred place of care and their individual choices and preferences featured as a primary focus when planning care.
- Information was available for patients and their relatives around different aspects of care at the end of life. This included what to expect at the end of life and coping with bereavement.

Emotional support

- Patients notes indicated they were kept actively involved in their own care and where appropriate relatives were also kept involved.
- A chaplaincy service was available with ministers from a variety of denominations employed. We were told there were 16 ministers within the chaplaincy team and that this included Church of England, Roman Catholic, Muslim, Sikh, Hindu and Jewish Rabbi chaplaincy support. Comfort and support was available 24 hours a day through the service and was available for people of diverse faiths or no faith.
- We observed ministers visiting patients on the wards and staff told us they were encouraged to use the service to support patients irrespective of their faith.
- Chaplains would sometimes accompany relatives to the mortuary and we saw that chaplaincy support was a part of the trust major incident plan. Chaplaincy staff told us they were available to provide emotional support to patients, relatives, visitors and staff alike.
- Spiritual care and support was seen to be important throughout the trust. The chaplaincy team had developed a spirituality assessment tool for staff on the wards and in the clinical areas to use. The tool involved identifying if a person had a belief system, how important it was to them and how they wanted their spiritual and emotional support to be a part of their care plan.
- Volunteers worked with ministers to provide listening for patients who wanted to talk.
- Chaplaincy staff told us that a lot of time and resource had been invested in meeting the spiritual needs of patients and their relatives. They had spent time working on what spirituality means to people and had developed a tool to assess people's spirituality and emotional needs on admission. Staff training had included aspects of spiritual distress and the provision of support.
- The lead chaplain told us they had felt overwhelmed by the investment the trust had made in meeting people's spiritual needs.
- A bereavement service was available across the trust for the families of patients who had died. At NSECH this service is provided by staff based at Wansbeck and North Tyneside general hospitals who spent time at NSECH on a rotational basis.

Are end of life care services responsive?

Outstanding ☆

We rated responsive in end of life as outstanding because:

End of life care services at NSECH were very responsive to the needs of individual patients and to the needs of the local community as a whole. We saw evidence that resources had increased to meet an increasing demand on the service across the trust as a whole. Joint working with the third sector saw the trust working with and involving other organisations in the way that services were planned to ensure they met people's needs. The trust had adopted an innovative approach to providing an integrated person-centred pathway of care in partnership to provide services that were flexible, focused on individual patient choice and ensured continuity of care.

We saw evidence that more patients were dying in their usual place of residence and that the trust was supporting increasing numbers of non-cancer patients.

When a complaint was made they were actively reviewed and taken seriously.Action was taken as a result with improvements to the service.

Specifically at NSECH we saw that where the need for palliative and end of life care services had been higher than anticipated, the trust had committed to additional nurse specialist hours. Overall, the trust was able to demonstrate a flexibility of service that ensured patient needs were met.

End of life care

Service planning and delivery to meet the needs of local people

- The palliative care hospital liaison service was widely embedded throughout clinical areas in the hospital, including the emergency department, critical care and general wards.
- Across the trust as a whole we saw there had been significant investment in end of life care services. The development of hospital liaison teams where band 5 and 6 palliative care nurses worked alongside band 7 specialist nurses had enabled the teams to support more patients.
- Work had been undertaken to increase specialist palliative care support to patients with non-malignant disease. This had increased across the trust from 280 referrals in 2013/14 to 643 referrals in 2014/15. This increase included the hospital liaison team. The percentage share of patients with non-malignant disease being supported by the team had increased from 27% to 30% during this time. At NSECH specifically this had increased further to 33% between June 2015 and December 2015.
- Since opening in June 2015 NSECH had seen a higher than expected number of referrals to the hospital liaison team (725). The management of the service had responded to this by identifying a second band 7 CNS role that was being actively recruited to at the time of our inspection.
- There was a 24 hour electronic referral system in place and an alert that notified the SPC to patients admitted who were known to the team and those who were commenced on the CDP document to support their end of life care. This ensured that patients were assessed in a timely way. We saw examples of patients who were seen by specialist PCT staff very quickly after admission as a result of the alert, including those who were in A&E at the time.
- Total referrals to palliative care went from 2013/14 (1024) to 2014/15 (2142). This increase included the hospital liaison team.
- Trust data showed an increase in patient deaths in their usual place of residence. In Northumberland this had increased in line with the national average and in North Tyneside this had exceeded the national average. For example, since 2010 this figure had increased from 41.6% to 50.3% in 2014 compared to the national average of 44.7%. There was good integrated working across the acute and community services within the trust to achieve home deaths.
- The integration of the palliative care service across the trust and partnership working with third sector organisations to enhance services had seen a more 'joined up' way of working across acute and community services. Specific examples include the integration of the management structure with a head of service, operations manager and clinical matron covering the trust wide palliative care service.
- The palliative care strategic plan includes the imminent achievement of full seven day working (January 2016); initially focusing on the development of a community based rapid response service. The aim of the service was to "provide a comprehensive, "joined up" palliative care service to patients and their families in all settings." A particular focus for this was to assist rapid discharge from acute care and to prevent avoidable admission to acute care.
- The development of the hospital liaison team structure included the introduction of a band 5 palliative care nurse with a focus on rapid discharge that included escorting patients into the community and providing support through the transition into community services. Staff we spoke with gave us examples of where this approach had worked successfully in supporting patients through their discharge to their preferred place of death.

Meeting people's individual needs

- Personalised, individual care plans ensured that care was tailored to meet the needs of the individual at the end of life. An end of life care pack was available in all clinical areas and by using the hospital liaison team to provide guidance for staff.
- Staff told us that that dementia and learning disability passports were used on a regular basis when caring for patients with dementia or a learning disability.
- There were dementia and learning disability teams available within the trust for advice and support.
- Staff we spoke with were aware of translation services available for patients whose first language was not English. One member of staff told us they could use picture prompts to aid communication with patients where this was appropriate. There was also a list of hospital staff with a second language available.

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.
- Emergency health care plans, treatment escalations plans and advance care planning were all seen to be in use and embedded in practice. The wishes, choices and beliefs of individuals were seen to be incorporated into all plans and we saw good evidence of recorded discussions with patients and their families about their care at the end of life.
- Mortuary, chaplaincy and ward staff told us they had access to information about different cultural, religious and spiritual needs and beliefs and that they were able to respond to the individual needs of patients and their relatives. We viewed an information booklet that had been compiled by the chaplaincy service detailing different cultural and religious beliefs and practices.
- We saw that chaplaincy services were described as being available to people of multiple faiths and those of no faith and we observed across the trust considerable respect for the cultural, religious and spiritual preferences of patients.
- Assessments documented by the specialist palliative care team included recording patients preferred location of care at the end of life.
- The hospital had a chapel and multi-faith prayer and quiet room available for patients, staff and visitors. There was a prayer tree available in the chapel for people to record their thoughts, prayers, wishes and concerns.
- The multi-faith room was appropriately equipped to meet the needs of a variety of religions.
- There was guidance in the mortuary on caring for people after death in line with their religious and cultural beliefs. Mortuary staff gave us examples of when they had supported families to ensure the religious and cultural needs had been met.
- Comfort care packs and facilities for overnight stays were available for relatives of patients at the end of life.
- Patients at the end of life were nursed in side rooms. Additional beds were made available for relatives who were able to stay in the room with the patient. Staff told us that additional beds had been purchased to meet the higher than anticipated need at NSECH.

Access and flow

- All patients we saw had gone through a process of assessment and risk assessment from both medical and nursing perspectives on admission.
- Ward staff we spoke with told us they knew how to access the specialist palliative care team and that the team were responsive to the needs of patients. We saw referrals being made in timely and appropriate ways and the use of the patient alert system meant that where patients were known to the palliative care team or where they were identified as needing to comment on the CDP document the team would be alerted straight away.
- It was the aim of the palliative care service to see patients referred within the hospitals within four hours. We observed and staff consistently told us that the palliative care staff responded very quickly and that usually they would see patients within an hour. For example, we observed staff referring a patient and their family for rapid discharge support and the palliative care CNS responded immediately. Staff on the ward told us this was common practice.
- We saw that resource folders on the wards included information for ward staff on how to access specialist advice outside of normal working hours when the specialist palliative care team were not available.
- We saw that advice given by the specialist care team was recorded in the patient notes with a sticker accompanying entries so that staff could quickly access the advice given.
- The chaplaincy service was accessible 7 days a week using an on call system.
- Staff across the trust told us they felt they were able to discharge patients quickly at the end of life if they chose to be cared for at home. We were told that arrangements with the pharmacy included the prioritisation of end of life medicines in this situation and that these could be available within a few hours. However, specialist staff told us there had been an occasion where family members had offered to collect medicines from community pharmacies to speed up the process as there was not an on-site pharmacy at NSECH.
- The service was recording preferred place of death in patient records when they were identified as being at the end of life. Since the implementation of a new electronic patient record system in September 2015 the trust had begun to record actual place of death in comparison to preferred place of death. At the time of

our inspection there were limitations to the data available although we saw clear evidence that the trust was beginning to capture the data in way that reflected patient choice and their performance against this.
- A palliative care ambulance was available to transfer patients at the end of life so that they did not have to wait. Staff told us that the ambulance would generally be available when they requested it.

Learning from complaints and concerns

- Complaints relating to end of life care would generally be investigated by the service manager or palliative care matron and would be discussed at the hospital liaison team meeting, with learning used to develop practice.
- There were very few complaints relating to end of life care and we saw just one specific to NSECH relating to a DNACPR decision.
- We saw that when a complaint was made they were taken seriously and that action was taken as a result. For example, we viewed a record of a complaint where a relative had complained about a DNACPR decision having been made without discussion with the family where the patient lacked mental capacity to be involved. Action taken included providing feedback and addressing learning with the clinicians responsible.
- Staff were aware of their responsibilities in supporting patients and family members who wished to make a complaint.

Are end of life care services well-led?

Outstanding ☆

We rated well-led in end of life as outstanding because:

There was a clear vision and strategy that focused on the early identification of patients at the end of life, patients being cared for in their preferred place of care and the use of partnership working to develop services. The leadership, governance and culture were used to drive and improve the delivery of high quality person-centred care through collaboration and partnership working. The trust had clear leadership for end of life care services that was supported at the top of the organisation. There was a clear proactive approach to seeking out and embedding new and more sustainable models of care. Investment in end of life and palliative care services was apparent and staff we spoke with consistently told us they felt that end of life care was a priority for the trust.

We saw evidence of innovation and improvement in relation to the model of working at NSECH with the alignment of palliative and end of life care with emergency care to ensure patients received specialist palliative care at the earliest opportunity. In addition the partnership working with Marie Curie and joint management and nursing posts enabled the trust to provide prompt support and continuity of care for patients being discharged to their preferred place of care in the community. Further innovations were seen in relation to a focus on spiritual support and an assessment model that aimed to increase understanding of spirituality and confidence around assessment.

Vision and strategy for this service

- A palliative care steering group was in operation to guide the trust in delivering effective palliative and end of life care. Membership of the group included key staff and representatives from a variety of specialities including elderly medicine, general practice and general medicine. This helped to ensure that responsibility for good quality end of life care did not solely sit with the palliative care team.
- There was a clear vision and strategy for end of life care. This centred on the identification of all patients at the end of life, the provision of an integrated service between hospital and community services, the provision of a seven day service, enabling patients to stay in their place of choice and to improve patient outcomes and experience.
- Following the National Care of the Dying Audit of Hospitals (NCDAH) results, the trust developed an action plan on how they intended to address the areas identified for improvement. This included the appointment of a trust lead for end of life care. The executive lead for end of life care was the executive medical director.
- Staff we spoke to consistently articulated the vision for good quality end of life care and staff were aware of their role in delivering the strategy. For example, specialist nursing staff at NSECH were focused on early identification of patients at the end of life and those in need of palliative care input. They worked

collaboratively with other hospital teams to raise their profile and increase awareness of their role in supporting general staff in delivery good quality end of life care. They engaged well with other teams through opportunistic ward visits and attendance at meetings.
- Ward staff were engaged in the provision of end of life care and we saw that with support from the specialist palliative care team they had a good understanding of what constituted good quality end of life care.
- The trust had invested in end of life and palliative care with the introduction of initiatives such as the hospital liaison service in collaboration with Marie Curie. Staff we spoke to at NSECH consistently told us they felt that the service was excellent and that the development of the hospital liaison model was working well.

Governance, risk management and quality measurement

- Specialist palliative care reports within the directorate structure of community and social care.
- The service is held to account by the palliative care steering group. The group consisted of trust directors, senior trust staff from related services and lay representation to ensure accountability.
- We saw that end of life care was discussed at board level. For example, we viewed minutes of a meeting where a patient story had been discussed. This helped to highlight to the board the importance of individualised care and a multi-disciplinary approach that supports meeting the wishes and needs of the patient and their family.
- There was representation from the SPCT at regular mortality review meetings. Their remit was to review and comment on the end of life care journey of patients and provide constructive feedback and advice in relation to ongoing learning and improving patient care.
- The service takes part in regular audits, locally and nationally. This included external NCDAH and national bereavement surveys.
- Internal measurements of quality included place of death data and use of other metrics including patient feedback and analysis of patient activity.
- Within the trust the Palliative Care service had won the Quality Award for 2014 for their commitment to improvement and the excellent patient experience feedback received.
- We viewed a divisional performance report that examined elements of safety and quality. We saw that end of life care quality goals had been set and that discussions were ongoing with CCGs about specific targets. This included the use of emergency healthcare plans, monitoring of DNACPR decisions in patients identified as lacking mental capacity and the use of best interest decision making.

Leadership of service

- There was end of life care representation/leadership at trust board level and we saw evidence of active engagement in end of life care at board level.
- The trust's palliative care steering group was chaired by one of the trust's executive medical directors which meant that the overall responsibility for monitoring of end of life care did not sit entirely with the specialist palliative care team.
- There was comprehensive leadership within the palliative care service with clearly defined leadership roles. The palliative care service was led by a head of service (consultant in palliative medicine), matron in palliative care, a general manager and an operations manager.
- The head of service was responsible for the strategic leadership and governance of the service, working closely with CCGs to ensure the service meets patient need and national standards.
- The matrons post in palliative care was created jointly with Marie Curie Care. The aim of the role was to ensure that the trust has the highest standard of end of life nursing throughout the community and hospitals and to provide nursing leadership to the service.
- General and operational management worked to ensure that the infrastructure and resources were effectively managed to deliver the service aims.
- The hospital liaison teams received both managerial and clinical leadership support. Direct management support was provided by the Marie Curie service manager and clinical support from the band 7 SPC CNS.
- All the staff we spoke with felt their line managers and senior managers were supportive and approachable.
- Ward staff knew the names of the SPC liaison team members and were able to give a variety of examples of how the team had worked with them to deliver end of life care.

Culture within the service

- Staff we spoke with demonstrated a commitment to the delivery of good quality end of life care. There was

evidence that ward staff felt proud of the care they were able to give and there was positive feedback from nursing and care staff as to the level of support they received from the specialist palliative care team.
- There was evidence that the culture of end of life care was centred on the needs and experience of patients and their relatives. Staff told us they felt able to prioritise the needs of people at the end of life in terms of the delivery of care.
- Members of the specialist palliative care team told us they were proud of the care they were able to deliver and the opportunities they had to support the development of the service.
- One ward manager we spoke with told us they had been nervous about the structure of palliative care support at NSECH as it was a new way of working. However, they told us that the model had worked well in increasing awareness of end of life care needs and developing the confidence of ward staff in delivering good quality care.

Staff engagement

- We saw that the hospital liaison teams had regular monthly meetings and that these gave team members the opportunity to share information, ideas and learning.
- Staff we spoke with told us they felt they had an opportunity to feedback to management and that they felt listened to.
- Staff told us they felt valued by the management of the trust and that the service they provided was seen as an integral part of the work being undertaken by the trust as a whole.
- All specialist palliative care staff had received an annual appraisal and a personal development plan as a result.

Public engagement

- The trust was in the top ten and came 6th out of all trusts in England for the quality of care reported by the Cancer Patient Experience Survey 2014.

Innovation, improvement and sustainability

- The specialist palliative care team were focused on continually improving the quality of care and we observed a commitment to this at ward level also.
- The trust had developed services in partnership with Marie Curie which had allowed them to increase their palliative care service provision.
- The trust had rolled out a regional advance care planning approach 'Deciding Right' and had created a treatment escalation planning approach so that all patients had a very clear plan in place should their condition change.
- The trust had reconfigured the hospital palliative care service, to provide cover across all hospital sites. This included a new staffing model that was focused on providing support to all patients at the end of life who were on a palliative care register or being cared for in hospital. In addition there is a band 7 specialist nurse to provide advice and support for the care of patients with complex palliative care needs, band 6 and band 5 posts had been created to provide additional support.
- Additional support included focused discharge planning and in particular the provision of support to ward nurses around the rapid discharge pathway and to support the transition from hospital to home. A particular innovation of this structure was the flexibility of the nurse to work across hospital and community settings and therefore accompany the patient home and provide support at home before handing over care to the district nursing teams and specialist nurses in the community.
- In particular at NSECH we observed examples of innovative ways of working where the specialist palliative care nurse worked alongside acute teams to provide palliative care input for patients who were receiving acute interventions. This meant that patients were able to receive support and intervention from palliative care specialists at an early stage in their hospital admission.
- Another area of innovation was the development of a tool for the assessment of patients spiritual needs that focused on providing staff with prompts that would make it easier for them to have this discussion with patients. The tool also helped staff to engage in a clearer way to ensure patients understood.
- Staff told us that by getting involved sooner with palliative care patients, including those in the accident and emergency department they were able to support patients when they were acutely unwell and help manage their symptoms more quickly.
- The trust was in the process of developing a 24 hour rapid response service to get supportive and specialist care to patients wherever they are, whenever they need it.

End of life care

- The trust demonstrated a commitment to working with other providers in partnership and across service boundaries within the trust to improve the quality of care.

Outpatients and diagnostic imaging

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

Information about the service

The Northumbria Specialist Emergency Care Hospital (NSECH) provided outpatient orthopaedic trauma clinics only as well as diagnostic imaging. The trauma clinics were located within the main entrance to the emergency department. There were three private consulting rooms and two treatment rooms available for use by the clinics.

The X-ray department provided two plain x-ray rooms, two CT scanners, two ultrasound rooms, three mobile x-ray machines, and three image intensifiers in theatre. There was also a plain x-ray room situated in the emergency department and a dedicated paediatric x-ray room with direct access to the paediatric emergency area. An independent company provided a managed MRI service although trust radiologists reported the MRI images.

The diagnostic imaging department (x-ray department) offered several imaging techniques including plain x-ray, CT, diagnostic ultrasound, and MRI. (A computerised tomography (CT) scan combines a series of X-ray images or pictures taken from different angles and uses computer processing to create cross-sections, or slices, of the bones, blood vessels and soft tissues inside the body. Magnetic resonance imaging (MRI) is a technique that uses a magnetic field and radio waves to create detailed images of the organs and tissues within the body. Diagnostic ultrasound, also called sonography, is an imaging method that uses high-frequency sound waves to produce images of structures within the body).

The inspection team visited outpatient trauma clinic areas, x-ray department, and pathology services at the Northumbria Specialist Emergency Care Hospital., the trust's central appointment bookings centre, and medical records. The central contact centre for appointment bookings and the medical records department were based at Trust Headquarters away from the hospital sites.

During our visit to the hospital and support services we spoke with 5 patients and 3 relatives. We also spoke with 17 staff including: doctors, clinical specialists, matrons, qualified and unqualified nurses, radiographers, students, medical records clerks, appointment bookings administrators, departmental and business managers, porters, receptionists, and volunteers. We looked at 4 sets of medical records and 4 electronic radiology records.

Outpatients and diagnostic imaging

Summary of findings

We rated outpatient and diagnostic imaging at NSECH as outstanding because:

The service was flexible and ensured continuity of care. People accessed services in a timely and convenient way. The hospital provided a seven day a week consultant led outpatient trauma service for people from across Northumberland and North Tyneside to access, and a teleconference clinic for patients in Berwick, almost 60 miles away. Trauma clinics and related services were organised so patients only had to make one visit for investigations and consultation or, if possible did not have to return to hospital for unnecessary appointments. It also provided patients with timely advice on the management of their injuries while at home. Radiology reporting was swift with an emphasis on "results within minutes" for trauma patients. This enabled medical teams to complete assessments and manage risks quickly. Reporting times for urgent and non-urgent procedures consistently met or were better than national and trust targets for all scans and x-rays for emergency patients, inpatients, and outpatients. There was widespread involvement with the local population, primary care, and commissioners to plan this new model of emergency care to ensure that the service met people's needs. Since the departments opened in June 2015, there had been no formal complaints. However, the department teams recorded any concerns and informal complaints and used patient feedback proactively to prevent recurrence that might affect others.

Staff and managers had a clear vision for the future of the service. They knew the risks and challenges the service faced. Staff we spoke with at all levels felt supported by their line managers, who encouraged them to develop and improve their practice. Staff embraced change and there was a real focus on patient experience and leaders and managers drove this. There were well embedded systems and processes for gathering and responding to patient experiences and the results were well publicised throughout the departments. Early feedback provided by patients for the virtual trauma service was very positive. There were effective and comprehensive governance processes to identify, understand, monitor, and address current and future risks. These were proactively reviewed. There was an open, honest and supportive culture where staff discussed incidents and complaints, lessons learned and practice changed. All staff were encouraged to raise concerns. The departments supported staff who wanted to work more efficiently, be innovative, and try new services and treatments and ways of engaging with the public

The hospital had good systems and processes in place to protect patients and maintain their safety. The departments were clean and hygiene standards were good. Medical records were stored and transported securely. Staff followed professional best practice guidelines to plan and deliver good quality care and took part in a wide range of national and clinical audits. Diagnostic imaging provided services for inpatients and emergency patients seven days a week and service availability was increasing and continuously improving. Staff undertook regular departmental and clinical audits to check practice against national standards.

Staff respected patients privacy, dignity, and confidentiality at all times. Staff spent time with patients and those close to them to give explanations about their care and encouraged them to ask questions.

Outpatients and diagnostic imaging

Are outpatient and diagnostic imaging services safe?

Good

We rated safe as good because:

The hospital had good systems and processes in place to protect patients and maintain their safety. Staff were knowledgeable about the process for reporting and investigating incidents. Performance data and minutes of trust meetings are widely communicated. There was a good reporting and feedback culture. The departments used an electronic system to report incidents. All the staff we spoke with knew how to use the system. Managers and governance leads understood risks relating to their own areas and across the trust, investigated incidents and shared lessons learned with staff.

Departments displayed safety data and cleanliness audit data and information summarised that there was a good track record of safety in all areas of reporting.

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

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

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

Staff in all departments knew the actions they should take in case of a major incident or emergency with business continuity plans in place.

Incidents

- There had been no never events and no serious untoward incidents reported in relation to the trauma clinics since the opening of the hospital in June 2015.
- The trust used an electronic programme to record incidents and near misses. Staff knew how to use the programme and how to report incidents. We saw from the business unit Datix (an electronic system used to record incidents) incident report that incidents were recorded by type, site, exact location, business unit, and date. Each incident was categorised by theme and the trust had assessed the majority of the outpatient department reports as causing no harm.
- Staff we spoke to could give examples of incidents that had occurred and investigations that had resulted in positive changes in practice. Within Clinical Support and Cancer Services Business Unit, Managers and staff reviewed incidents at weekly IR1 (Incident Reporting form) meetings. The incidents graded moderate and above were discussed at monthly governance meetings. Every three months the Surgical Business Unit met at a shared meeting with North Cumbria University Hospitals NHS Trust. Staff understood their responsibilities of the recently introduced duty of candour regulations and all staff described an open and honest culture. We saw evidence of telephone call logs and letters to patients offering an apology and information about incidents and complaints.

Diagnostic Imaging:

- There had been one plain film radiological incident reported under Ionising Radiation (Medical Exposure) Regulations (IR (ME) R) 2000. This was low level and radiographers took an image of the incorrect body part. Trusts must report to the Care Quality Commission (CQC) any unnecessary exposure of radiation to patients. There was evidence staff had checked the reasons why the incident occurred, took appropriate action, and produced an action plan following learning. The radiation protection advisor had reported that the frequency and severity of incidents were within national standards for a trust of this size.
- Consultants, reporting radiographers, and sonographers discussed radiology discrepancy incidents by case review at monthly education and learning meetings. Staff took the opportunity to learn, work as a wider team and liaised with the specialty medical teams across the trust. Images reported by an agency underwent discrepancy checks carried out by the agency and there was a reciprocal agreement in place for both parties to carry out quality assurance checks on randomly selected images.

Outpatients and diagnostic imaging

Cleanliness, infection control and hygiene

- Staff undertook hand hygiene and 'Saving Lives' (reducing infection, delivering clean and safe care in the NHS) audits which demonstrated that staff working within the departments were compliant with best practice guidelines. Staff documented results for each area in the Infection Control Accreditation Audit reports (April to August 2015).
- Staff provided sufficient supplies of personal protective equipment (PPE) including disposable gloves and aprons. Staff disposed of used PPE safely and correctly. We saw PPE being worn when treating patients and during cleaning or decontamination of equipment or areas.
- We saw, and patients reported, that staff washed their hands regularly before attending to each patient. Hand gel stations were provided for use by patients, relatives and staff and we saw all these groups using the hand gel.
- Staff had undertaken patient-led assessments of the care environment (PLACE) audit since the hospital had opened. The result from this audit was 97% and demonstrated that the staff were achieving standards in compliance with national guidance. There was a policy and procedure to ensure that staff reported any results of 92% or below to the modern matron, senior manager and chief matron.
- A monthly audit of hand hygiene was undertaken. The results improved each month showing 100% compliance in September 2015.
- Domestic services staff carried out daily and weekly cleaning regimes and followed an equipment cleaning schedule. Staff adhered to a standard operating procedure for setting up and clearing each clinic.
- All patient waiting areas, consultation and treatment rooms, and private changing rooms were visibly clean and tidy. The trust provided single sex and disabled toilets and these areas were clean. Patients told us in their view they found the hospital to be clean and well maintained.
- We saw that staff ensured treatment rooms and equipment in all departments were cleaned regularly. Staff cleaned and checked diagnostic imaging equipment regularly. Staff cleaned and decontaminated rooms and equipment used for diagnostic imaging after use.

Environment and equipment

- The hospital was a brand new build and had recently opened in June 2015. The trauma clinic environments were located in the entrance to the emergency department and the facilities were modern.
- Resuscitation equipment was available and located within each department. We found that resuscitation trolleys for adults and equipment including suction and oxygen lines were visibly clean. Staff checked them weekly and checklists were signed and up to date. Staff locked and tagged trolleys and made regular checks of contents and their expiry dates. No drugs or equipment had exceeded expiry dates.
- We observed no obvious environmental hazards during our inspection.
- Staff carried out environmental audits. Staff reported concerns to managers and the estates department and had developed action plans to address areas for improvement. We observed a quick response from the hospital estates department when staff found a cracked plug on a portable x-ray machine. Staff placed a warning notice on the machine with the date they reported it. An engineer completed the repair within a few hours. Staff told us that the estates department always acted quickly when health and safety problems were reported.
- Managers ensured equipment throughout the departments was calibrated and maintained with appropriate maintenance contracts and service level agreements for specialist equipment.
- The medical engineering department carried out testing of electrical equipment (safety testing) and on a rolling programme basis serviced all equipment. Confirmation of completion of servicing was on stickers on the equipment.
- We saw, and staff confirmed that, there was enough equipment to meet the needs of patients within all departments. Staff told us they were encouraged by senior management to raise any immediate concerns to ensure they were rectified quickly or escalated to the department manager.
- The medical records department was well organised and the notes were uniformly stored in accordance with the health records digital programme. Staff in medical records carried out risk assessments on the thickness of large sets of notes and two people lifted boxes of notes.

Diagnostic Imaging:

- The design of the environment within the x-ray department kept people safe. There were radiation

warning signs outside any diagnostic imaging areas. Imaging treatment room no entry signs were clearly visible and in use throughout the departments at the time of our inspection.

- Staff wore dosimeters (small badges to measure radiation) and lead aprons in diagnostic imaging areas to ensure that they identified and accurately recorded any exposure to higher levels of radiation than was considered safe. Staff collected dosimeters and sent them for testing every month. Results were all within the safe range.
- All x-ray equipment at NSECH was new and used direct digital radiography (DR) processing. This is where digital X-ray sensors are used instead of traditional photographic film. Advantages include time efficiency through bypassing chemical processing and the ability to digitally transfer and enhance images. Also, this uses less radiation to produce an image of similar contrast to conventional radiography. The regional medical physics advisor had measured all x-ray equipment and had recorded significantly lower radiation doses than other kit used across the trust.
- Staff carried out, quality assurance (QA) checks in diagnostic imaging for all x-ray equipment. These were mandatory (must do) checks based on the Ionising Radiation Regulations 1999 and (IR (ME) R) 2000. These protected patients against unnecessary exposure to harmful radiation.
- Radiation protection supervisors (RPS) carried out risk assessments with ongoing safety indicators for all radiological equipment and its use by staff. These were easily accessible to all diagnostic imaging staff.
- Staff in diagnostic imaging demonstrated safe working methods to record patient doses for radiation.

Medicines

- We checked the storage of medicines and found staff managed them well. No controlled drugs were stored in the main outpatients departments. Small supplies of regularly prescribed medicines were stored in locked cupboards and where needed, locked fridges. We saw the record charts for the fridges that showed that staff carried out temperature checks daily and that temperatures stayed within the safe range. All medicines we checked were in date.
- Pharmacists managed stock control on a monthly basis and staff told us that the pharmacists provided good support to the departments when requested.
- Medicines management training figures were 91% for registered nurses across the outpatients departments.
- Staff followed systems that demonstrated compliance with the Medicine Act 1968 and the Misuse of Drugs Act 1971.
- Staff used locked medicine fridges which were part of the electronic dispensing system. The monitoring of the temperature of the fridges was electronic; this alerted the pharmacy department if the temperature was out of range.
- Medical gases were stored safely in separate rooms.
- Staff used paper records for medicine prescribing in the trauma clinic and recorded patients allergy status on the electronic patient record system.

Diagnostic Imaging:

- All intravenous infusions and contrasts were stored in their original boxes or in appropriately labelled containers.
- Patient group directions (written instructions for the supply or administration of medicines) for use in x-ray had been completed and reviewed.

Records

- Records showed that patient notes were prepared and available for patients attending the trauma clinics 99% of the time.
- The trust had a centralised medical records library open 24 hours each day, seven days a week to support urgent retrievals, requests and returns of patients medical notes. There were standard operating procedures in place for electronically for tracking the movement of patient notes throughout all of the trusts locations.
- The medical records library entry was secure, monitored, and controlled and visitors signed in and out of the department. The service was open 24 hours a day, seven days a week to support urgent retrievals, requests, and returns of medical notes.
- The library staff used a full terminal digital health records management programme to store notes. All staff were trained and qualified to a nationally recognised medical records qualification.
- The trust had an electronic software programme in place for tracking notes throughout all of its locations. A dedicated team had been established to operate a planned trial for responding to urgent emails for supplying notes to NSECH.

- Records contained patient-specific information about the patients previous medical history, presenting condition, personal information such as name, address and date of birth, medical, nursing, and allied healthcare professional interventions.
- Staff managed notes safely and ensured notes were not left unattended. We observed staff checking patient identification against their medical notes when booking in for their appointments at the trauma clinic.
- We reviewed seven patient records which were completed with no obvious omissions. Some contained faxed referral letters from within the trust and one from a hospital external to the trust. The information contained within the faxes was legible, relevant and detailed the reason for referral. All contained patient demographics and contact telephone numbers.
- Outpatients and diagnostic imaging staff completed risk assessments including National Early Warning Score (NEWS), pre-assessment for procedures and pain assessments. Nurses recorded these in patient records and escalated any concerns to medical staff in clinics.

Diagnostic imaging:

- Patient information, diagnostic images and reports were stored electronically and available to doctors using Picture Archiving and Communications System (PACS), Clinical Radiology Information System (CRIS) and Pathology reports and diagnostic image reports available using Integrated Clinical Environment (ICE) systems. The requests populated the 'outstanding list' or current worklist and staff used these systems to automatically record procedure requests and rejections, examinations marked as complete and a record of the radiology activity undertaken.
- We reviewed six electronic patient records in x-ray. Staff referred patients into diagnostic imaging electronically and radiology staff viewed details on the CRIS system.
- All records had full and complete patient demographics, the investigation requested, relevant clinical information and where contrast checklists and pre-investigation blood tests were required, these appeared were completed correctly.

Safeguarding

- Staff on duty in the trauma clinics were up to date with both adults and children's safeguarding level 1 and 2 training and appropriate staff were up to date with their safeguarding training at level 3.
- We did not have access to a breakdown of staff attendance of mandatory Safeguarding training at this hospital site. However, managers held up to date information on their own staff and had plans in place for staff training in priority and mandatory training. Department records showed the majority of staff had completed workbooks for level 1 and face to face training for level 2 adult and children's safeguarding training. Managers displayed plans in staff areas. Attendance and achievement against compliance targets were not recorded at a trust level.

Mandatory training

- The trust provided us with performance data for mandatory training, and a variety of modules specific to departments and staff roles had been completed across all sites. The data was not complete for the Northumbria Specialist Emergency Care Hospital as staff had been redeployed from other sites within the trust, or newly recruited from June 2015.
- Staff on duty told us they were up to date with their mandatory training. The overall ongoing training figures for the departments demonstrated that between 85% and 100% of staff had completed these modules to date against a trust target of 85%.
- Mandatory training was delivered in e-learning modules and some study days. Staff regularly used e-learning as an accepted method of learning. Subjects included fire safety, basic life support, essence of care, learning disabilities, mental capacity level 1and 2, risk management, moving and handling, slips trips and falls.
- Managers made sure staff attended training and allocated time in staffing rotas. The training and development department produced and distributed monthly reports on mandatory training and departmental managers checked compliance regularly.

Assessing and responding to patient risk

- Staff followed specific approved streamlining criteria to decide on whether a patient attended the trauma clinic or could be contacted using the virtual trauma team. For example, staff considered patients with minor fractures or patients requiring no formal orthopaedic follow up and where recovery could be managed at home were suitable for referral into the virtual fracture clinic pathway.
- Virtual fracture clinic staff advised the team if they had concerns in respect of a particular individual patient

(examples given were; age, the nature of the injury, co-morbidities, underlying health-related issues or safeguarding concerns) and in this event staff asked patients to attend in person to address any particular risk factors which may hinder their full recovery.
- The trust had clear policies and guidance in place for managing medical emergencies. Staff received basic life support training as a minimum and they were aware of the '2222' telephone system to call the resuscitation team in cases of emergencies. Staff were up to date with basic life support training. Staff knew actions to take if a patients condition deteriorated while in each department and explained how they could call for help, call the paediatric and adult cardiac arrest teams and how to transfer a patient to the emergency department.
- There were enough resuscitation trolleys and defibrillators across all departments.

Diagnostic imaging:

- There were emergency assistance call bells in patient areas in radiology. Staff confirmed that, when patients activated emergency call bells, they answered them immediately.
- Staff followed the radiation protection policy and procedures in the diagnostic imaging department. Managers ensured that roles and responsibilities of all staff including clinical leads were clear and therefore managed and minimised risks to patients from exposure to harmful substances.
- Prior to the opening of the hospital, all radiology equipment had been risk-assessed and safety tested to ensure the safety of staff and patients. Specific testing and reporting on equipment included radiographic tubes and generators, ultrasound, CT and image intensifiers.
- Diagnostic imaging policies and procedures were written in line with the Ionising Radiation (Medical Exposure) 2000 regulations IR (ME) R.
- Named and certified radiation protection supervisors (RPS) provided advice when needed to ensure patient safety. The trust had radiation protection supervisors and liaised with the radiation protection advisor (RPA).
- Arrangements had been agreed for radiation risks and incidents defined within the comprehensive local rules. Local rules are the way diagnostics and diagnostic imaging work to national guidance and vary depending on the setting. Staff had written and agreed policies and processes to identify and deal with risks. This met with IR (ME) R 2000.
- Staff asked patients if they were or may be pregnant in the privacy of the x-ray room therefore preserving the privacy and dignity of the patient. This met with the radiation protection requirements and identified risks to an unborn foetus. We saw staff follow different procedures for patients who were pregnant and those who were not. For example, patients who were pregnant underwent extra checks and staff completed checklists to record them.
- Diagnostic imaging, screening, and endoscopy departments used adaptations of the WHO safer surgical checklist for all interventional procedures. Staff audited checklists for completion and quality. Compliance rates had shown a marked improvement since audit began. An audit of radiology markers on x-rays had shown that 90% of all images had anatomical markers and staff had demonstrated an improvement from 36% to 56% for manual markers.

Nursing and allied health professional staffing

- Senior nursing staff told us that they had recently undertaken a comprehensive review of staffing that involved a review on the number of clinics, tasks, and chaperone requirements. Early indications showed that an increase in outpatient nurse staffing to meet present and future demand of the service was required.
- Managers had increased the numbers of outpatient nursing staff at Wansbeck General Hospital to take account of the rotational cover to the trauma clinics.
- At the time of our visit there were three nursing assistants, three qualified nurses along with two receptionists covering the trauma clinic. One of the qualified nurses was dedicated to covering the virtual trauma clinic. There were no vacancies.
- The trust had recently allocated a Matron specifically attached to outpatient's services across the trust. The trust had recently recruited two new Band 7 grades to share the four main outpatient hospital sites.
- All department managers told us that staff were flexible to ensure they provided cover for each clinic and department. There were no departments with significant vacancies to affect the way they could function.

Outpatients and diagnostic imaging

- Staff completed trust and local induction which was specific to their roles. We saw completed documentation in staff files showing successful completion of local induction. Staff told us that they had received appraisals. The 2015/16 trust wide appraisal report showed that staff were up to date with their appraisals. There were systems within departments to make sure that staff received an annual appraisal and the trust target of completing all appraisals by March 2016 was on track. In all departments, staff were encouraged to discuss development needs at appraisal and as opportunities arose.
- Managers told us they monitored staff sickness and rates were consistently low.

Diagnostic imaging:

- There was a site lead radiographer based permanently at NSECH. Radiographers worked on a rotational basis to staff NSECH and retain their range of skills.
- Rotation of radiology staff to the new hospital and departmental changes had caused some attrition. However, recruitment was now well underway and staff told us that once new starters were in post there would be enough staff. Existing staff were working overtime and bank shifts to meet service and patient needs and to have enough time to give to patients.
- Radiology provided a workflow coordinator on each shift to assess activity and schedule procedures.

Medical records department:

- The total staffing establishment for the bookings team was for 42 whole time equivalents (WTE) and there were two vacancies for part time staff and two staff were on long term sick leave. One member of staff was currently on secondment to the centre and working full time. Agency staff were not used. Team leaders encouraged staff to work together to cover planned and unplanned absences. The manager told us that they monitored the rate at which the work load was increasing on a quarterly basis. The last quarter report showed an increase of 17,000 notes requested and in response they had produced a business case for an increase in staffing levels.

Medical staffing

- The consultant orthopaedic rota included seven day a week medical cover for both trauma clinics.
- There was a national shortage of radiologists. The trust had four vacancies and had recorded this on the risk register. The department used the services of a locum breast radiology consultant on alternate weeks and a new locum general radiology consultant had started in post on the week of our inspection. At the time of our inspection, there were enough staff to provide a safe service for patients, and managers used NHS Waiting List Initiative (WLI) work to manage staffing shortfall.

Diagnostic Imaging:

- Two consultant radiologists were on duty on weekdays between 8am and 8pm. At weekends there was one consultant on duty from 8am and out of hours cover was outsourced.
- Diagnostic imaging reporting was routinely outsourced to meet reporting time targets. There was a service level agreement, quality assurance agreement, and contract written for this and radiologists undertook quality checks in line with the departmental discrepancy policy.
- The sickness rate for radiologists in the previous financial year, 2015, was 1.95%.
- There were two radiology specialist registrars who were supernumerary in order to facilitate their training on Mondays to Fridays. Registrars told us that they were provided with good working experience and radiologists and the department supported them well. The trust had secured funding for some additional specialist registrar posts.
- The trust carried out medical revalidation for all consultants radiologists.
- Consultant radiologists had annual appraisals with a named appraiser and used a clarity toolkit. They had dedicated SPA (supporting professional activities) time, study leave allowance and funding.

Major incident awareness and training

- We saw the major incident policies along with the business contingency plans available within departments. Staff had carried out a table top exercise across the whole hospital to test the major incident plan and emergency preparedness the month before our inspection.
- There were business continuity plans to make sure that specific departments could continue to provide the best and safest service in case of a major incident. There

were cross-trust agreements for support services such as pathology and radiology with service level agreements with local trusts. Staff understood these and could explain how they put them into practice.

Are outpatient and diagnostic imaging services effective?

Not sufficient evidence to rate

We are unable to provide a rating for effective in outpatient and diagnostic imaging services. However:

The service used creative and innovative approaches and ideas for care and treatment of its patients. They used modern technology appropriately to review patients, provide testing at the point of care, and ensure safety and quality assurance and to communicate with patients and staff. Staff followed professional best practice guidelines to plan and deliver good quality care and took part in a wide range of national and clinical audits.

The service was committed to develop its staff through their skills, knowledge, and competence. Staff were able to make use of opportunities to learn, develop, and share good practice. Multidisciplinary teams met daily and included both medical and non-medical staff. Discharge and transfer of patients to other trust sites and GPs was assessed and planned well to meet their care needs in the best way possible.

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

Evidence-based care and treatment

- Staff had developed standard operating procedures in line with best practice guidelines for streamlining fracture care and for specific fracture management within the emergency department and included detail of the initial treatment and ongoing management based upon the diagnosis. Staff followed these guidelines to determine the patients referral and ongoing treatment pathways based upon the diagnosis.

Diagnostic imaging:

- We saw reviews against IR(ME)R and learning sharedwith staff through team meetings and training.
- The trust had a radiation safety policy, which met with national guidance and legislation. The purpose of the policy was to set down the responsibilities and duties of designated committees and individuals. This was to ensure the work with Ionising Radiation undertaken in the trust was safe as reasonably practicable.
- Radiation protection supervisors for each modality led on the development, implementation, monitoring, and review of the policy and procedures to comply with IR (ME) R.
- Senior staff shared National Institute for Health and Care Excellence (formerly National Institute for Clinical Excellence, NICE) guidance to departments. Staff we spoke with understood this and other specialist guidance that affected their practice such as stroke and head injury pathways. All policies and guidelines were stored on the trust intranet. As staff received new guidance and directions, the department managers ensured updates to clinical practice.
- Procedures were followed to ensure the diagnostic imaging department were following National Institute for Health and Care Excellence guidance to prevent contrast induced acute kidney injury and evidence based documentation was completed before, during and after interventional procedures which included adaptations of the World Health Organisation (WHO) safer surgical checklist and National Early Warning System (NEWS) assessments.
- The departments were adhering to local policies and procedures. Staff we spoke with understood the impact they had on patient care.
- The diagnostic imaging department carried out quality control checks on images to ensure the service met expected standards.

Pain relief

- Pain relief advice was included as part of patients ongoing management plan and records showed the medication given to each patient.
- All patients reviewed at the virtual fracture clinic were offered pain relief advice and staff considered the on-going need for pain relief in all individual patient reviews and treatment plans.

Nutrition and hydration

Outpatients and diagnostic imaging

- The trust provided water fountains for patients use and there was a shop and a hospital café where people could purchase drinks, snacks, and meals.

Patient outcomes

- Staff ensured that following a patients initial treatment at the emergency department and urgent care centres, they received timely follow up and advice about the ongoing management of their injuries. Emergency department teams informed patients on the purpose of their referral to the virtual trauma clinic and what to expect from the service. The virtual trauma clinic involved the consultant reviewing the patients notes and x-rays from the previous day's attendance along with their medical histories. Following review a management plan was proposed and a specialist nurse would telephone each patient to advise them of the plan. If a patient could not be contacted a letter would be sent to advise them of the recommended care and treatment for their injury. The virtual review reduced the need for patients to attend the trauma clinic.
- There could be a range of clinical outcomes resulting from the trauma reviews: patients could discharged back into the care of their GP, be referred onto specialist clinics and/or for further planned follow up reviews in a clinic closer to their home.
- On the occasions where staff were unable to make contact with patients they sent a letter explaining to the patient that staff had tried to contact them and if they had any concerns to make contact. Staff wrote to patients GPs regarding the outcomes from the clinicians review.
- Waiting times within the trauma clinics were monitored and there were clear escalation plans in place with actions assigned for staff to follow if waiting times reached 15 to 30 minutes and from 30 minutes and above. Staff informed patients of waiting times. However, there were no clinic delays during our inspection.

Diagnostic imaging:

- Staff carried out audits throughout the radiology department. Audits included themes on correct completion of consent forms and health records including patient assessments in line with National Institute for Health and Care Excellence guidance. Where audits produced results different from what was expected or needed, managers reported results and made changes to procedures accordingly. Results were consistently good.
- Radiologists undertook a quality assurance audit on quality of reporting. They double reported 50 CT and MRI scans. Reporting radiologists and the clinical lead reviewed these.
- All diagnostic images were quality checked by radiographers before the patient left the department. Staff followed national audit requirements and quality standards for radiology activity and compliance levels were consistently high.
- The diagnostic imaging department key performance indicators included waiting times in all modalities for both in and out patients as well as emergency and general practitioner (GP or family doctor) patients and all met national standards.
- The Radiology department was part of all major pathways in the hospital. Examples included the stroke pathway and head injuries pathway, which staff developed through involvement of specialist staff.
- Managers in x-ray had compiled an audit and governance display board which was situated in the staff only area of the department. This showed trust and departmental data surrounding quality assurance, IR (ME) R, hand hygiene, radiology meeting minutes, complaints and compliments, IR1 minutes, clinical governance, risk assessments, action plans and duty of candour information.

Competent staff

- Staff completed trust and local induction which was specific to their roles. We saw completed documentation in staff files showing successful completion of local induction.
- Staff were encouraged to question practice if they had any concerns. The trust had agreed all local protocols and competencies. Managers held staff competency packs within the departments and staff were encouraged to attend courses to update their skills and knowledge.

Diagnostic imaging:

- Senior staff checked and documented staff competencies and medical devices training in all departments. Managers supported staff to carry out

continuous professional development activities, complete mandatory training, and appraisal and diagnostic imaging staff completed specific modality training and competencies. Radiation protection supervisors undertook annual training updates.
- Nominated key staff led on specialist information and guidance in radiology on areas such as radiation protection and education for referrers.
- The trust offered newly qualified radiographers the opportunity for career progression to Band 6 using Annex T: a competency framework to be achieved within a set timescale of 23 months from recruitment. Radiographers told us staff supported them to complete competencies. They believed this programme helped with recruitment of new radiographers to this trust when in competition with other local trusts.
- Medical students spent a half day of training with a consultant radiologist.
- Students were welcomed in all departments and students told us they felt supported and encouraged to develop when working within the departments. One radiography student told us the department had offered good opportunities to achieve the required learning for their placement. There was a designated educational lead for radiology who supported all radiography students. Several staff had chosen to work at the trust following student placements.

Multidisciplinary working

- There was evidence of multidisciplinary (MDT) working in all departments we visited. In the trauma clinics the onward management of the patients treatment could involve intervention from physiotherapy, radiography, plaster room technicians, and occupational therapy.
- Staff had links with other departments and organisations involved in patient journeys such as GPs, support services, community services, and therapies.
- Staff worked together towards common goals, asked questions, and supported each other to provide the best care and experience for the patient.

Diagnostic imaging:

- An MDT daily briefing meeting took place in the emergency department at 8am each morning. The site lead radiographer, or nominated deputy, attended every day to share information and raise any issues relevant to the location as a whole and which may impact on service provision for that day. Staff received this information at the x-ray team huddle.
- Medical staff could contact a duty Radiologist any time to discuss issues and to provide support to other doctors and staff throughout the trust. Doctors liaised with staff at other trusts and could refer patients with complex or specialist needs to regional centres such as oncology services.
- Radiologists regularly liaised and worked with staff at another trust and shared good practice.
- A play specialist accompanied children attending for investigations and procedures from the emergency paediatric department.

Seven-day services

- The trust provided trauma clinic services seven days a week.
- The trust had a centralised medical records library open 24 hours each day, seven days a week to support urgent retrievals, requests and returns of medical notes.

Diagnostic imaging:

- Diagnostic imaging provided services seven days a week. The trust provided a 24 hours a day, seven days a week service for emergency plain x-ray imaging, emergency CT, out of hours portable images and emergency theatre screening and imaging. Radiologists were on duty from 8am to 8pm seven days a week.
- An external company provided MRI but the trust had secured a managed seven-day service. There was a service level agreement incorporating trust policies and protocols with the private company that ran the MRI service. MRI staff attended trust training programmes. The service ran from 6am until midnight seven days a week. Trust radiologists reported the MRI scans but an outsourced reporting company provided reports out of hours; between 8pm and 8am.

Access to information

- All staff had access to the trust intranet to gain information on policies, procedures, National Institute for Health and Care Excellence guidance, and e learning.

Outpatients and diagnostic imaging

- Staff could find all patient information such as diagnostic imaging records and reports, medical records and referral letters through electronic records. Staff followed procedures if patient records were not available at the time of appointment.
- Staff used notice boards, emails, communications files, and diaries to pass messages and information between teams on different shifts. This made sure that information was documented and available for staff at any time.

Diagnostic imaging:

- Diagnostic imaging departments used picture archive communication system (PACS) to store and share images, radiation dose information and patient reports. Staff undertook training to use these systems and could find patient information quickly and easily. Staff used systems to check outstanding reports and staff could prioritise reporting and meet internal and regulator standards. There were no breaches of standards for reporting times.
- The diagnostic imaging department kept an electronic list of approved referrers and practitioners. Senior staff vetted internal and external staff against the protocol for the type of requests they were authorised to make.
- There were systems to flag up urgent unexpected findings to GPs and medical staff. This met the Royal College of Radiologist guidelines.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- Staff recorded patient difficulties in relation to capacity and consent at their emergency department attendance. Staff documented and escalated concerns at this point to the medical and safeguarding teams in compliance with trust policy. Staff told us it was unlikely they would refer patients with capacity problems to the virtual clinic and an appointment at the trauma clinic would be the preferred pathway.
- Staff training included understanding learning disabilities and mental capacity levels 1 and 2. The staff in the department had achieved overall training compliance scores of between 90 and 95% against a trust target of 85%.
- Nursing, diagnostic imaging, therapy, and Medical staff understood their roles and responsibilities and knew how to obtain consent from patients. They could describe to us the various ways they would do so. Staff told us they usually obtained verbal consent from patients for simple procedures such as plain x-rays and phlebotomy (taking blood samples for testing). In some general cases this was inferred consent.

Diagnostic imaging:

- Staff obtained consent for any interventional procedures in writing according to the pre-assessment policy before attending departments for endoscopy or biopsy procedures. Staff checked and confirmed consent at the time of the procedure. Staff adhered to the Trust Consent Policy.
- There was a trust policy to ensure that staff were meeting their responsibilities under the Mental Capacity Act and Deprivation of Liberty Safeguards. Staff completed this training as part of the trust Mandatory training programme.
- Patients told us that staff were good at explaining what was happening to them before asking for consent to carry out procedures or examinations.
- Staff obtained consent from patients undergoing endoscopy while they were on the ward.

Are outpatient and diagnostic imaging services caring?

Good

We rated caring as good because:

Staff respected patients privacy, dignity, and confidentiality at all times. Patients told us, and we saw without exception that staff treated them kindly, and in a caring and compassionate way at every stage of their journey. Staff spent time with patients and those close to them to give explanations about their care and encouraged them to ask questions.

There were a range of services and opportunities to provide emotional support for patients and their families. Staff at all levels were trained to identify when people needed emotional support with their care. Staff reacted compassionately to, or pre-empted patient discomfort or distress by using appropriate communication methods to suit individual needs. Staff involved patients by discussing and planning their treatment and patients could make informed decisions about the treatment they received.

Outpatients and diagnostic imaging

Compassionate care

- Staff interactions with patients in all areas we inspected were polite, courteous, and respectful. Staff in all departments we inspected were caring and compassionate to patients. We watched positive interactions with patients. Staff approached patients and introduced themselves, smiling and putting patients at ease.
- We spoke with five patients and three people close to them and all said that staff were friendly with a caring attitude. There were no negative aspects highlighted to us. We observed a staff member approach a patient to enquire how they were. The patient stated that they were hot. The staff member asked the patient if they would like them to open a window and to move nearer to it and offered a cold drink.
- One patient told us: "they speak to me nicely and kindly". Reception staff respected the patients privacy when they were checking personal details on arrival for their appointments.
- Managers used the Friends and Family Test (FFT) to obtain information from patients on their experience. Results demonstrated that staff were caring. The most recent results had shown that 87% of people would recommend the trust to others (slightly worse than the England average of 92%). 3% of patients or those close to them would not recommend it (the same as the England average).

Diagnostic imaging:

- Staff respected patients privacy and dignity. Staff took patients to private changing facilities with a lockable door to ensure privacy and dignity. Staff knocked on doors before entering and closed doors when patients were in treatment areas. Patients and relatives told us staff had treated them with dignity and respect.
- Staff personally escorted patients back to their respective ward areas.

Understanding and involvement of patients and those close to them

- Bookings staff sent out letters to all patients to confirm their appointment. They attached a comprehensive welcoming leaflet which included information on what to expect before and following arrival at their outpatient appointment. This included for example; transport, doctors in training, specific information for people with communication difficulties or special needs, appointment reminders and requesting feedback on their experiences. The bookings team arranged translation and interpreter services if requested.
- Staff provided patients with treatment information and information regarding their onward referral to the trauma clinics following their attendance at the emergency department and urgent care centres.
- Patients told us they were involved in their treatment and care. Those close to patients said nursing and medical staff kept them informed and involved. All those we spoke with told us they knew why they were attending the departments and agreed with their care and plans for future treatment. We saw staff explaining treatment.
- Staff told us they would invite families into consulting rooms as long as the patient was agreeable.
- Patients and families were given time to ask questions.
- A mother with her daughter stated that she felt: "very well informed" by staff and that"I have been informed of the tests I am having done and the reasons for them. The doctor explained everything. He was excellent and told me what was happening. Nice. Professional".
- A relative of a patient commented that she felt as though the staff really wanted to get to know her aunt by asking lots of questions. She was particularly pleased to see they were looking at how she would cope at home after the planned procedures.

Emotional support

- Patients told us they felt supported by the staff in the departments. They reported that, if they had any concerns, they were give the time to ask questions.
- Staff made sure that people understood any information given to them before they left the departments. Medical, nursing, and allied health professionals provided support for individuals and their carers to cope emotionally with their conditions, treatments, and outcomes.

Diagnostic imaging:

- Staff understood that a very anxious relative of a patient undergoing CT scanning had hearing difficulties. Staff spoke to both the patient and the relative in a clear and concise manner, checking understanding and allowing time for questions. Staff offered the relative the option, with patient permission, to be present during the procedure.

Outpatients and diagnostic imaging

- A play specialist accompanied children attending for investigations and procedures from the emergency paediatric department.

Are outpatient and diagnostic imaging services responsive?

Outstanding ☆

We rated responsive as outstanding because:

The service was flexible and ensured continuity of care. People accessed services in a timely and convenient way. The hospital provided a seven day a week consultant led outpatient trauma service for people from across Northumberland and North Tyneside to access, and a teleconference clinic for patients in Berwick, almost 60 miles away. Trauma clinics and related services were organised so patients only had to make one visit for investigations and consultation or, if possible did not have to return to hospital for unnecessary appointments. It also provided patients with timely advice on the management of their injuries while at home. Radiology reporting was swift with an emphasis on "results within minutes" for trauma patients. This enabled medical teams to complete assessments and manage risks quickly. Reporting times for urgent and non-urgent procedures consistently met or were better than national and trust targets for all scans and x-rays for emergency patients, inpatients, and outpatients.

There was widespread involvement with the local population, primary care, and commissioners to plan this new model of emergency care to ensure that the service met people's needs.

Staff made sure services could meet every patients individual needs, but in particular, those with conditions such as dementia, people with learning or physical disabilities, or those whose first language was not English. Staff, including reception and portering staff, knew how to support people living with dementia and had completed the trust training programme. The learning disability specialist nurse worked with departments in advance of patients with special needs attending for procedures.

Since the departments opened in June 2015, there had been no formal complaints. However, the department teams recorded any concerns and informal complaints and used patient feedback proactively to prevent recurrence that might affect others. They reviewed and acted on problems quickly and demonstrated an open and transparent outlook with the aim to learn from them and improve patient experience.

Service planning and delivery to meet the needs of local people

- The hospital opened in June 2015 following several years of planning and widespread public engagement. The hospital provided a seven day a week consultant led outpatient trauma service for people from across Northumberland and North Tyneside to access.
- The trust provided a drop off area for patients directly at the main entrance, disabled parking near to the main entrance and large parking areas manned by parking attendants offering direction to drivers.
- The trust has a shuttle bus service running between Wansbeck and North Tyneside General hospitals for patients and relatives to use.
- The trust has also worked with external transport agencies to develop shuttle bus services from a range of destinations to the hospital and the details are available on the trust website.
- The virtual fracture clinic was set up following a review of similar service provision at a facility in Glasgow and after pilots at trust base sites. A consultant orthopaedic surgeon and staff nurse working in the clinic at the time of the inspection confirmed this had been implemented to meet the needs of their patients across the trust, to address wide spread geographical issues avoiding the need for patients to spend time and cost in travelling unnecessarily to hospital and allow more patients to be reviewed in a shorter period. The virtual fracture clinic was a consultant led non-patient attended 7 day clinic where the team reviewed the patients injury, diagnosis, and considered treatment options. A consultant orthopaedic surgeon and staff nurse reviewed the patient records (24 at the time of our inspection and a maximum of 30 each session) and planned care and treatment accordingly. Staff informed patients by telephone and followed up in writing.
- The trust also provided an orthopaedic telemedicine clinic linking specialist orthopaedic staff at NSECH with healthcare colleagues and patients in Berwick through a video conferencing facility as an alternative to face to face appointments which staff commented was well received by patients. This avoided the need for staff and patients having to travel significant distances for review.

The team aimed to improve the service for patients as well as reduce the number of those who did not attend their appointments (DNAs). One staff member stated this has been "very positive" and a "great idea".

- Following the initial clinical review at the trauma clinics we saw patients requiring further ongoing management and follow up. Staff offered a choice of appointments at a clinic closer to their home.

Access and flow

- Did not attend (DNA) rates were at 6% (slightly lower than the 7% national average). The DNA rate had improved since the onset of an automated telephone system to remind patients seven days, and again one day, before their appointments. Clinicians undertook a review of referrals and medical records for patients who DNA. They completed an outcome form to determine further follow up actions.
- The numbers of patients referred to the trauma clinics varied from day to day. On the day of our visit five children and 19 adults had appointments at the trauma clinic.
- Access and flow for patients who needed to attend the trauma clinic was improved by only asking those to travel to the clinic when a face to face consultation or further investigations were necessary. Following clinical assessment of patients injuries, those who did not require admission to hospital were referred for onward management of their injuries to the trauma clinics.
- Consultants led the clinics and a team of medical records/reception staff supported them along with qualified and unqualified outpatient nursing staff on rotation from other hospitals. The majority of staff rotating to the trauma clinics were from Wansbeck General Hospital outpatients department.
- The virtual clinic reviews negated the need for patients to travel unnecessarily to hospital clinics while still providing them with timely advice on the management of their injuries while at home.
- The percentage of patients waiting for over 30 minutes to see a clinician in outpatients across the trust was 5.9%. There were no delays during our inspection at this site but staff told us they followed the trust protocol for delays and would tell patients about delays and the reasons for them. Outpatients staff audited patient waits from the time patients booked in at reception.
- Staff followed waiting time escalation plans with actions attached in the event of clinic delays. These actions included monitoring, staff reviews, discussion with medical staff and informing patients, escalation to senior managers, offering patients refreshments and recording extended delays as an incident. However, there were no delays during our visit.
- Waiting times within the trauma clinics were monitored and there were clear escalation plans in place with actions assigned for staff to follow if waiting times reached 15 to 30 minutes and from 30 minutes and above. Staff informed patients of waiting times. However, there were no clinic delays during our inspection.

Central appointment booking centre:

- Staff at the appointment bookings centre were responsible for managing the bookings of 2,000 clinics across the trust. They provided a point of contact for patients from 08.00 to 18.30 Monday to Friday. The centre was closed on bank holidays.
- The clinic bookings staff worked in teams for medicine and surgery along with the referral teams responsible for managing urgent two-week and 18-week referrals and choose and book referrals. All of the information was electronically stored.
- Team members showed us how patient two-week referrals were monitored which included the request for appointment, any patients not attending booked appointments, patients requesting appointments after the two week targets and the reason provided for this request.
- All clinic bookings were up to date.
- Operational service managers and clinicians within each of the specialities set the bookings rules and these included the schedules on the number and timings of patient appointments. The clinical business unit operational managers managed requests from specialists for additional clinics to assist in meeting increased capacity and demands of the service.
- Clinicians and clinical nurse specialists were responsible for triaging (an assessment to decide the order in which patients could be seen) patient referrals. There were no patient appointments made more than 13 weeks in advance.

Medical Records:

Outpatients and diagnostic imaging

- All of the medical records teams were dedicated and committed to ensuring patient notes arrived to clinics on time. Every member of staff we spoke with exuded pleasure and a pride in their role. They felt supported by senior managers. Staff found the Chief executive to be very approachable and they told us he had visited the department.
- The medico-legal team checked all requests for notes from external agencies.
- In diagnostic imaging, staff recorded the arrival time of every patient and explained any unexpected delays to individuals. Diagnostic waiting times for this trust had performed consistently better than the England average and for most months less than 0.5% of patients had to wait longer than the 6 week target time.
- On the occasions where staff were unable to contact patients they sent a letter explaining to the patient that staff had tried to contact them and if they had any concerns to make contact. Staff wrote to patients GPs regarding the outcomes from the clinicians review.

Diagnostic imaging:

- The x-ray department provided diagnostics within minutes for trauma patients. An example of this was when a consultant from the emergency department accompanied their patient with a suspected stroke to the CT scanner. The radiographer carried out the scan immediately and as the images appeared the consultant and on-call radiologist could see that a brain tumour was the cause of the symptoms. The emergency care consultant was able to change the patients care pathway immediately.
- Turnaround times for urgent radiology reports were 60 minutes with an allowance of 90 minutes outside normal working hours (between 8pm and 8am) for general scans and 30 minutes for urgent images such as those for suspected stroke patients.
- Reporting times for urgent and non-urgent procedures consistently met or were better than national and trust targets for all scans and x-rays for emergency patients, inpatients, and outpatients. Staff reported images for patients with head injuries or trauma within one hour, inpatient images on the same day, and urgent outpatients on the 62 day pathway within two weeks, and CT scans within 48 hours. 97% of trauma and head injury images within an hour. Reporting was routinely outsourced and at night they reported trauma images within one and a half hours. Reporting radiographers completed "hot reporting" on skeletal images for emergency patients. One example of this was when a patient with a suspected broken ankle had an x-ray taken and the image had been reported by the time the patient returned to see the doctor in the emergency department.
- Radiology staff told us that occasionally patients attended for routine x-rays after being sent by their GP. Staff explained to patients and GPs that the hospital was for emergency patients only but never turned anyone away.

Meeting people's individual needs

- Translation services were available for patients to access and staff were aware of how to obtain this service. The trust used two providers to ensure they maintained effective communication at the appointment. The translator could be arranged in advance or immediately should the need arise. At the weekend prior to the inspection, staff had accessed translation services for a mother (who could not speak English) attending with her 9 year old son (who could speak English) to ensure that the correct information was being passed on to her from the doctor. They confirmed this did make the appointment slightly longer than it would have been but the mother was very pleased that staff had arranged the service and that she didn't have to rely upon her 9 year old son's interpretation of his care.
- Staff used private areas to hold confidential conversations with patients and receptionists told staff quickly if patients had difficulties with speaking, listening, or understanding.
- Patient information leaflets, condition specific information, health promotion information and trust information was present in out-patient and x-ray areas. The information was easily accessible to all visitors and patients to the respective departments.
- Staff knew how to support people living with dementia and had completed the trust training programme. They understood the condition and how to be able to help patients experiencing dementia. Reception and portering staff informed us that they had received training in caring for patients who were living with dementia alongside their mandatory training.
- Patients attending appointments with memory impairment and learning difficulties were identified through their appointment bookings and staff would

ensure these patients were not kept waiting unduly. The learning disability specialist nurse worked with departments in advance of patients with special needs attending for procedures.

- Staff offered a choice of appointment times for those with children or if a patient had a particular need such as dementia where waiting in a busy waiting area could be distressing. Staff used a private room should a particular patient need this type of waiting area. Staff confirmed that priority was generally given to people with additional needs should it assist in their time at the out-patients department.
- Departments helped patients in wheelchairs or who needed specialist equipment. 'Meet and greet' staff were in attendance to assist people arriving at the main entrance. There was enough space to manoeuvre and position a person using a wheelchair in a safe and sociable manner. There were hoists for patients who needed help with mobility.
- There was bariatric furniture and equipment available in all departments (for people who were larger or heavier and could not use standard furniture).
- The departments were accessible for people with limited mobility and people who used a wheelchair. The main reception area held a store of wheelchairs and 'meet and greet' staff were in attendance to assist.
- Disabled toilet facilities were available in all departments.
- There were two outpatient waiting areas with plentiful and comfortable seating. In the main reception area, televisions were on display and showed information about the trust and health related topics. A sub-waiting area was also available beyond the main reception. The reception area had a designated hearing loop.
- There was easy to follow signposting for all departments.

Diagnostic imaging:

- Diagnostic investigations and procedures were organised to meet patient needs. Teams worked together and specialist procedures were organised so all investigations and consultations happened on the same day. Doctors, nurses and therapists worked together to carry out joint assessment and treatment.
- Staff had selected new CT scanners and x-ray equipment to enable access for larger and heavier patients.
- Staff had designed, modelled for, and produced posters for patient changing cubicles to demonstrate in step by step photographs how to put on a hospital gown.
- Staff had written information leaflets for patients on topics such as having a CT scan and a day in the life of a radiographer.
- The x-ray department had no formal reception however signage directed those attending to a small waiting area. The waiting area was clean and well maintained, provided comfortable seating, a water cooler, patient information leaflets, and a staff call buzzer facility. Radiology staff explained that the radiographer greeted patients in the waiting room and escorted them to the procedure room.
- Portering staff were present at the x-ray entrance however it was unmanned at various times during the day. Staff explained that in the original design for the department they did not expect patients to arrive unaccompanied but as the service had developed patients did attend without an escort. The trust installed a CCTV camera to enable staff to see when patients arrived. There was a small notice in the waiting area asking patients to wait for a member of staff to meet them.

Learning from complaints and concerns

- The trust complaints report from September 2014 to August 2015 showed there were no complaints or concerns recorded against the trauma clinic services.
- The trust had systems and processes in place to learn from complaints and concerns and we saw evidence from weekly business unit governance meetings, departmental meetings, safety and quality meetings that staff discussed complaints during these meetings.
- Staff understood the local complaints procedure and were confident in dealing with concerns and complaints as they arose. Staff in all departments told us they received very few verbal or informal complaints. They could identify patterns and themes from patient concerns and would help patients to use the patient advice and liaison service (PALS). Department managers shared lessons learned from complaints and concerns with their teams.
- None of the patients we spoke with had ever wanted or needed to make a formal complaint. Staff had listened

and dealt with their concerns and, where possible, had taken action to address the concern. Patients and relatives were all happy with the experience they received from the departments.

Diagnostic imaging:

- Since the new hospital had opened in June 2015 there had been no formal complaints made against the radiology service.
- Staff managed informal complaints and showed us logs of actions they had taken to address concerns and their outcomes.

Are outpatient and diagnostic imaging services well-led?

Outstanding ☆

We rated well led in outpatients and diagnostic imaging departments as outstanding because:

All staff within the outpatients and diagnostic imaging departments were clearly engaged with the new model of specialist emergency care at Northumbria and its associated support services. Teams were motivated and had been involved in planning and preparation for new departments and services. They evaluated their performance continually against the plans and were preparing for the year ahead.

Staff and managers had a clear vision for the future of the service. They knew the risks and challenges the service faced. Staff we spoke with at all levels felt supported by their line managers, who encouraged them to develop and improve their practice. Staff embraced change and there was a real focus on patient experience and leaders and managers drove this.

There were effective and comprehensive governance processes to identify, understand, monitor, and address current and future risks. These were proactively reviewed.

There were well embedded systems and processes for gathering and responding to patient experiences and the results were well publicised throughout the departments. Early feedback provided by patients for the virtual trauma service was very positive.

There was an open, honest and supportive culture where staff discussed incidents and complaints, lessons learned and practice changed. All staff were encouraged to raise concerns.

The departments supported staff who wanted to work more efficiently, be innovative, and try new services and treatments and ways of engaging with the public. Staff had received nominations and awards for innovation and changes in practice. Staff were proud to work in the new hospital and its departments. Staff worked well together as a newly formed, productive team and had a positive and motivated attitude.

Vision and strategy for this service

- Staff were aware of the trust's values and knew how to access this information from the intranet. A new member of staff was informed at induction of the vision and strategy for the service. They had the opportunity to meet the chief executive and ask questions regarding the trust vision and strategy.
- The quality strategy for 2014 to 2016 was publicised on the trust website and outlined the aims and key objectives of the strategy. It incorporated 'The Northumbria Way'; the trust's overall vision, values, and priorities.
- Staff were proud to work in the new hospital and departments and they enjoyed the opportunity to propose and make changes for new ways of working in line with changing needs and demands of the local population. Teams worked together to agree local ideas about providing the best possible seven-day service for patients. They focused on patient experience and care, which was driven by the hospital, directorates, department leadership, and staff.
- Teams were motivated and had been involved in planning and preparation for new departments and services. They evaluated their performance continually against the plans and were preparing for the year ahead.
- We saw business plans for all services and departments within outpatients and radiology. These included strategies for dealing with winter pressures and staff had contributed as teams towards these documents.

Diagnostic imaging:

- The radiology department were looking at staff roles and responsibilities with an aim to improve and streamline their services across the trust for outpatients

and GP patients. Managers had created eight reporting radiographer posts and four trainee sonographer positions to train existing staff, improve skills pathways and were providing training for operating department practitioners. These posts were introduced to improve ultrasound capacity, plain x-ray reporting levels and in response to the national shortage of radiologists.
- Radiology staff had presented a business case to provide a new service for small bowel radiology.

Governance, risk management and quality measurement

- In governance terms the outpatient services were part of the Emergency Surgery and Elective Care Business Unit. The unit had a number of committees all reporting to the governance group then onwards to the assurance committee then to the board.
- A governance system was in place with the production of incident summaries and themes, complaints, compliments, workforce statistics and data.
- A monthly strategy meeting took place that discussed finance, performance data including quality and timeliness of procedures and reporting, changes to clinical practice and audit activity. Staff were clear about challenges for the departments and were committed to improving the patient care journey and experience.
- The department risk registers were available and regularly reviewed to record and show actions taken regarding current risks. A lead officer was responsible for each risk and they gave descriptions of key controls to mitigate risks.
- Staff reported on risk, incidents, and complaints and could influence what risks were included on risk registers. Serious incidents were discussed at departmental meetings, led by the operational service manager and senior staff attended to discuss trends and serious incidents.
- Managers shared learning from incidents across the organisation using regular directorate and operational service manager meetings, and staff emails.

Diagnostic imaging:

- Diagnostic imaging staff carried out risk management as a team with modality (specialist diagnostic imaging services for example CT and ultrasound) leads and radiology protection specialists. The radiation protection advisor provided support and guidance in all aspects of risk assessment.
- The organisation checked up to date National Institute for Health and Care Excellence guidance to make sure they put any relevant guidance into practice; in diagnostic imaging, this included radiology related stroke thrombolysis and non-thrombolysis imaging times.
  CT radiographers were following National Institute for Health and Care Excellence guidance on reducing the risk of acute kidney injury and carried out an ongoing compliance audit on checklists for the use of CT contrast. The teams had developed guidelines to help prepare patients for the safe use of contrast and how to care for them following the procedure.

Leadership of service

- All departments we inspected had good leadership and management and staff told us managers involved them in strategic working and planning.
- The departments had clear management structures at both directorate and departmental level. There were clear lines of management support and accountability for the business unit as a whole. Leadership was strong, supportive and staff felt they were listened to.
- Staff had met the Chief Executive Officer (CEO) and the senior management team on more than one occasion and that they felt as though they could approach them with any issues or points they wanted to raise. Staff told us that the CEO brought a real energy and proactive approach to the service. Staff knew the executive team, who invited and listened to new ideas for change and sent out regular messages to staff.
- There was confidence and respect in the management. We saw good, positive, and friendly interactions between staff and local managers. Integrated teamwork was evident in all departments.
- Senior managers had strengthened nursing leadership of the outpatients service with the recent allocation of a Matron and two band 7 nurses had been appointed to share the four main hospital sites.
- Teams in outpatients and radiology had come together and worked on rotation from departments at Wansbeck, Hexham, and North Tyneside and although they had been working together for only a few months they showed respect and a positive attitude towards each other. Although some staff said they had felt this difficult at first, especially extra commuting time, they were motivated to succeed, and morale was good.

Outpatients and diagnostic imaging

- Managers followed recruitment and selection procedures to ensure staff were skilled and had relevant knowledge. One manager explained the protocol for recruitment regarding Disclosure and Barring Service (DBS) checks for all staff.
- Staff told us they completed annual appraisals and were encouraged to manage their personal development. Staff could access training and development provided by the trust and the trust would fund justifiable external training courses.

Culture within the service

- Staff were proud to work at the hospital. Staff commented that "it is a dream facility" and "it's just a great place to work".
- Staff told us they were openly encouraged to report incidents and complaints and felt their managers would look into them consistently and fairly. Staff were all aware how to report. Managers asked staff for their ideas on how to improve their service.
- Staff told us of an "open door" philosophy where staff are encouraged to speak with managers "on first name terms". Staff commented that they felt listened to. Staff described the culture as open and transparent. Some staff felt they were working under pressure with new systems and different working conditions but all were positive and motivated to do their best for patients and the organisation. Staff felt there was a strong culture to develop and support each other. Staff were open to ideas, willing to change and would question practice within their teams and suggest changes.
- Staff commented on the strength of teamwork and everyone pulling together during the transition and opening of the 'new hospital'. Staff told us there was a good working relationship between all levels of staff. We saw there was a positive, friendly, but professional working relationship between consultants, nurses, allied health professionals, and support staff. A staff member reported that working for the trust felt like being "part of a family where everyone supports each other".
- Staff at the appointment bookings centre told us that the team and managers were very supportive and helpful. One new starter had completed corporate induction training and was currently undertaking local induction training. They told us about local training they had completed and showed us evidence of plans for their further development in IT and human resources.

Diagnostic imaging:

- Consultants throughout the trust used the radiology service for advice and guidance and we saw them regularly visiting departments throughout our inspection. Staff told us that emergency care doctors regularly accompanied patients for scans and surgeons were happy with the service. There was good involvement of doctors with the radiology service across all the departments. Doctors approached radiology staff directly and we could see that staff worked well together as an extended team.
- Radiology staff told us how managers had acted quickly when staff had reported that self-closing doors had been causing problems when wheeling patients on trollies between departments. The trust had carried out risk assessments and removed spring closures from doors where it was safe to do so.

Public engagement

- NSECH opened in June 2015 following widespread public engagement.
- There were well embedded systems and processes for gathering and responding to patient experiences and the results were well publicised throughout the departments. As the hospital only opened in June 2015 results from the early feedback provided by patients for the virtual trauma service indicated 'it's a great service' and the patients were especially pleased as they didn't have to travel to hospital appointments unnecessarily.
- Staff collated information from patient experience surveys, "Two minutes of your time" questionnaires, PALS, and formal and informal complaints. Feedback was consistently positive.
- We saw information on public display informing patients on how to provide feedback on their experiences through the 'We're listening' feedback for staff, patients and public to let the trust know how to make services even better.
- The trust website enabled patients and the public to comment on the care they had received. Departments displayed compliments and complaints received.
- Staff reported early feedback from patients which indicated patients were especially pleased as they didn't have to travel to hospital appointments. One patient said 'it's a great service'. This was just one of several positive comments.

Diagnostic imaging:

- The radiology department had designed and introduced a survey to capture the thoughts of young people. It had not been successful but the team were undaunted and were working on another version to try to engage this population group.

Staff engagement

- The trust used a range of internal communication and engagement methods with staff. These included: weekly staff updates e-bulletins to all employees, monthly team briefs cascaded to staff from executive management, and a quarterly staff magazine. Staff were aware of this information and on how to access it from the intranet and extranet.
- Staff told us the executive team had undertaken road shows across the trust to update them on major developments and to enable staff to ask questions. The trust posted outcome notes from road shows on the intranet.
- Business units held local department meetings monthly. The agendas were standardised across the service to include a range of issues, for example, incidents and complaints, staffing, clinical risks, patient involvement and patient experiences, and education and training. This ensured staff were kept up to date with operational and performance delivery as well as the patient experience across the services.
- Staff told us they took part in team meetings and were confident to talk about ideas and sharing of good news as well as issues occurring in the previous days or planning for anticipated problems. Staff felt they were listened to and they had opportunities to contribute towards the development of the new unit.
- Following the configuration of services and resource planning, when portering staff had begun working in the new hospital they felt their team was understaffed due to a higher number of patients attending than expected and the demand on their resource in x-ray. Staff felt that management addressed this issue immediately and allocated sufficient staff to assist with the demand.

Diagnostic imaging:

- Radiology staff contributed in the writing of standard operating procedures (SOPs) across the department and invited theatre staff to input into procedures involving their practice. Lead radiographers for mammography and fluoroscopy controlled the SOP for their own specialty.
- At the time of our inspection, there were no staff surveys available relating to the new hospital departments.
- Radiographers said since staff worked on rotation from other sites within the trust they did not yet feel like a true team. Managers had organised a Christmas party for all staff with the hope that a social event could pull the team together.

Innovation, improvement and sustainability

- The trust established the trauma clinics as part of the programme of streamlined fracture care and specific fracture management within the emergency department. Following clinical assessment of injuries from the previous day, patients who did not require admission to hospital were referred for onward management of their injuries to the trauma clinics. A virtual trauma clinic which did not require the patient to attend the hospital was also established. This involved the consultant reviewing the patients notes and x-rays from the previous day's attendance along with their medical histories. Following review a management plan was proposed and a member of the trauma clinic team (a doctor or a specialist nurse) contacted the patient by telephone to advise them of the plan and treatment. If staff were unable to contact a patient, they would send a letter to advise them of the recommended care and treatment for their injury. The virtual review reduced the need for patients to attend the trauma clinic.
- The effectiveness of the innovations within the virtual trauma clinic and the telemedicine facility were monitored and informal feedback from staff was, this was working well for the patients and in turn, having a positive impact for staff.
- The DNA rate had improved since the onset of an automated telephone system to remind patients seven days, and again one day, before their appointments. Clinicians undertook a review of referrals and medical records for patients who DNA. They completed an outcome form to determine further follow up actions.
- Staff told us that they were consistently asked for their input into new ideas and service improvement initiatives.
- Senior managers told us that changes to the consultant job plans and on call arrangements were still ongoing following the opening of the new hospital. The trust had

also identified a number work streams to look at efficiencies around population of clinics and clinic reconfiguration. This work was ongoing at the time of our inspection.

Diagnostic imaging:

- Radiologists and pathologists had developed a service with a North West of England trust to provide virtual autopsies. These were done out of hours and CT and MRI protocols had been developed for post-mortem imaging.
- Trust radiographers had received a Healthcare Innovation Award for their Radiographer Discharge programme by radiographer practitioners in minor injuries. This process facilitated the discharge of patients having soft tissue injuries directly from radiology by suitably trained radiographers. The idea was prompted by changes in the NHS such as the NHS Plan which encourages the crossing of professional boundaries to optimise expertise while improving patient care. This new and improved patient pathway provided many benefits including shorter waiting times and fewer trips between departments. The programme was in place at North Tyneside General Hospital and Wansbeck General Hospital when the Accident and Emergency departments were based there and it was planned to be rolled out as systems and processes settled at the Northumbria Specialist Emergency Care Hospital.
- Radiographers across the trust had been awarded "Radiography Team of the Year" in 2014.
- The radiology team had received the Health Education North East Allied Health Professional Service Improvement Award for their radiographer reporting service project.

Outstanding practice and areas for improvement

Outstanding practice

In critical care services:

- Over 300 days without an avoidable pressure ulcer and the overall safety thermometer results.
- Patient outcomes and the access and flow data were adjusted internally to monitor the standardised mortality ratio following the trust's change to the model of delivery of care.
- A member of staff had been nominated for multiple awards for their compassionate care: The NHS FAB stuff awards; patient champion of the year: North East and they came second in trust experience nationally.
- The pit stop handover for all admissions to the unit had been developed with human factors training using formula one pit-stop models, to facilitate a structured handover and improve patient safety.
- The culture of everyone was valued and had a voice seemed embedded in the daily multidisciplinary safety huddle.
- Staff considered patients individual preferences and evidently went out of their way to exceed expectations to meet their wishes particularly in end of life care.
- Staff had adapted the "This is me" booklet and used it for long term patients where they included information from relatives and visitors about patients personal preferences.
- The rehabilitation after critical illness service.
- Leadership of the service was excellent particularly in relation to the planning, preparation and the move to NSECH. Time was taken to engage staff in cross-site working prior to the move and work undertaken to standardise guidelines, procedures and equipment.

In children and young people's services:

- Planning for the new model of care and facilities in the hospital was excellent. Managers had fully engaged staff in planning which resulted in a smooth transition into the new build and services being quickly up and running. Following a training needs analysis, staff had received additional training to ensure they had the correct skills to deliver the new model of care. There was ongoing work to further support staff in adjusting to the new services especially in the Children's Unit.
- The volume of information collected from service users was outstanding. The trust had innovative ways of engaging with patients and used a number of different methods for collecting information. This was shared with managers and clinical staff in order to improve services for children and young people.
- A mother told us that whilst she was in recovery following the birth of her baby, a member of staff from the special care baby unit brought her a picture of her baby. She was extremely happy with this, as she was upset that she had to be separated from her new born baby. We thought this was extremely caring and responsive to her needs.
- A parent passport was in place in the special care baby unit. This was held and completed by parents to increase their involvement in caring for their baby. The passport summarised the parents confidence and competence in carrying out this care. Following discharge, it provided a record for other healthcare professionals to understand the continuing needs of the parents in caring for their baby.
- The trust was supporting a Consultant Clinical Psychologist in a longitudinal study to address the question of how health services could contribute most effectively to facilitating successful transition of young people with complex health needs from childhood to adulthood. The study involved young people from the conception of the research idea and throughout the course of the programme. Information from the study was fed into the National Institute for Care Excellence (NICE) as part of a consultation on draft guidelines on transition. The trust had a robust trust policy, which included transition and transfer of young people with long-term conditions and disabilities, which was being rolled out across business units. We thought the work on transition was outstanding.

In end of life care:

- The model of end of life care services working alongside acute services at NSECH and out into the community was an innovative and pioneering approach to care.

Outstanding practice and areas for improvement

- Specialist palliative care was aligned with emergency care to ensure patients received specialist palliative care at the earliest opportunity.
- The trust had responded to a higher than anticipated number of referrals to the specialist palliative care team by increasing the specialist palliative care resource within the hospital.
- The trust had adopted an innovative approach to providing an integrated person-centred pathway of care in partnership to provide services that were flexible, focused on individual patient choice and ensured continuity of care.
- The trust had taken positive action to increase the number of patients who were dying in their usual place of residence.
- The trust was supporting increasing numbers of non-cancer patients.
- The leadership, governance and culture were used to drive and improve the delivery of high quality person-centred care through collaboration and partnership working. The trust had clear leadership for end of life care services that was supported at the top of the organisation.
- Investment in end of life and palliative care services was apparent and staff we spoke with consistently told us they felt that end of life care was a priority for the trust.
- Innovations were seen in relation to a focus on spiritual support and an assessment model that aimed to increase staff understanding of spirituality and confidence around assessment.
- Partnership working with Marie Curie and joint management and nursing posts enabled the trust to provide prompt support and continuity of care for patients being discharged to their preferred place of care in the community.
- The development of a tool for the assessment of patients spiritual needs that focused on providing staff with prompts that would make it easier for them to have this discussion with patients. The tool also helped staff to engage in a clearer way to ensure patients understood.

In outpatient and diagnostic imaging services:

- The hospital provided a seven day a week consultant led outpatient trauma service for people from across Northumberland and North Tyneside to access, as well as a teleconference clinic for patients who lived in Berwick, almost 60 miles away.

Areas for improvement

Action the hospital MUST take to improve

- Complete a comprehensive gap analysis against the recommendation made for the University Hospitals of Morecambe Bay NHS Foundation Trust.
- Ensure that the maternity and gynaecology dashboard is fit for purpose, robust and open to scrutiny.
- Ensure that the entry and exit to ward 16 in Maternity are as safe as possible to reduce the risk of infant abduction.
- Ensure that the storage of emergency drugs, within maternity services, are stored safely in line with the trust's pharmacy risk assessment.
- Ensure risk assessments in relation to falls, pressure ulcers, VTE and nutrition are consistently completed for all patients within medical care services.

Action the hospital SHOULD take to improve

Action the hospital SHOULD take to improve

- Ensure that levels of staff training continue to improve in the hospital so that the hospital meets the trust target by 31st March 2016.

In the emergency department:

- Ensure nursing care documentation is completed consistently throughout the department.
- Create a more dementia friendly environment (cubicle) to support patients with dementia.

In medical care services:

- Continue to review staffing levels on medical care wards.

In critical care services:

Outstanding practice and areas for improvement

- Review the nurse staffing establishment to consider the inclusion of an additional supernumerary registered nurse over and above the clinical co-ordinator as recommended in Core Standards for Intensive Care Units (2013).
- Review the provision of the critical care outreach service following the change in model of delivering care and in relation to national critical care outreach standards.
- Consider the role of a clinical nurse educator on the unit as recommended in Core Standards for Intensive Care Units (2013).

In Maternity and gynaecology services:

- The trust should ensure that the clinical strategy for maternity and gynaecology services which is embedded within the Emergency Surgery and Elective Care Annual Plan, sets out the priorities for the service with full details about how the service is to achieve its priorities, so that staff understand their role in achieving those priorities.
- Ensure all Patient Group Directions are signed by staff as appropriate.
- Consider sorting emergency drugs in tamper evident boxes if they are stored in an open ward area.
- Ensure that record keeping is consistent across all services.
- Consider reviewing midwifery staffing levels across the trust to ensure the midwife to birth ratio and NSECH is reduced from 1:36 to 1:28 as recommended.
- Consider the reconfiguration of pregnancy assessment unit to the Northumbria Specialist Emergency Care Hospital, to improve assess and flow of patients.
- Consider the provision of midwifery support for Teenage mothers in Northumbria in order to provide an equitable service throughout the Trust.

In children and young people services:

- Fully embed the duty of candour with all staff.
- Ensure patients clinical records are always available for children attending for day surgery at the hospital.
- Address the issue of clerical support at weekends in the Children's Unit, to ensure there is not a delay in sending out electronic discharge summaries to GPs.
- Ensure that non-qualified staff in the Children's Unit have clearly defined job roles and have robust competencies in place.

This section is primarily information for the provider

Requirement notices

Action we have told the provider to take

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

Regulated activity	Regulation
Maternity and midwifery services Treatment of disease, disorder or injury	Regulation 17 HSCA (RA) Regulations 2014 Good governance The provider must: • Complete a comprehensive gap analysis against the recommendation made for the University Hospitals of Morecambe Bay NHS Foundation Trust. • Ensure that the maternity and gynaecology dashboard is fit for purpose, robust and open to scrutiny.

Regulated activity	Regulation
Maternity and midwifery services Treatment of disease, disorder or injury	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 (Part 3). Regulation 12 (1) (a) (b) (g): Safe care and treatment. The provider must: · Ensure that the entry and exit to ward 16 in Maternity are as safe as possible to reduce the risk of infant abduction. · Ensure that the storage of emergency drugs, within maternity services, are stored safely in line with the trust's pharmacy risk assessment. · Ensure risk assessments in relation to falls, pressure ulcers, VTE and nutrition are consistently completed for all patients within medical care services.

This section is primarily information for the provider

Requirement notices

This section is primarily information for the provider

Enforcement actions

Action we have told the provider to take

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

This section is primarily information for the provider

Enforcement actions (s.29A Warning notice)

Action we have told the provider to take

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

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