Care Quality Commission

Northumbria Healthcare NHS Foundation Trust

Wansbeck General 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)	Outstanding ☆
Surgery	Outstanding ☆
Maternity and gynaecology	Good ●
End of life care	Outstanding ☆
Outpatients and diagnostic imaging	Outstanding ☆

Summary of findings

Letter from the Chief Inspector of Hospitals

Wansbeck General Hospital is one of the acute hospitals providing care as part of Northumbria Healthcare NHS Foundation Trust. This hospital provides emergency care from an emergency care centre, medical and surgical services, a limited maternity service which included a pregnancy assessment unit, ante natal clinics and elective gynaecology, end of life care and a range of outpatient and diagnostic imaging services. Wansbeck General Hospital does not provide critical care and children and young people's services. Services had been reconfigured in June 2015 when the Northumbria Specialist Emergency Care Hospital (NSECH) opened. The opening of NSECH had resulted in a new model of care and different patients pathways in emergency, medical and surgical care and maternity services.

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. Wansbeck General Hospital has 207 beds.

We inspected Wansbeck General Hospital as part of the comprehensive inspection of Northumbria Healthcare NHS Foundation Trust, which included this hospital, Hexham General Hospital, North Tyneside General Hospital, Northumbria Specialist Emergency Care Hospital, and community services. We inspected Wansbeck General Hospital between 10 and 13 November 2015.

Overall, we rated Wansbeck General Hospital as outstanding. We rated it outstanding for being caring, responsive and well-led, and good for being safe and effective.

We rated end of life care, medical and surgical services, and outpatient and diagnostic imaging services as outstanding. Urgent and emergency care and maternity and gynaecology services, we rated as good.

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.
- When we spoke with managers and staff throughout the hospital, the “Northumbria Way”, which incorporates the trust’s values, behaviours and culture, was evident.
- 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.
- There were processes to ensure patients were cared for in the right place at the right time. Patient flow was a priority, and the hospital proactively managed this.
- For all performance measures relating to the flow of patients the hospital was performing the same or better than the England average.

Summary of findings

- The transfer of patients between NSECH and the 'base' hospitals was still being embedded at the time of inspection and staff were working flexibly to accommodate patient needs.
- 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 at the time of inspection, compliance was high.
- Between April and October 2015 there had been no cases of methicillin resistant staphylococcus aureus (MRSA) at this hospital.
- In the same time period, the hospital had reported very low numbers of cases of c-difficile and MSSA.
- Nurse staffing was maintained at safe levels in most areas. The hospital had implemented a 'Safer Nursing Care Tool' (SNCT) to assess the staffing requirements across wards.
- The proportion of consultants and junior doctors at this hospital was very similar to the England average.
- 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.
- 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 surgical services:

- The development of the 'block room' had resulted in a streamlined approach to the recovery of patients following surgery.
- Guidelines for oncoplastic breast reduction and guidelines for best practice in reducing surgical site infections had been developed.
- 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.

In end of life care:

- The model of end of life care services at this hospital saw that dedicated palliative care beds were operated alongside a specialist palliative in-reach service to general ward areas. This meant that specialist staff worked alongside general staff to deliver effective, coordinated care within a holistic approach.
- Services worked across both acute and community settings with a strong multi-disciplinary ethos.

Summary of findings

- An Oasis room was available for relatives of patients at the end of life where they could rest or take time to themselves. The room was stocked by volunteers with drinks, snacks and toiletries using funds that were dedicated for this purpose.
- 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.
- 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.
- 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.
- The Palliative Care service had won the Quality Award for 2014 for their commitment to improvement and the excellent patient experience feedback received.

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.

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 care centre:

- Consider circulating guidance to staff about when to stop using the 'see and treat' model when the department is busy and revert to the triage model, to ensure patient safety and improve responsiveness.
- Consider training for reception staff to help identify patients who may need to be brought to the attention of clinical staff more quickly.
- Consider increasing the number of independent nurse prescribers to enable more flexibility in prescribing of medication in the ECC when there are no doctors available.

In Medical Care services:

- Ensure that resuscitation equipment is checked consistently, in line with trust procedures, on all medical wards.

Summary of findings

- Ensure that fridge temperatures are checked consistently, in line with trust procedures.

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.

In outpatient's and diagnostic imaging:

- Ensure waiting time targets in ultrasound in diagnostic imaging services continue to improve as more staff are appointed.

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 care centre at this hospital as good because: We observed that staff followed policies and procedures including infection control and medicines management. Cleanliness and hygiene were good and the environment was well maintained. Safeguarding processes to protect vulnerable adults and children were in place and referrals were made in a timely manner when necessary. The department used a 'See and treat' model. If the department was busy there were no clear guidelines about when staff should switch from the see and treat model to the triage model. There were sufficient medical and nursing staff employed by the department and staffing levels were acceptable. There were some areas where the department was not meeting the trust expected compliance rate for mandatory training however action plans were place to ensure that this was achieved by April 2016. Staff were up to date with annual appraisals. There were evidence based policies and procedures in place which were easily accessible to staff. These were audited to ensure staff were following relevant clinical pathways. Information about patients such as test results were readily accessible. There was evidence of multi-disciplinary working throughout the department and the department offered a seven-day service. Staff understood their responsibilities in relation to taking consent from patients and the principles of the Mental Capacity Act 2005. The care given to patients by the department was good. Privacy and dignity were maintained and people were dealt with in a kind and compassionate way. Staff ensured that patients received the care and support they needed. Patients and families were involved in decisions about their care and they had emotional support during difficult situations. Patients who visited the department had their individual needs met. Interpreters were available and there were facilities available to assist patients with disabilities or specific needs. Pain relief and nutrition and hydration needs of patients were met. Most patients were discharged within three hours of admission and four hour waiting time targets were met. The trust was

Summary of findings

performing better than the England average for a number of other performance measures relating to the flow of patients. Patient complaints were managed in line with the trust policy and feedback was given to staff. Lessons were learned and where applicable, practice was changed to minimise the likelihood of recurrence. Staff were fully engaged in the future development of the department and the vision and strategy of the trust were embedded in practice.
There were robust governance, risk management and quality measurement processes in place to enhance patient outcomes. Patient voice was seen as important and there were a number of initiatives within the trust designed to ensure that the opinions of patients influenced the delivery of services.
Staff felt that there was good leadership not only in the department but also within the trust. There was an inclusive, learning and supportive culture in the department and staff felt valued and appreciated. Staff were encouraged and supported to be innovative and we saw examples of innovative ways of working within the department.

Medical care (including older people's care) — **Outstanding** ☆

We rated medical care services as outstanding because: An experienced and cohesive team who demonstrated a clear understanding of the challenges of providing high quality, safe care, managed the medical services. They had identified and implemented actions and strategies to manage this and this had been done with the involvement of frontline staff. This meant staff we spoke with felt valued and were engaged with the process. Staff felt valued and were encouraged to contribute to service development. The directorate had a clear vision and business strategy. Governance processes were embedded 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. Feedback from patients and visitors was overwhelmingly positive. Patients felt involved in their care and their physical needs were not the only

Summary of findings

consideration. Patients and relatives understood what their plan of care was and were able to be involved with this. All staff were committed to providing high quality patient focused care.
Staff were encouraged to report incidents of harm or risk of harm and learning from incidents was demonstrated. The wards were visibly clean and organised. There was sufficient equipment but there were gaps in the daily checking of resuscitation equipment and fridge temperatures on some wards. The level of staff completing mandatory training was good and above trust targets. Medicines management was appropriate. There were some nurse staffing vacancies but the trust was recruiting to fill posts. On some wards planned and actual levels were not always consistent. However it was evident that staffing numbers of unqualified staff were increased to supplement the shortages. We were also told that staff were brought from other wards to assist during these periods.
The service participated in national audits and had a robust system of local clinical audits. Information about peoples care and treatment and their outcomes were routinely collected and monitored. Outcomes are positive and meet expectations.
There were processes to ensure patients were cared for in the right place at the right time. Patient flow was a priority, and the bed management team proactively managed this. The movement of patients during admission was monitored effectively.

Surgery **Outstanding** ☆

We rated surgery as outstanding because:
Senior managers had a clear vision and strategy for the division and identified actions for addressing issues within the division. 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 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

Summary of findings

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.
The trust had a commitment to a people centred approach delivering high quality care with robust assurance and used for continuous improvement. Staff were encouraged to challenge existing practices, look for improvements and suggest ways to develop and introduce innovative practice. Strong leadership and visibility of senior members was evident throughout the inspection. Staff felt motivated and shared the trust's vision and values. The trust was within the top 20% of trusts in England based on staff survey results. We saw constructive engagement with staff and managers at all levels. Leadership in the organisation inspired and motivated staff and staff told us repeatedly that they were proud to work for the organisation.
The number of operations cancelled by the trust was consistently below the England average. The trust was meeting the NHS operational target of 92% of patients waiting less than 18 weeks for treatment. Six theatres were open at Wansbeck General Hospital five days a week and also included regular weekend sessions.
Innovative practice was demonstrated through the development of the 'block room' (improving the recovery of patients following surgery), guidelines for oncoplastic breast reduction and reducing surgical site infections and the development of dedicated bone health clinics. A dedicated team had been set up to contact patients by telephone following discharge.
The services at Wansbeck General Hospital received consistent positive feedback scores and comments from patients through the NHS Friends and Family test, the local '2 minutes of your time' survey, a real-time feedback process and a social media feedback approach managed by the trust Communications and PALS team.
We observed patients cared for with dignity, compassion and respect by all staff. Without exception, patients felt involved in their care and valued. All patients spoken to gave positive feedback about relationships with staff.
Meeting people's emotional needs was embedded and documented in the care plans, with well-established and skilled staff providing post discharge support after surgery.
Performance showed a good track record in regard to patient safety. The service had reported no serious

incidents or never events at the hospital. We saw governance processes in place to ensure that incidents were discussed, and lessons were learned and communicated to staff in order to improve services. Skilled, competent staff were available across site and staffing levels were appropriate for the service delivered and recruitment processes were in place to fill vacant posts. Mandatory training at the hospital was attended by all staff groups and overall compliance targets had been achieved.
Patients were treated based on national guidance and the division took part in all the national clinical audits that they were eligible for. Local protocols had been developed for the effective handover of patients to NSECH when needed.

Maternity and gynaecology — Good

Overall we rated maternity services as good with the well-led domain rated as requires improvement because:
The service had effective systems in place for reporting, investigating and acting on serious adverse events. We saw that the supply of equipment, particularly in the antenatal clinics, was more than adequate. Medicines were stored and managed carefully and securely. The environment and equipment were clean and ready for use. Staff followed safety guidance for infection prevention and control. Staff planned care and treatment using strict admission criteria to support the assessment of patient risk so that complex births were handled by the consultant led unit at Northumbria Specialist Emergency Hospital (NSECH). Nurse and midwife staffing was appropriate. Medical staffing arrangements were such that they were available to attend as required which could lead to medical assessment and treatment being delayed.
The pregnancy assessment unit and gynaecology services provided effective care in accordance with recommended practice. Staff received the necessary training and assessment of competence so that they could respond appropriately to women's care and treatment. Midwives had supervision of their practice and opportunities for development.
The individual needs of women were taken into account in planning the level of support throughout pregnancy. Staff respected the privacy and dignity of women and their partners. There were no issues related to the demands on the service or fluctuation of workload.

Summary of findings

Women using the service could raise a concern and be confident this would be investigated and responded to. Formal complaints were dealt with according to the trust's policy.
However, 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 maternity dashboard.

End of life care

Outstanding ☆

We rated end of life care as outstanding because:
Leadership, governance and culture of the trust were designed to drive high quality end of life care services using an innovative model of working and effective partnership working. There had been significant investment in palliative and end of life care services and the trust was responsive to addressing the needs of the local population in the development of end of life care services across both acute and community. There was a clear vision, strategy and leadership at all levels of the organisation with a focus on good quality end of life care. 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.
There was a strong person-centred culture and we saw that staff were motivated and inspired to do more through a holistic approach to care and support. Examples included a trust wide emphasis on the assessment of spiritual, cultural and emotional needs

and additional support to patients and families around discharge home where services crossed acute and community boundaries to ensure people received the support they needed. Information demonstrated that more patients were dying in their usual residence than there were five years before and we saw clear plans to continue this trend and ensure an emphasis on patients preferred place of care.
We saw evidence of the use of national guidance and appropriate anticipatory prescribing of medicines at the end of life. There was a strong culture of multidisciplinary working across services within the hospital and the community. The use of a dedicated palliative care unit and hospital liaison meant that there was a culture of understanding of palliative and end of life care that was integrated across disciplines and with other services. Patients and their families were involved in care and we saw a number of initiatives in use and embedded to record patient wishes including advance care plans, emergency healthcare plans and treatment escalation plans.
The trust performed in the top ten NHS trusts in England in the 2014 National Cancer Patient Experience Programme national survey, with 95% of respondents rating the care as being excellent or very good. 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.

Outpatients and diagnostic imaging

Outstanding ☆

We rated Wansbeck General Hospital outpatients and diagnostic imaging services as outstanding because:
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. 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.
Outpatient 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. Waiting times for all types of appointments consistently met national targets. Some specialties had experienced capacity and performance difficulties but these had been well managed and resolved. All appointments were booked within acceptable timescales. Prior to emergency services moving to NSECH in June 2015, the radiology department had developed trauma image reporting, which was swift with an emphasis on "results within minutes" for emergency patients. This was the process that had been adopted at the new NSECH hospital and enabled medical teams to complete assessments and manage risks quickly. A radiographer discharge programme facilitated the discharge of patients having soft tissue injuries directly from radiology by suitably trained radiographers. The departments for outpatients and diagnostic imaging learned from complaints and incidents, and developed systems to stop them happening again. The departments delivered services to respond to patient needs and ensured that departments worked efficiently.
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.
Patients were happy with the care they received and found it to be caring and compassionate. Staff worked within nationally agreed guidance to ensure that patients received the most appropriate care and treatment. Trust policies protected patients from the risk of harm by making sure they met any individual support needs. Staff demonstrated understanding of these policies and followed them.

Wansbeck General Hospital

Detailed findings

Services we looked at
Urgent & emergency services; Medical care (including older people's care); Surgery; Maternity and Gynaecology; End of life care; and Outpatients & Diagnostic Imaging.

Detailed findings

Contents

Background to Wansbeck General Hospital

Wansbeck General Hospital is one of the acute hospitals providing care as part of Northumbria Healthcare NHS Foundation Trust. This hospital provides emergency care from an emergency care centre, medical and surgical services, a limited maternity service which included a pregnancy assessment unit, ante natal clinics and elective gynaecology, end of life care and a range of outpatient and diagnostic imaging services. Wansbeck General Hospital does not provide critical care and children and young people's services. Services had been reconfigured in June 2015 when the Northumbria Specialist Emergency Care Hospital (NSECH) opened. The opening of NSECH had resulted in a new model of care and different patient pathways in emergency, medical and surgical care and maternity services.

Northumbria Healthcare NHS Foundation Trust provides services for around 500,000 people across Northumberland and North Tyneside with 999 beds. Wansbeck General Hospital has 207 beds.

We inspected Wansbeck General Hospital as part of the comprehensive inspection of Northumbria Healthcare NHS Foundation Trust, which included this hospital, Hexham General Hospital, North Tyneside General Hospital, Northumbria Specialist Emergency Care Hospital, and community services. We inspected Wansbeck General Hospital between 10 and 13 November 2015.

The emergency care centre (ECC) at Wansbeck General Hospital is situated in the former Accident and Emergency department of the hospital. In June 2015, the department ceased to be an A&E department and became an emergency care centre. Patients who should attend the emergency care centre are those with minor illnesses and injuries, such as broken bones, nosebleeds, sprains, strains, cuts and bites. Children's minor ailments are also managed within the department. The department may accept patients who attend by ambulance but only after prior agreement by the department. More seriously ill or injured patients or those needing ambulance transport attend the Northumbria Specialist Emergency Care Hospital (NSECH) in Cramlington. Facilities at the Wansbeck Emergency Care Centre mean that patients who attend with more serious conditions are stabilised, kept safe and transferred by ambulance to NSECH.

Northumbria Healthcare NHS Foundation Trust provides medical care, including older people's care, across four sites including Wansbeck General Hospital. Northumbria Specialist Emergency Care Hospital opened on 16 June 2015 providing specialist emergency care for seriously ill and injured patients from across Northumberland and North Tyneside. The opening of this new hospital resulted in changes to Wansbeck General Hospital. Most medical admissions came from Northumbria Specialist Emergency Care Hospital and patients were transferred from there out to "base" sites which included this

Detailed findings

hospital. It had five medical wards and an ambulatory care unit. The medical wards at the hospital covered stroke / rehabilitation, respiratory, cardiology, haematology, ortho geriatric and general medicine. The hospital also has an endoscopy unit which is Joint Advisory Group (JAG) accredited, which provides planned procedures at this hospital. Emergency procedures are completed at the emergency hospital.

Surgical services at Wansbeck General Hospital were part of the wider hospital network, incorporating the Northumbria Specialist Emergency Care Hospital (NSECH) emergency care model. This allowed patients to access elective care at the hospital and ensured emergency support, using NSECH, was also available. The Hospital provides elective and non-elective treatments for breast surgery, colorectal surgery, gastrointestinal surgery, orthopaedics and urology.

Up until June 2015, approximately 2000 babies were delivered each year at consultant-led maternity services at the Wansbeck General Hospital; however since June 2015 there were no delivery services provided from this location. The Wansbeck General Hospital offered a limited number of maternity services which included a pregnancy assessment unit, ante natal clinics and elective gynaecology. Community midwives did not have an allocated base at this location, however, would attend the unit for advice or to review one of their clients. Miscarriage and termination of pregnancy was managed at Wansbeck.

The hospital had a 20 bed dedicated palliative care unit for patients with end of life and palliative care needs.

Patients requiring end of life care would also be cared for in ward areas throughout the hospital with support from the hospital liaison palliative care team. 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.

Wansbeck General Hospital provided a range of outpatient clinics covering the majority of clinical specialities, including general surgery, orthopaedics, urology, oncology and cardiology. The department had around 40 consulting rooms including private consulting and treatment rooms. The clinics were allocated into four separate waiting areas supported by a team of qualified and unqualified nurses.

Diagnostic imaging services were open from 24 hours a day, seven days a week. The department offered several imaging techniques including plain x-ray, CT scanning from 8am to 8pm with a service for head CT scans overnight, diagnostic ultrasound and mammography from 8am to 6pm Monday to Friday, and fluoroscopy which is a computerised tomography (CT) scan which 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. A private company managed the MRI scanning department independently from 8am to 5pm seven days a week. Trust radiologists provided reports for MRI scans. There was a designated children's outpatients service.

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.

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.

Detailed findings

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 10 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 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 Wansbeck General Hospital

Wansbeck General 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 saw 73,000 patients on wards, carried out 36,476 operations and is responsible for 1.4million appointments with patients outside of its hospitals.

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.

Since the new configuration of the department as an emergency care centre, from July 2015 to October 2015 the department has seen 7152 adult patients and 2407 children.

From January to December 2014 Wansbeck General Hospital undertook 125,021 outpatient appointments.

Detailed findings

From April 2014 to March 2015,193 medical and 113 surgical terminations of pregnancy were undertaken.

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	Good	Good	☆ Outstanding	Good	☆ Outstanding	☆ Outstanding
Surgery	Good	Good	☆ Outstanding	☆ Outstanding	☆ Outstanding	☆ Outstanding
Maternity and gynaecology	Good	Good	Good	Good	Requires improvement	Good
End of life care	Good	☆ Outstanding	☆ Outstanding	☆ Outstanding	☆ Outstanding	☆ Outstanding
Outpatients and diagnostic imaging	Good	Not rated	Good	☆ Outstanding	☆ Outstanding	☆ Outstanding
Overall	Good	Good	☆ 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

The emergency care centre (ECC) at Wansbeck General Hospital is situated in the former Accident and Emergency department of the hospital. In June 2015, the department ceased to be an A&E department and became an emergency care centre. Patients who should attend the emergency care centre are those with minor illnesses and injuries, such as broken bones, nosebleeds, sprains, strains, cuts and bites. Children's minor ailments are also managed within the department. The department may accept patients who attend by ambulance but only after prior agreement by the department. More seriously ill or injured patients or those needing ambulance transport attend the Northumbria Specialist Emergency Care Hospital (NSECH) in Cramlington. Facilities at the Wansbeck Emergency Care Centre mean that patients who attend with more serious conditions are stabilised, kept safe and transferred by ambulance to NSECH.

The department is staffed by a combination of consultant and junior doctors and GPs, emergency nurse practitioners (ENP), nurses and health care assistants. There is consultant medical cover from 9am to 5pm, GP cover from 5pm to midnight, Monday to Friday and ENP cover seven days a week, 24 hours a day. On-call medical cover is accessible by using the on-call medical team working across the wider hospital.

Since the new configuration of the department as an emergency care centre, from July 2015 to October 2015 the department has seen 7152 adult patients and 2407 children. As the new reconfiguration of services had been in place for four months at the time of our inspection, the staffing of the department and the number of patients attending had varied as the public became familiar with the new ways of working.

The ECC at Wansbeck General Hospital is part of the medicine clinical business unit.

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

Urgent and emergency services

Summary of findings

We rated the emergency care centre at this hospital as good because:

We observed that staff followed policies and procedures including infection control and medicines management. Cleanliness and hygiene were good and the environment was well maintained.

Safeguarding processes to protect vulnerable adults and children were in place and referrals were made in a timely manner when necessary. The department used a 'See and treat' model. If the department was busy there were no clear guidelines about when staff should switch from the see and treat model to the triage model.

There were sufficient medical and nursing staff employed by the department and staffing levels were acceptable. There were some areas where the department was not meeting the trust expected compliance rate for mandatory training however action plans were place to ensure that this was achieved by April 2016. Staff were up to date with annual appraisals.

There were evidence based policies and procedures in place which were easily accessible to staff. These were audited to ensure staff were following relevant clinical pathways. Information about patients such as test results were readily accessible. There was evidence of multi-disciplinary working throughout the department and the department offered a seven-day service. Staff understood their responsibilities in relation to taking consent from patients and the principles of the Mental Capacity Act 2005.

The care given to patients by the department was good. Privacy and dignity were maintained and people were dealt with in a kind and compassionate way. Staff ensured that patients received the care and support they needed. Patients and families were involved in decisions about their care and they had emotional support during difficult situations.

Patients who visited the department had their individual needs met. Interpreters were available and there were facilities available to assist patients with disabilities or specific needs. Pain relief and nutrition and hydration needs of patients were met. Most patients were discharged within three hours of admission and four hour waiting time targets were met. The trust was performing better than the England average for a number of other performance measures relating to the flow of patients. Patient complaints were managed in line with the trust policy and feedback was given to staff. Lessons were learned and where applicable, practice was changed to minimise the likelihood of recurrence.

Staff were fully engaged in the future development of the department and the vision and strategy of the trust were embedded in practice.

There were robust governance, risk management and quality measurement processes in place to enhance patient outcomes. Patient voice was seen as important and there were a number of initiatives within the trust designed to ensure that the opinions of patients influenced the delivery of services.

Staff felt that there was good leadership not only in the department but also within the trust. There was an inclusive, learning and supportive culture in the department and staff felt valued and appreciated. Staff were encouraged and supported to be innovative and we saw examples of innovative ways of working within the department.

Urgent and emergency services

Are urgent and emergency services safe?

Good

We rated the safety of services as good because:

There were systems to protect patients and maintain their safety. Incident reporting was common practice throughout the department and there were examples that staff learnt from incidents, near misses and errors. Cleanliness and hygiene were good and the environment was well maintained. Staffing levels were adequate to provide safe care to patients. Medication was stored and dispensed safely. Records were stored securely. Information held within records was sufficiently detailed and subject to clinical audit.

The department had processes in place for identifying patients at risk of harm and for assessing patients when they first presented to the department, as well as for monitoring and escalating the support of patients, when they remained in the department for extended periods or if they began to deteriorate. Staff mandatory training figures were below the trust standard for a number of subjects however, an action plan was in place to ensure that by the end of the year, all staff would be fully up to date with their mandatory training.

The department used a See and treat model. If the department was busy there were no clear guidelines about when staff should switch from the see and treat model to the triage model.

Incidents

- There were no serious incidents or never events reported by the department between June 2015 and October 2015.
- Between June 2015 and October 2015, there were 12 incidents in the Emergency Care Centre.
- Of the 12 incidents, nine resulted in no harm, two resulted in minor harm or damage and one resulted in moderate harm.
- The two most commonly reported categories of incidents were: abusive or violent behaviour from a patient and pressure ulcers.
- There was evidence that the trust took action to learn lessons and informed patients when there had been errors or potential harm. This demonstrated that staff were aware of the duty of candour and actively informing patients or their relatives when required to do so.
- Mortality and Morbidity meetings took place regularly across the directorate. They were attended by a member of staff from the ECC who reported any findings or lessons learned at departmental meetings.

Cleanliness, infection control and hygiene

- Since the reconfiguration in June 2015 the trust reported that there had been no incidents of MRSA (methicillin resistant staphylococcus aureus) or clostridium difficile in the emergency care centre.
- When we visited the department, we found it to be very clean. Patient rooms were cleaned in between patients and waiting area floors and seating were in good order.
- Patient toilets were clean.
- Staff could call cleaners to the department 'out of hours' if required however, health care assistants were responsible for general cleaning and wiping of patient equipment such as blood pressure machines. We witnessed staff carrying out cleaning of equipment between patients.
- There was ample personal protective equipment (PPE) such as aprons and masks available to staff. We routinely saw staff using this equipment during our inspection. Patients also told us that staff washed their hands and used gloves and aprons.
- The trust routinely monitored staff hand hygiene procedures. Compliance at the time of inspection was 100%.
- The department carried out monthly environmental audits and scored consistently above 95%.
- The department had a policy in place to ensure that patients who needed to be isolated could be done so safely. There were cubicles with solid walls and doors to ensure that patients who attended with potentially contagious conditions could be treated safely.
- We looked at the areas where equipment were cleaned and these were clean and there were cleaning schedules in place for all equipment, along with evidence that cleaning had taken place in line with the schedules.

- Medical and nursing staff undertook infection prevention and control training as part of their mandatory training. Medical staff were 89% compliant and nursing and midwifery staff were 29% compliant for the year to date.
- There were policies in place to ensure that clinical and other waste were managed safely. Environmental audits, carried out by staff, made sure that policies were followed and waste disposed of safely.

Environment and equipment

- The waiting area used by patients was well lit and had ample seating.
- Consulting and treatment rooms were an acceptable size and contained the necessary patient equipment. Privacy was maintained as much as possible using curtains.
- We found that equipment in the department had been safety checked. Most of the equipment we looked at had up to date tests however two pieces of equipment did not. We told the nurse in charge about this and the medical electronics department completed the tests on these items of equipment before we completed our inspection.
- As there were maintenance contracts in place, equipment was serviced and maintained in line with manufacturer's guidelines. The medical electronics team co-ordinated equipment servicing and repairs throughout the trust. To ensure accuracy the medical electronics team also ensured that equipment was regularly calibrated.
- We checked the resuscitation trolley and found that this was mostly checked daily however there were a small number of gaps in the records in both the paediatric and adult equipment records.

Medicines

- Medicines management was part of mandatory training. Compliance was at less than the department target of 85% for medication management, drug history compilation and reducing harm from medicines. There was an action plan in place to ensure compliance by April 2016.
- Medication was stored securely and fridge temperatures were regularly checked to ensure that drugs were stored at the correct temperatures. Medication was stored in an Omnicell directly linked to pharmacy who managed stock control. Omnicell is a computerised, refrigerated medication storage unit.
- Patient group directives (PGDs - specific written instructions for the supply and administration of medicines to specific groups of patients) were used in the department. We saw that staff had signed to say that they understood them. PGDs were up to date and had been reviewed appropriately.
- None of the emergency nurse practitioners (ENP) we spoke with were nurse prescribers. This meant that they could only dispense medication in accordance with the PGDs. These were very specific and meant that sometimes staff could not prescribe medication when patients did not fit the criteria of the PDG. Staff reported that there were occasions when patients had to go to another service, such as A&E, to get a prescription for the medication they needed.

Records

- We looked at the clinical records of seven patients who had attended the ECC on the day of our inspection.
- We saw that there was clear information about the patients presenting condition in the records.
- Medication and pain scores were not always completed however there were clear treatment and care plans. The support needs of patients were recorded where applicable.
- We had no concerns about the standard of record keeping. All of the records we looked at contained the necessary information about patients, such as presenting condition, diagnosis, treatment plan and any additional support needs patients may have.
- Staff were able to access records either in paper format if the patient had been seen recently, or in electronic format. Staff created paper records when patients attended. These records were kept in the department for three months and then scanned and archived.
- We discussed record keeping audits with the management team of the department. They assured us that record keeping audits took place every month. They informed us that the department performed well in these audits.
- All medical staff and 76% of nursing staff were up to date with Information Governance training.

- 89% of staff were up to date with Essence of Care record keeping training and 85% were up to date with Health and Social Care Records Management and Keeping training.

Safeguarding

- We looked at the processes and policies the trust had in place for safeguarding vulnerable adults and children. They provided staff with good, detailed information about the action they should take if they had concerns about any patients who attended the department.
- We spoke with a number of staff from all disciplines about the action they would take if they were concerned about the safety and welfare of patients. They demonstrated good working knowledge.
- We saw evidence that referrals for vulnerable adults and children were regularly made and information was routinely sent to health visitors about all children who attended the department.
- Staff knew about specific safeguarding topics such as sexual exploitation, people trafficking and female genital mutilation (FGM).
- The IT system used by the department routinely displayed the number of attendances patients had made during the previous 12 months. Where there were concerns about patient welfare, the system also displayed an alert to staff that gave specific details about any risks to the patient or to staff.
- All staff had undergone specialist training to treat children and used a specific tool to enable them to assess children and identify any specific safeguarding concerns.
- At the time of the inspection, safeguarding training overall was not meeting the trust expected standard of 85%. Training figures showed compliance as follows: Safeguarding adults level one 85%, safeguarding adults level two, 13% (three of 24 staff, trust standard was 66%), safeguarding children level two, 95% and safeguarding children level three 67% (33 of 49 staff). There was an action plan in place to ensure compliance by April 2016.

Mandatory training

- Staff told us they had no problems accessing mandatory training.
- The trust organised annual mandatory training days as well as using workbooks and e-learning to enable staff to complete mandatory training.
- Medical staff were not meeting the trust standard of training for 18 of 31 modules. They were meeting the trust standard for the following modules: deprivation of liberty, fire safety, health and safety, infection prevention and control, information governance, investigation of incidents, Mental Capacity Act level 2, moving and handling patients, safeguarding adults level one, safeguarding children and young people level two, slips trips and falls, specialty induction and trust induction.
- Nursing staff were not meeting the trust standard of training for 32 of 48 modules.
- We discussed levels of training with staff and managers who informed us that there was an action plan in place to ensure compliance by April 2016.

Assessing and responding to patient risk

- Between June and September 2015, 95% of patients were treated within 2 ½ hours and 95% were discharged within three hours.
- The department used a See and Treat model of care. This meant that patients were not formally triaged or seen within 15 minutes of arrival. Clinical staff relied on information provided by patients to identify how unwell a patient was. Reception staff listened for trigger words and phrases to help with this; however they had not had any formal training to assist them with this. If reception staff identified a patient using a trigger phrase, this patient was brought to the attention of clinical staff so that clinical staff could make a decision about whether the patient should be seen more quickly. There was a risk that poorly patients would not be identified quickly and a risk that because initial observations were not carried out, that deteriorating patients were difficult to identify.
- The trust had identified that between 6pm and midnight, the department was too busy to safely run the see and treat model and had employed a nurse specifically to triage patients. At other times, when the triage nurse was not working, if the department became busy, the triage model of care was used and one of the ENPs took on this role. There was no clear standard operating procedure or guidance about when to revert

to the triage model. Staff told us, and during our inspection we saw, there were times when patients waited longer than 60 minutes before being seen by any clinician.

- Staff reported that patients who were inappropriate to treat at the ECC regularly attended and had to be stabilised before being transferred to other services. There was a protocol in place to identify such patients and ensure that their transfer was safe. The frequency of this was being recorded and the trust was carrying out a piece of work to analyse the impact of these occurrences.
- When patients were identified as needing to be transferred to another service, staff ensured that the patient remained safe and was stable. A standard operating procedure was in place and patients were transferred by ambulance to the most suitable service for them, such as NSECH. We saw this happen during our inspection.
- Staff were fully aware of the action they should take if patients deteriorated and there was a process in place for staff to follow however when the see and treat model was in use, initial observations were not carried out, therefore it was difficult to identify if a patient had deteriorated since arriving to the department. Additionally, the waiting room was not within the direct eye line of clinical staff. There was a risk that deteriorating patients may be missed.
- There was emergency medical equipment in the department and most staff had undergone life support training. This meant that patients could be stabilised while an ambulance was called to transfer them to the most suitable service for them, such as NSECH.
- We saw that known patient allergies were recorded in patient records and patients with allergies were given a red wristband to wear to ensure that patients with allergies were easily identifiable.

Nursing staffing

- Although the department did not formally use an acuity tool, at the time of the introduction of the new configuration of the service, NICE recommendations for staffing levels had been adopted. Staff and managers told us that staffing levels were regularly monitored to ensure that staffing levels matched the demand for services.
- Nurse actual and expected staffing levels were displayed in the department and updated on a daily basis. We looked at the rotas for nursing staffing for the previous six weeks. We found that although there were some gaps in rotas, these were not excessive and nursing cover in the department was at acceptable levels.
- We saw that staff effectively communicated the presenting symptoms and care needs of patients to colleagues starting the new shift or taking over responsibility for care. We had no concerns about the handover process.
- There were qualified members of the nursing team who worked in advanced roles as emergency nurse practitioners, treating patients over two years of age with minor injuries and illnesses.
- All nurses had undergone training to treat children and used a triage tool to assist with triage.
- The manager of the department told us that there were currently seven nursing vacancies in the department. The trust was in the process of recruiting further staff. There were no health care assistant (HCA) vacancies.
- Internal bank staff were used to manage absences and annual leave.
- Information sent to us by the trust showed that from July 2015 to October 2015 there was 11 hours of agency use in the ECC which was very low.
- We saw that there was a local induction in place for all new staff including temporary staff.
- Newly qualified staff were given preceptorship (mentoring and support) and newly employed staff shadowed existing staff prior to being counted as a member of the team for staffing purposes.
- According to information provided to us by the trust between April 2014 and March 2015 there was a nursing staff turnover rate of 2% (one staff) and a 0% HCA turnover rate.
- The sickness rate for nursing staff was 2.4% and for HCAs it was 5.9%.

Medical staffing

- Monday to Friday, the department was staffed by a consultant and junior doctor between 9am and 5pm and GPs with a background in A&E between 5pm and midnight. There was access to out of hours GP cover and the hospital on-call medical staff between midnight and 9am. Medical staff worked closely with local GPs to ensure cover. This meant that the department had at least 16 hours cover by a doctor at specialist trainee level four or above.

Urgent and emergency services

- Overnight and weekend cover were provided by GPs who could be supported by consultants based at the main NSECH site if necessary.
- We observed doctors discussing patients and handing over relevant information to colleagues both verbal and in written format. We had no concerns about this process.
- There were no medical staff vacancies in Wansbeck General Hospital ECC. Between April 2014 and March 2015 sickness was at 3.5%.
- There was limited locum use in the department and locums who were used were used regularly and were therefore familiar with the policies, procedures and organisation of the department.

Major incident awareness and training

- Staff in the department were aware of the role they would play if there was a major incident in the region. All staff told us that they would only accept patients with minor injuries who presented themselves. They would not accept ambulance patients.
- The department had a policy in place to manage patients presenting with suspected Ebola. There was sufficient equipment and a designated area of the department. Staff were aware of their roles and responsibilities in the event of a possible presentation.
- There was limited equipment available in the event of a major incident, such as hard hats, high visibility jackets, disposable body suits and washing equipment. These were stored in an area accessible to staff.
- The department had business continuity plans in place, in the event of system failures.
- The department had developed a plan to manage increased demand, particularly over the winter months, such as adopting the triage model rather than see and treat if demand was high.
- Security staff were based on the site and were accessible if required.
- The department could be locked down easily to ensure the safety of patients should the need arise. Staff were aware of their roles and responsibilities.

Are urgent and emergency services effective?

(for example, treatment is effective)

Good

We rated the effective at this service as good because:

There were policies and procedures in place and these were evidence based. Audits, such as for compliance with the College of Emergency Medicine (CEM) guidelines took place to ensure that staff were following relevant clinical pathways. The hospital was taking part in local and national audits and monitoring patient outcomes. It was performing within acceptable standards. Staff were able to access information about clinical guidelines. Information about patients such as test results were readily accessible.

Pain relief was offered to patients on arrival at the department and regularly during the duration of their attendance at the department. Patient and relative nutrition and hydration needs were managed and we saw patients being offered drinks and food while we were inspecting the department. Relatives also confirmed that they had been offered food and drinks.

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

Evidence-based care and treatment

- There was a wide range of departmental policies and guidelines for the treatment of both children and adults.
- Departmental policies were based upon NICE (National Institute for Health and Clinical Excellence) and Royal College guidelines. We looked at a reference tool available to staff and found that guidelines had been updated to reflect recent updates to NICE guidance.
- We saw evidence that the department followed NICE guidance for a number of conditions such as sepsis, head injury and stroke. Where patients presented to the ECC with these conditions, pathways were commenced and arrangement made to transfer the patients to the most relevant service, such as NSECH.
- Care was provided in line with 'Clinical Standards for Emergency Departments' guidelines and there were audits in place to ensure compliance.
- Local audit activity took place within the department to measure staff compliance with departmental guidelines.

For example, a new care bundle had been introduced to improve the care of patients with acquired kidney injury. This had been rolled out across all the ECC departments.

Pain relief

- CQC's national A&E survey 2014 showed that the trust performed 'about the same' as other similar trusts for the time patients waited to receive pain medication after requesting it.
- In the same survey, the trust performed 'about the same' as other similar trusts when patients were asked whether staff did everything they could to control people's pain.
- A local patient survey for April to July 2015 showed that 83% of patients thought that staff had done everything they could to control pain at Wansbeck hospital.
- We heard patients being asked if they required pain relief and it was noted if patients refused. Patients were checked regularly to see whether they needed further pain relief.
- We saw nurses use PGDs to give patients pain relief such as paracetamol and ibuprofen.

Nutrition and hydration

- CQC's national A&E survey 2014 showed that the trust performed 'about the same' as other similar trusts for the ability of patients to access food and drinks while in the A&E Department.
- Staff told us, and we saw, that there were food packs available for patients in the department. Sandwiches and drinks were available to patients and there were vending machines present that relatives and carers could access.
- We overheard staff asking patients if they wanted drinks or snacks.

Patient outcomes

- Between June 2015 and September 2015 the trust had a better than the England average rate for unplanned re-attendance at A&E within seven days at 0% compared to the trust threshold of 5%.
- Departmental staff took part in CEM audits where they were applicable however due to changes in configuration of the department, only some aspects of the audit were applicable to the department. Managers told us that data was aggregated across the trust and submitted as one trust, rather than as individual locations. The available audit results related to audits carried out prior to reconfiguration of services and therefore were no longer applicable to the service.
- The department had no CQUIN (Commissioning for quality and innovation) targets for 2014/2015 or for 2015/2016.
- Results of the 2014 A&E survey showed that the trust performed better than expected in eight of the 35 questions; time to talk, clear explanations, discussing anxieties and fears, confidence and trust, involving family and friends, explaining test results, purpose of medication and danger signals. No results were worse than expected.
- During the inspection we saw that waiting times were displayed in the waiting area along with information about the last time the board had been updated.
- Trauma audit research network (TARN) information related to the department prior to its reconfiguration and was no longer applicable to the current configuration of the department as an emergency care centre.

Competent staff

- According to information provided by the trust, between April 2014 and March 2015, 28% of nursing and health care assistant staff underwent annual appraisal. In the same year, 86% of the medical staff underwent an annual appraisal. Staff told us they had regular 'catch ups' with their managers.
- Staff felt well supported and able to discuss clinical issues openly with colleagues and managers.
- We saw evidence that not all staff were up to date with basic or advanced life support and advanced paediatric life support training. For example, we saw that 44% of medical staff were up to date with accredited advanced paediatric life support and 83% of nursing staff were up to date with paediatric life support training. No nursing staff were up to date with basic life support training. There was, however a plan in place to ensure that all staff would be up to date by March 2016.
- Health care assistants performed advanced roles such as taking blood. Staff were trained to put on plaster casts and take electrocardiograms (ECGs), among other duties.
- Newly qualified staff were given preceptorship by qualified mentors.

- Staff competencies were informally monitored throughout the year by senior members of staff and managers told us that action was taken to address any concerns about staff competencies. This applied to both medical and nursing staff.
- All staff were part of the revalidation scheme and we identified no concerns about compliance within the department.

Multidisciplinary working

- The ECC team worked effectively with other specialty teams within the trust for example by seeking advice and discussing patients, as well as making joint decisions about where patients should be admitted to.
- There was good access to psychiatry clinicians within the department with 24-hour access to psychiatric liaison staff by telephone.
- There was a substance and alcohol misuse liaison team available by telephone to support patients and staff treating them.
- Allied health professionals attended the department. This meant that patients who needed therapy input or assessment prior to discharge could be seen quickly and efficiently.
- There were local pathways in place, written in conjunction with local GPs and other community services including social services to ensure that patients were discharged with packages of care in place if this was required.
- The department worked closely with the ambulance trust, local GPs and the out of hours service to ensure that unnecessary attendances and admissions to the department were avoided.
- We saw that medical and nursing staff worked well together and communicated clearly and effectively about patients.

Seven-day services

- The ECC offered a seven-day service, with consultant cover between 9am and 5pm during the week and ENP cover 24 hours a day, every day. There was also on-call consultant cover, by telephone to NSECH so staff could seek advice if required.
- There was 24 hour seven day access to some diagnostic tests such as x-rays. Patients who needed more advanced testing were transferred to NSECH.

Access to information

- Staff were able to access patient information using the electronic system and using paper records. This included information such as previous clinic letters, test results and x-rays.
- When patients were transferred between sites, paper records were transferred with them. A verbal handover was given to the ambulance staff doing the transfer and the transferring clinician called ahead to the receiving site to pass on any relevant information.
- Clinical guidelines and policies were available on the trust intranet.
- There was no system in the department to track patients or record how long they had been waiting to ensure that they did not breach waiting times.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- We spoke with staff about the Mental Capacity Act (MCA) 2005 and deprivation of liberty safeguards (DoLs). Staff understood the basic principles of the Act and were able to explain how the principles worked in practice in the department. Staff were less clear about how DoLs worked in practice.
- Training figures for MCA level two for medical staff were at 86% and 71% for nurses. Doctors were 86% for DoLs. Nursing staff did not have to undertake DoLs training as part of their mandatory training.
- Staff we spoke with understood the need to obtain consent from patients to carry out tests and treatments. Staff told us that they accepted implied consent as the patient agreeing to a procedure. We saw evidence of staff explaining procedures to patients and patients agreeing to them. Consent training was not indicated as mandatory training for staff working in the ECC.

Are urgent and emergency services caring?

Good

We rated the level of care and compassion patients received as good because:

We witnessed patients being supported and receiving good treatment in the department. Patient feedback for the department was good.

Urgent and emergency services

Patients were involved in decisions about their care and treatment and diagnoses were explained in ways that patients could understand. There was a partnership relationship between patients and staff.

Emotional support was present for patients and wider support mechanisms were in place as required by patients and their relatives.

Compassionate care

- During our inspection, we spoke with four patients and two relatives. They described the care they received as caring and supportive. Patients described to us how staff treated them with dignity and respect. One parent told us about how staff had reassured their child and "even made her smile" when she was upset and in pain.
- Survey results from the trust showed that 87% of patients thought they had enough privacy when discussing their symptoms and 92% 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.
- The parents of two children attending the department told us that staff showed empathy towards them and their children and were understanding of their concerns.
- In the CQC 2014 in-patient survey for compassionate care the trust scored about the same as other trusts.
- In the Patient Led Assessment of the Care Environment survey (PLACE) for the last three years, the trust scored 93% for privacy, dignity and wellbeing (national average, 87%).
- In the 2014 Accident and Emergency survey the trust performed better than other trusts in eight of the 24 compassionate care questions. The trust scored 'about the same' as other trusts for the remaining 16 questions.
- The friends and family test showed that 94% of patients would recommend this trust's A&E/ ECC departments compared to a national average of 88%.However, response rates were low and the department carried out other patient engagement such as, "We're listening" and local patient surveys. Results from these were positive about the care and treatment patients received at Wansbeck General Hospital.

Understanding and involvement of patients and those close to them

- According to patient feedback, from April 2015 to July 2015, 90% 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%. 96% of patients thought that nurses and doctors listened to what they had to say and 79% of patients thought that staff addressed fears or worries they had. 84% of patients thought they were involved as much as they wanted to be in decisions about their care and treatment and 74% of patients had the results of tests explained to them in a language they could understand. 88% of patients were happy with the amount of information they received when visiting the department.
- During the inspection, we witnessed patients being given their diagnoses. Where fractures were involved, if patients wished to, they were shown their x-rays and breaks were pointed out and explained. We observed one young girl being shown the break in her bone in such a way that she wasn't scared any longer.
- Patients and relatives told us that staff were responsive to their questions and made sure they understood their care (or treatment pathways and next steps), before they left the department. When patients needed to be transferred to another hospital, staff were seen explaining how this would happen and what would take place once the patient arrived at their new destination.

Emotional support

- We observed staff talking with patients and relatives offering reassurance to both concerned patients and their family members. This was done in a calming way.
- According to patients, staff offered support and gave information about support services if this was required.
- Staff could refer patients who presented with alcohol or drug problems (regardless of their age) to support services available under the 'Healthy Hospitals' campaign.
- To make sure patients felt supported during their treatment, staff were observed sitting with patients.

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

Good

Urgent and emergency services

We rated the responsive as good because:

The department and services around the region had been reconfigured to better meet the needs of the public. Patient pathways had been introduced to ensure that patients attended the most appropriate service to their needs. Patients who visited the department had their individual needs met. Since July 2015 the department had met the national four hour waiting time target and most patients were discharged within three hours of attendance. The trust was performing better than the England average for a number of other performance measures relating to the flow of patients.

Interpreters were available and there were facilities available to assist patients with disabilities or specific needs. Patient complaints were managed in line with trust policy and feedback was given to staff. Lessons were learned and where applicable, practice was changed to minimise the likelihood of recurrence.

Service planning and delivery to meet the needs of local people

- The management of the department were aware of the changing demands on the department and worked closely with the local out of hours provider to manage demand, for example, by identifying patients who had minor ailments and arranging for these patients to see a GP based in a department close by if this was appropriate.
- Managers were aware of the type of patients who attended the department and the potential major incidents that could occur locally and had ensured that the department had the necessary equipment and trained staff to manage such situations.
- Recent reconfiguration of services managed by the trust meant that some services had been consolidated on a different site. This meant that some patients had to travel a significant distance to access the department. The trust had tried to manage the situation by offering transport for patients as well as having a service level agreement with the ambulance trust to transfer poorly patients.
- The department had acknowledged the mental health needs of the local population and had good access to mental health services.
- Children under the age of two could not be treated in the department between midnight and 9am. At these times, walk in children went to NSECH and children travelling by ambulance were taken to the A&E department of the Royal Victoria Infirmary that was part of a different NHS trust.

Meeting people's individual needs

- The waiting room was large and spacious. This meant that the department was easily accessible to patients who used wheelchairs. Additionally, there were dedicated disabled toilets available.
- On average, 25% of patients that attended the department were under the age of 16. There was a dedicated paediatric waiting room. Treatment rooms for children were separate from the adult treatment area. This meant that young people were away from the adult waiting and treatment rooms.
- There were facilities, such as beds and wheelchairs, for bariatric patients.
- The trust had access to interpreting services for people whose first language was not English. Staff told us that in an emergency situation they may use a family member in the very first instance, but would try to access an interpreter as quickly as possible. The trust could also access telephone interpreters if necessary.
- Most patient information was available in different formats such as large print, audio, CD, braille and languages other than English on request.
- There were private areas for relatives to wait while patients were being treated. Although there was no dedicated relatives' room, there was a private room where people who were recently bereaved were supported. They could wait in privacy.
- The staff we spoke with about patients living with dementia (or a learning disability) all told us that they would treat patients as individuals. However, they would try to find out about them in order to make a decision about whether they needed any extra support, such as to be seated in a private area. Staff told us that whenever possible, people with dementia or a learning disability would be seen as quickly as possible in order to minimise distress for the patient.
- Some patients with learning disabilities had patient passports. When the patient or carer presented this at the department, staff used the information to assist them in making decisions about patient needs and wishes.
- If patients had specific needs, alerts were put on to the electronic record system to alert staff. The electronic

records system had a built in alert system that highlighted any patients attending the department who were at risk of self-harm, or of harming others. This made sure that staff were aware of safety risks to patients and to themselves. Security staff were called to the department when necessary, for the safety of patients and staff.
- Information about expected waiting times was clearly visible and updated regularly, with the time of update noted. This meant that patients knew how long they could expect to be in the department.
- For patients and relatives of all faiths or none there was 24 hour access to Chaplaincy services.
- Patients with purely mental health needs often waited in a designated room with two exits, both within sight of the medical station.

Access and flow

- Due to the recent reconfiguration of the department in June 2015, from an Accident and Emergency department to an emergency care centre , there was limited information about either the length of time patients waited to be treated, or a decision was made to admit, transfer or discharge them. Additionally, ambulance waiting times were too low to be statistically significant because only a very small number of patients were brought to the department by ambulance.
- Since July 2015, three patients had waited in the department for more than six hours before they were either admitted, transferred or discharged. However, 95% of patients were in the department for less than 180 minutes (3 hours) before being admitted, transferred or discharged. Delays were due to patients waiting for ambulance transfer to NSECH.
- The unplanned re-attendance rate for July 2015 to September 2015 was 0% (only one patient). This was significantly better than the threshold of 5% set by the trust.
- Only 1.7% of patients left the department before a clinician saw them. This was significantly better than the 5% standard set by the trust.
- Between July 2015 and September 2015, 99% of patients who attended Wansbeck General Hospital ECC were seen within four hours.
- From our observations and discussions with patients and staff, patients were treated quickly. None of the people we spoke with expressed concerns about excessive waiting times. We looked at the clinical records of seven patients. Five of the patients were in the department for 60 minutes or less. Two patients were in the department for more than 60 minutes. The maximum a patient was in the department was 85 minutes.
- Patients who needed to be transferred to NSECH occasionally experienced delays. Staff told us that this was because patients needed to be transferred by ambulance. Delays transferring patients were as a result of capacity issues within the local ambulance trust. The hospital trust and the local ambulance trust were working together to address capacity issues and possible delays. During our inspection, we saw that patients often had to wait more than 60 minutes for an ambulance to transfer them. We found that this did not have an adverse impact on patients, as they were safe, stabilised and often receiving preliminary treatment. Where patients were identified as deteriorating, a more urgent ambulance transfer was requested.
- Since the reconfiguration of the service, Wansbeck General Hospital ECC had had no black breaches. A black breach is when a patient waits more than 60 minutes to be handed over from the ambulance crew to the hospital staff. This was because the hospital no longer accepted ambulance admissions other than by prior agreement.

Learning from complaints and concerns

- Patients and relatives we spoke with were confident about how to make a complaint to the trust although none of the people we spoke with had complained about the department.
- There was information about how to raise concerns about the department (or the trust as a whole) on display in the department and there were leaflets available for patients to take away with them.
- Staff were able to describe to us the action they would take if a patient or relative complained to them.
- Between June and August 2015 there were five complaints received about the emergency care centre. Of these complaints, three related to all aspects of clinical treatment. There was evidence that complaints had been acknowledged and responded to in line with the trust's complaints policy. Feedback had been given to the staff involved and where appropriate, additional training had been given.

Urgent and emergency services

Are urgent and emergency services well-led?

Good

We rated well-led in the emergency care centre at Wansbeck General Hospital as good because:

Staff were engaged in the future development of the department and the vision and strategy of the trust were embedded in practice. There were governance, risk management and quality measurement processes in place to enhance patient outcomes.

Patient voice was seen as important and there were a number of initiatives within the trust designed to ensure that the opinions of patients influenced the delivery of services.

Staff felt that there was good leadership not only in the department but also within the trust. There was an inclusive, learning and supportive culture in the department and staff felt valued and appreciated. Staff were encouraged and supported to be innovative and we saw examples of innovative ways of working within the department.

Vision and strategy for this service

- The trust had introduced a vision and five core values as well as three areas of focus for continuous improvement. Staff we spoke with demonstrated these values in the way they spoke about the department and the way they interacted with patients who attended. For example, staff told us that they felt part of a team and that everyone within the team was as important as each other.
- The trust had recently implemented a new way of working across the entire trust and in particular, in the way urgent and emergency care services were delivered. Staff and managers were able to describe the vision for urgent and emergency care. Staff were aware that the model was still evolving, developing and adapting to the new ways of working.
- Managers in the department were aware of the changing demands on the department and the types of patients accessing the department. Work was continually underway to ensure demand was managed appropriately and safely. Staffing numbers were continually reviewed and revised.

Governance, risk management and quality measurement

- There was a clinical governance system in place across the department. Staff worked across sites and were able to attend clinical governance, patient safety and clinical audit meetings. We saw that information was shared with all staff by those who attended the meetings, and to ensure that all staff were aware of the outcomes of the meetings, minutes were circulated around the department.
- There was a process in place to ensure that all relevant NICE guidance and drug alerts were implemented and that staff were aware of any changes.
- The staff we spoke with were clear about the challenges the department faced. They were involved in discussions about future developments in the department.
- A departmental risk register was available and was under regular review to ensure that the content of the register was reflective of the real-time risks within the department.
- The trust held regular Mortality and Morbidity (M&M) meetings and staff frequently attended and discussed relevant cases at team meetings.
- Each morning, the consultant working in the department that day, reviewed the clinical records of patients seen over night to ensure that all patients received the appropriate care and treatment. They additionally reviewed any x-rays to ensure no fractures had been missed. On the occasions when a fracture had been missed, the consultant contacted the patient to inform them and advise them of any treatment they needed. Feedback was provided to the clinician who had missed the fracture.

Leadership of service

- We found that the leadership in the department was strong. During our inspection, we found that senior managers were visible within the department and readily available to support staff. Staff confirmed that this was the case.
- Staff told us that members of the executive team occasionally visited the department. Staff were

complimentary about the senior management of the trust and a number expressed their disappointment that the chief executive was leaving. According to the NHS staff survey 2014, 87% of staff trust wide, knew who their senior managers were. This was better than the national average of 84%.

- Staff felt that their hard work was recognised and they felt appreciated. Trust wide, according to the staff survey, 70% of staff felt that their employer valued their work. This was better than the national average of 65%.
- Nursing staff told us that they felt well-led at a local level and that they had no concerns with their line managers. They felt that they could raise concerns and be confident that they would be resolved whenever possible in a timely manner. They told us that the management team was open, approachable and provided good leadership.
- In the NHS 2014 staff survey, 56% of staff believed that staff who were involved in an incident, error or near miss were treated fairly. This was better than the national average of 48%.
- 57% of staff said they agreed or strongly agreed that they received feedback about changes made in response to incidents, errors, or near misses. The national average was 44%.
- We saw evidence from meeting minutes that nursing values (the 'six c's') were discussed with staff on a regular basis.

Culture within the service

- The structure of the department and the way we saw staff interact with each other demonstrated that there was an open and respectful culture.
- Staff told us that staff supported each other to learn from incidents.
- The trust scored better than the national average for fairness and effectiveness of procedures for reporting errors, near misses and incidents at 3.67 (out of 5) compared to the national average of 3.54.
- According to the 2014 NHS staff survey, 77% of staff felt that they would be secure raising concerns about unsafe clinical practice. This was better than the national average.
- Staff told us that although patients were always at the centre of everything, they also felt important and valued by their colleagues, managers and the trust. The national NHS staff survey showed that 84% of staff believed that care of patients was the trust's top priority. This was better than the national average of 71%.
- Overall, staff told us they were proud to work for the hospital. The team appeared to be efficient, and teamwork was clear from our observations at the inspection. Staff worked well with each other.

Public engagement

- The trust took part in the national Friends and Family initiative and carried out local surveys and questionnaires. Additionally, the trust had introduced an initiative called "We're Listening". This was a relatively new introduction however, preliminary results provided by the trust were positive.

Staff engagement

- We saw that regular staff meetings took place every month for both medical and nursing staff.
- The national staff survey of 2014 showed that the trust as a whole scored better than other similar trusts for staff working extra hours, staff witnessing or experiencing bullying or harassment and staff witnessing potentially harmful errors or near misses. There were no specific results for the emergency care centre.
- The national staff 2014 survey showed that the trust as a whole was performing better than other similar trusts in a number of areas such as: staff thinking their role made a difference to patients, effective team working, receipt of health and safety training, staff reporting errors, near misses or incidents witnessed, staff feeling pressure to attend work when unwell, staff motivation, staff receiving equality and diversity training in the last year and overall engagement. There were no specific results for the emergency care centre.
- Staff told us that they were kept fully informed about changes to the configuration of the department and were given the option to work solely at Wansbeck General Hospital, or to work some shifts at NSECH. Staff we spoke with were happy to work across both sites to enable them to maintain their skills in dealing with more serious conditions that were treated at NSECH.

Innovation, improvement and sustainability

Urgent and emergency services

- The configuration of emergency care services delivered by the trust was in itself innovative. There were three emergency care centres (Wansbeck General Hospital being one of them) and NSECH which cared for patients with greater emergency health needs.
- There were clear pathways in place for patients to ensure that they attended the most appropriate hospital to meet their needs, with ambulance patients taken to NSECH.
- The staff in ECC were able to speak to consultants using a video phone so the specialist clinician could see the patient. This meant that specialist advice was also based on visual information as well as verbal information.
- There is a hospital admissions avoidance team in place. They will arrange home visits from physiotherapy and occupational therapy to ensure patients are safe in their homes and avoid being admitted.
- As long as patient safety remained paramount, staff told us that the trust encouraged innovation and was supportive of staff who wanted to try new ways of working.

Medical care (including older people's care)

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

Information about the service

Northumbria Healthcare NHS Foundation Trust provides medical care, including older people's care, across four sites including Wansbeck General Hospital. Northumbria Specialist Emergency Care Hospital opened on 16 June 2015 providing specialist emergency care for seriously ill and injured patients from across Northumberland and North Tyneside. The opening of this new hospital resulted in changes to Wansbeck General Hospital. Most medical admissions came from Northumbria Specialist Emergency Care Hospital and patients were transferred from there out to "base" sites which included this hospital. It had five medical wards and an ambulatory care unit. The medical wards at the hospital covered stroke / rehabilitation, respiratory, cardiology, haematology, ortho geriatric and general medicine. The hospital also has an endoscopy unit which is Joint Advisory Group (JAG) accredited, which provides planned procedures at this hospital. Emergency procedures are completed at the emergency hospital.

We spoke with 15 patients, 27 staff members including the management team, doctors, nurses, social workers, therapy staff, health care assistants, and administration staff. We reviewed 11 sets of patient records. We visited all wards and the ambulatory care unit, where we observed care and the environment. We observed meals being provided to patients, nursing handover and a multidisciplinary team meeting. Prior to the inspection we reviewed the hospitals performance data.

Summary of findings

We rated medical care services as outstanding because:

An experienced and cohesive team who demonstrated a clear understanding of the challenges of providing high quality, safe care, managed the medical services. They had identified and implemented actions and strategies to manage this and this had been done with the involvement of frontline staff. This meant staff we spoke with felt valued and were engaged with the process. Staff felt valued and were encouraged to contribute to service development. The directorate had a clear vision and business strategy. Governance processes were embedded 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.

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

Staff were encouraged to report incidents of harm or risk of harm and learning from incidents was demonstrated.

Medical care (including older people's care)

The wards were visibly clean and organised. There was sufficient equipment but there were gaps in the daily checking of resuscitation equipment and fridge temperatures on some wards. The level of staff completing mandatory training was good and above trust targets. Medicines management was appropriate. There were some nurse staffing vacancies but the trust was recruiting to fill posts. On some wards planned and actual levels were not always consistent. However, it was evident that staffing numbers of unqualified staff were increased to supplement the shortages. We were also told that staff were brought from other wards to assist during these periods.

The service participated in national audits and had a robust system of local clinical audits. Information about people's care and treatment and their outcomes were routinely collected and monitored. Outcomes are positive and meet expectations.

There were processes to ensure patients were cared for in the right place at the right time. Patient flow was a priority, and the bed management team proactively managed this. The movement of patients during admission was monitored effectively.

Are medical care services safe?

Good

Services in medicine were safe because:

Staff said they were encouraged to report incidents of harm or risk of harm and learning from incidents was demonstrated. In particular, we saw patients at high risk of falls cared for in high visibility bays. Staff were aware of the statutory duty of candour and patients were provided with an explanation and apology following an incident. All staff clearly understood the safeguarding policies and processes.

The wards were visibly clean and organised. Most wards followed the 'well organised ward' model. There was sufficient equipment but there were gaps in the daily checking of resuscitation equipment on some wards. The level of staff completing mandatory training was good and above trust targets. Medicines management was appropriate.

There were some nurse staffing vacancies but the trust was recruiting to fill posts. On ward 8, 6 and 9 we found that planned and actual levels were not always consistent. The rotas showed shortages in the numbers of actual qualified staff against the planned staffing numbers. However, it was evident that staffing numbers of unqualified staff were increased to supplement the shortages. We were also told that staff were brought from other wards to assist during these periods.

The proportion of junior doctors and consultants within this trust were very similar to the national average. Although there was a slight increase in the number of appointed junior doctors.

Clinical records were well organised and divided according to medical and nursing input. All contained standard risk assessments and escalation plans where appropriate.

Incidents

- Staff at all levels said they were actively encouraged to report incidents including grade one-pressure ulcers.

They were confident about reporting incidents, near misses and poor practices. Staff were able to describe recent incidents and the actions taken because of investigations to prevent recurrence.

- Service wide a total of 65 serious incidents (SI's) were recorded from August 2014 to July 2015. The highest numbers of SI's were slips, trips and falls at 45 (69%).
- Between July 2014 and July 2015, there were 11,190 incidents reported trust wide. Of these 8,139 (73%) were reported as no harm and 22 (0.20%) reported as severe harm.
  - The number of reported NRLS incidents is higher than the England average at 10.6 for 100 admissions for the same period data was requested.
  - Matrons and ward managers advised us that they attended the weekly 'IR1 meetings'. At this meeting, all incidents reported during the previous week are discussed. Matrons and ward managers from all medical wards attend and discuss the incidents pertaining to their areas of responsibility including detailing the actions implemented.
  - The hospital used an electronic recording system. A ward sister told us that they share all incidents reported with doctors and at the handovers.
  - We were told that root cause analysis was completed if required, and again these would be fedback at the IR1 meeting and the monthly clinical governance 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.
  - A policy was in place for the reporting and investigation of incidents. We saw incidents reported electronically on an online reporting system.
  - We were told that safety incidents were discussed at team meetings and at safety huddles on ward 6.

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".
- We saw safety thermometer data displayed on every ward we visited during our inspection. Staff we spoke to were aware of the safety thermometer. 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**.**
- VTE assessment was variable on the medical wards. The lowest compliance was 83% on ward nine in July 2015; however data showed a gradual improvement in more recent months. Low single figures were recorded for falls resulting in harm on wards nine, eight, six and four between October 2014 and April 2015.
- Data for Wansbeck General Hospital showed ward two reported two CAUTI's between the same period. Ward three reported two and ward eight reported five. Ward three reported one new pressure ulcer grade 3 (September 2015), ward six reported three grade two (February 2015; March 2015; and August 2015), ward eight reported one at grade 3 (July 2015) and ward nine reported four. Three of which were grade two (November 2014; January 2015; and May 2015) and one at grade three (June 2015).

Cleanliness, infection control and hygiene

- The service had reported relative low numbers of cases of c-difficile and MSSA over a 13 week period up to June 2015 with all reported cases seeming to fall to zero in June 2015. Ward 8 experienced 1 case in September 2015 and ward 9, 1 case in April 2015 and 1 in May 2015.
- There was no methicillin-resistant Staphylococcus aureus MRSA bacteraemia from April to October 2015.
- All areas we visited were visibly clean and well maintained
- 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.

- Hand hygiene performance data displayed on the wards indicated that hand hygiene compliance was 100% across all grades of staff each week between 21st June 2015 and 23rd August 2015.
- The decontamination unit within endoscopy was to be replaced. However, the current system found to be safe and compliant with JAG requirements.
- We spoke with a ward manager who told us that hand hygiene audits were completed on a Monday each week to ensure consistency. This audit was delegated to a band 6 in her absence.
- We observed a porter entering and leaving a ward that did not wash their hands or use the gel dispensers provided.
- We observed a doctor use an empty gel dispenser on a ward but did not report this to anyone.
- Another ward manager told us that hand hygiene, commode, sharps bins and intravenous cannula audits were usually undertaken weekly but due to staffing pressures on her ward, the frequency was not always consistent.
- Infection control training showed 100% compliance against a trust target of 85% for the last 12 months.
- There were suitable arrangements for the safe disposal of waste. Linen that presented an infection risk was segregated and managed appropriately. Colour-coded bags segregated clinical and domestic waste. Sharps, such as needles and blades, were disposed of in approved receptacles.

Environment and equipment

- Staff on all wards said that equipment including falls sensors was readily available and any faulty equipment either replaced or repaired promptly. Ward 23 held a small amount of equipment stock at all times due to the dependencies of their patients.
- We checked the resuscitation equipment on all of the wards we visited. Records showed the resuscitation trolley on ward 9 was not checked for 5 days in October and 2 days in November 2015. We saw that ward 6 checked the trolley weekly.
- 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 approximately six items of equipment and found this consistent in all cases.
- Bariatric equipment was available for patients when required. All wards had appropriate disability access. There was access to bariatric equipment onsite. Staff felt that access to equipment was very good.
- Staff told us that the medical devices department coordinated the monitoring of equipment and calibration of scales each year. We saw the asset register and safetytesting schedule, which was up to date. The checks of sluice areas on most wards and commodes appeared clean and labelled with the date of cleaning.
- On ward 8, the ward manager told us that they had a system in place to monitor stock levels including expiry dates. This was part of the 'Well organised Ward' (WOW) initiative, which ensures ward equipment is stored consistently across the trust.
- We saw evidence of 15 steps audits, which were undertaken on most wards. One ward manager explained that they were aware of the process but found it difficult achieving non-clinical time to complete this.

Medicines

- There is a pharmacy on site at the hospital. 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.
- We reviewed the controlled drugs (CD) register on wards 3 and 6. This was found to be correct and up to date. A staff nurse told us that these were checked every Sunday night and staff signed the front of the CD book to confirm this.

- We checked the fridge temperatures on ward 6. We saw that ward 6 did not record the minimum and maximum temperatures until 21st September2015, however there were subsequent gaps in the recording.
- We checked the fridge on ward 3. It was found to be unlocked but kept in a locked room. The fridge temperatures had not been checked every day. Temperatures in October were not checked on the 1st-5th, 11th, 13th-15th, 17th-22nd, 25th-28th and 30th. We saw that fridge temperatures on ward 3 fluctuated significantly. We asked the ward manager to reset the fridge but she was not aware how to do this.
- A ward manager told us: 'Medicines don't always come with the patient from NSECH'. Staff advised that medications had been ordered ready for transfer but often it was found that they had had not been ordered.
- Staff told us: 'There had been times that medicines weren't available and the on-call pharmacist had refused to come out'. However, the trust told us that the out of hours pharmacy service is for emergency supplies and/or information only. Pharmacists use their professional judgment to decide whether or not to attend to make a supply of medicines.
- One patient record showed that Glyceryl trinitrate (GTN) was prescribed. The medication record showed it was omitted for two days as the medication was not available.
- These incidents were not logged on the datix system.

Records

- During our inspection, we reviewed eight sets of patient records. The trust used personalised in-patient nursing care assessment records which clearly identified which assessments had been completed at NSECH prior to patient transfer.
- Two patients records from three that we checked on ward 3 did not have a completed VTE risk assessment in place.The third had received an assessment on the 9th November 2015 but medication was not prescribed until the following day.
- A ward manager 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, falls stickers and medication review following a fall.
- Records were stored securely to ensure patient confidentiality, although there were open patient notes on the central desk area visible on many of the wards.
- Information governance training in the medical division was 100% for nursing and midwifery registered staff against a target of 95%. Essence of care record keeping was 100% and health and social care records management was 100% against a target of 85%.

Safeguarding

- All frontline staff we spoke with had received safeguarding training and were aware of their individual responsibilities regarding the safeguarding of both children and vulnerable adults. All wards we visited had an adult safeguarding pathway displayed in the ward area.
- The medical division-training rate in adults level 1 safeguarding was recorded as 100% against a target of 85%, adults level 2 safeguarding training was 100% against a target of 66% and children safeguarding level 2 was 100%. There was a system in place for raising safeguarding concerns. There was an established safeguarding team for both adults and children. Staff were aware of the safeguarding process and could explain clearly definitions of abuse and neglect. There were processes in place to obtain advice and support from the adult safeguarding team. The ward manager on ward 8 advised us that a member of the safeguarding team would attend all safeguarding meetings.
- We saw safeguarding events arranged for staff to attend to develop their skills and knowledge.

Mandatory training

- Levels of mandatory training within the medical division were above the trust targets. In most cases ward staff achieved results of 100% compliance, which was above the internal target of 80%.
- Staff told us that they were given opportunities to attend mandatory training.
- One junior doctor on ward 8 told us: 'I receive more teaching here than I have ever had'.

Assessing and responding to patient risk

- We saw an audit performed by the trust which concluded that all policies, procedures and protocols along with any associated training was in line with the requirements set out in the National Patient Safety Agency (NPSA) patient safety alerts.

Medical care (including older people's care)

- Early Warning Scores facilitate early detection of deterioration by categorising a patients severity of illness and prompting nursing staff to request a medical review at specific trigger points. We saw NEWS charts in use across all medical wards at the hospital.
- Information provided by the trust indicated 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 August, which showed completion at 97% however an appropriate response to triggers was only 50%. This would indicate that nursing staff are failing to appropriately escalate deterioration in a patient or medics are failing to respond when requested to do so. However, in more recent months rates had significantly improved.
- Sepsis is a common and potentially life-threatening condition triggered by an infection. It is estimated that sepsis claims 36,800 UK lives annually, and it carries a 35% risk of mortality. 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.
- The resuscitation team did not include an anaesthetist but the use of airways that did not require intubation had been introduced and this practice conformed to guidelines issued by the Resuscitation Council.

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. There were escalation procedures in place to address any staffing shortfalls.
- Planned and actual numbers of staff were displayed in each ward area.
- At the time of our inspection we observed on some wards we visited the actual qualified staffing was less than the planned qualified staffing numbers. This was supplemented with an unqualified member of staff. We were told that qualified staff could be moved from other wards to assist during these periods.
- On ward 6 we saw that the planned staffing levels were three RN's and 4 HCA's on days and 2 RN's and 2 HCA's on nights. On 11/11/15, there were two RN's and 3 HCA's on duty on the morning, and 2 RN's and 2 HCA's on nights. This meant that the actual staffing was less than the planned for day shifts.
- On ward 9, we saw that the planned staffing levels were 3 RN's, 2 HCA's on day shift, 2 RN's, and 1 HCA's on night duty. The actual staffing levels on 11/11/15 were 2 RN's; however, this was compensated for by having an extra HCA on duty. The night duty was covered at the planned staffing levels.
- However, Ward 2 showed a fill rate of 98% for qualified nursing staff and 100% for care staff. Ward 3 showed 100% for both.Ward 4 showed a fill rate of 99% for qualified nursing staff and 98% for care staff. Ward 6, 94% and 100%, ward 8, 97% and 100%, and ward 9, 82% and 100%.
- The ward managers we spoke with told us staffing establishments were not quite right but they felt assured that a recent acuity audit using the safer nursing care tool should address this.
- A ward manager told us that staff were often moved around the hospital to support wards that required it, and consistent agency staff were sourced to ensure safe clinical practice.
- We saw data relating to the emergency care and medicine business unit that showed 7 whole time registered nurse vacancies. This was trust wide for medicine.
- Data showed that there was a 5.9% sickness rate in the above medicine business unit.

Medical staffing

- The proportion of consultants and junior doctors at this trust was very similar to the England average**.**
- 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.
- The ratio of consultants was better than the England average. The trust showed 35% consultant cover compared to the 34% England average. Registrars were slightly below at 37% compared to the 39% England average. In the medical division, staff ratios were

comparable to the average national data, although there was a slight increase to the percentage of junior doctors employed by the trust. A review of staffing had increased the number of junior medical staff.
- A junior doctor told us that they received a ward induction when starting their placement.
- Weekend on-call arrangements consisted of 1x F1 or F2, 1x CMT and x1 Med Registrar but only until 12 p.m on Saturday.
- There was a geriatrician on-call from NSECH. Staff told us that there is 'always' an available geriatrician for advice.

Major incident awareness and training

- There was a major incident plan in place and staff we spoke with displayed an understanding of this.
- 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.

Are medical care services effective?

Good

We rated effective as good because:

Staff clearly followed national guidelines and policies. The service participated in national audits and had a robust system of local clinical audits. Information about people's care and treatment and their outcomes were routinely collected and monitored. Outcomes are positive and meet expectations.

The nutritional needs of patients were met and we received positive feedback regarding meals and nutritional support. There is a robust tool to measure patients levels of pain and this was incorporated into the core plan of care.

Staff appraisals were well managed. We saw effective multi-disciplinary team working with the 'hospital to home team' integration to ensure safe prompt discharge.

Not all healthcare professionals offer seven day service availability from this hospital. However, the support from NSECH ensures all cover is provided from Cramlington at the weekend and evenings.

Evidence-based care and treatment

- Staff used both the National Institute for Health and Care Excellence (NICE) and Royal College 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.
- Specific local audits were undertaken within each of the medical wards. Hand hygiene, cannulation, NEW's, catheter acquired urinary infections, DNACPR and controlled drugs checks. Sepsis audits are also completed but this is conducted by a specific team.
- 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.

Pain relief

- Pain relief was provided as prescribed and there were systems to make sure additional pain relief could be accessed if required.
- Patient records included the management of pain relief and were 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.

Nutrition and hydration

- Patients were assessed regarding their nutritional needs using the Malnutrition Universal Screening Tool (MUST). This was confirmed in the notes that we looked at.
- We saw that nutritional assistants were employed by several of the medical wards to provide patients with eating and drinking assistance.

- Mealtimes were protected, however visitors told us that there was flexibility to support relatives with their meals.
- We observed completed fluid balance charts, however there was no daily goal shown on any of the records that we observed.
- We observed dementia friendly crockery in use on the wards.
- Patients spoke positively regarding the choice and variety of meals in the hospital. We observed all patients had fresh water available and appropriate crockery at hand.
- Data showed that nursing and midwifery staff at Wansbeck General Hospital had a compliance figure of 85% against a target of 85% in the essence of care nutrition training.

Patient outcomes

- 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, Wansbeck General Hospital had an overall level of B. This is the second highest score possible.
- There were no active CQC outliers.
- Wansbeck General Hospital scored better or the same for the England average on 3 measures of the 4 in the 2014 Heart Failure Audit.
- The Myocardial Ischemia National Audit Project (MINAP) showed that Wansbeck General Hospital was worse in two and improved in one of the three measures compared to the previous audit. This hospital was below the England average in two measures and above in one.
- There was an acute stroke integrated care pathway and record for patients. We visited ward 9 which provided stroke and rehabilitation care, and we observed patients receiving therapy support.
- The average length of stay at Wansbeck General Hospital for non –elective general medicine was better than the England average of 3.3 against the national average of 6.4 for general medicine.
- Elective admissions were also better than the England average of 2.5 days against a national average of 3.5 for general medicine.
- The standardised relative risk of re-admission rate for non-elective general medicine was lower (better) than the England average of 94 compared to the national average of 100.

Competent staff

- We reviewed appraisal data at Wansbeck General Hospital which showed that, between 1st April 2015 and 30th September 2015, 24% of appraisals had been completed. However, this represents only part of the full appraisal year and plans were in place to ensure completion by trust target date. All staff receive full induction training which covers duty of candour and safeguarding awareness.
- A junior doctor told us that: 'I have had some of the best training here. My consultant will contact me when there are training opportunities available'.
- Another junior doctor told us: 'This is the best ward I have ever worked on. It's down to the team dynamics and the staff interaction'.
- Junior doctors were rotated across the hospitals including the new emergency care hospital to ensure all junior doctors had appropriate skills.
- Some SHO junior doctors (Core Medical Trainees) stated that they did not find their experience adequate at this hospital in terms of medical care, in that it did not give exposure to patients in the acute phase of their illness (which was all concentrated on NSECH).
- The consultants and managers recognised this and were actively working on ways to improve the experience. Foundation Doctors (FY1's and FY2's) did get some time at NSECH as did Registrars (Specialist Trainees).
- Within endoscopy a decontamination booklet for bands 3 and 5 have been developed but this is currently waiting to be ratified.
- An annual training programme is to be developed for endoscopy staff for input by lead consultant and specialist nurses.
- A matron told us that there was a robust revalidation programme in place which was reviewed by the matrons.
- A junior doctor told us that he was issued with an induction booklet which was developed specifically for new doctors as by the consultant. This was an overview of the ward and the important points to remember.

Multidisciplinary working

- Multidisciplinary teams (MDT's) worked well together to ensure coordinated care for patients. From our

observations and discussions with members of the multi-disciplinary team, we saw that staff across all departments genuinely respected and valued the work of other members of the team.
- On ward 8 we saw effective handovers and MDT working. Health care assistants were given clear direction and nurses prioritised high risk patients and those ready for discharge.
- Staff told us that they were supported by a specialist mental health nurse for patients diagnosed with a dementia.
- Within endoscopy the trust manages the programme for the North East bowel cancer screening.
- We spoke with the 'hospital to home team' who told us: 'this is a combined team consisting of social workers, occupational therapists, care managers and nurses'. The aim of the team is to: 'provide safe prompt discharges and provide short and long term care packages in the community as well as signposting patients to other health services'.
- We observed the 'hospital to home' handover in preparation for weekend discharges. The team prioritised safety issues and ensured equipment, medication and community services were in place.

Seven-day services

- Consultant cover was available Monday to Friday for the medical wards with a geriatrician available at NSECH at the weekend and during the night.
- Ward rounds took place in the morning with the medical team seven days a week.
- Staff we spoke to told us that there was access to on-call physiotherapists, radiologists and chaplaincy.
- Physiotherapy was available 7 days each week but occupational therapy Monday to Friday.
- The 'Hospital to home team' currently only worked Monday to Friday, however there were plans to extend this service to cover the weekend in the future.
- The trust provided seven day services for all emergency attendances and admissions using NSECH. It met all ten national standards for seven day working. A comprehensive transfer plan was in place for deteriorating patients to access emergency care seven days a week.

Access to information

- Doctors told us that they received test results and information in a prompt time frame.
- We saw the use of an 'app' for doctors which allowed them to view clinical policies and procedures directly.
- On ward 6 we saw a ward round in which a portable laptop was used so x-rays and blood results could be seen at the bedside.
- Guidelines were stored on the trust intranet system, which was accessible to all staff.
- The adult safeguarding pathway was displayed in all wards we visited, to ensure consistency across the trust.
- We were shown daily handover sheets which were updated each night.
- Ward sisters and matrons received bulletins through the medical division and incident alerts were sent electronically to them.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- The trust had a policy in place to cover DoLS. This included details of the appropriate process and contacts for when DoLS applications were required.
- Patients were asked for their consent to procedures appropriately and correctly. We saw staff obtaining verbal consent when helping patients with personal care.
- Staff told us that information on DoLS and the Mental Capacity Act was contained within an easy access folder.
- All staff we spoke with were confident in identifying any issues with regard to mental capacity and knew how to escalate concerns in accordance with trust guidance.
- We reviewed four patient records containing urgent and standard authorisation forms which had been completed fully. A referral was also made to the mental health team.
- We reviewed four patient records containing MCA documentation. Both assessments were completed and had been signed by families involved.
- Training figures for both Mental Capacity training and DoLS showed 100% compliance against a target of 85%.

Are medical care services caring?

Outstanding ☆

We rated caring as outstanding because:

Medical care (including older people's care)

Feedback from patients and visitors was overwhelmingly positive. There was a person centred culture. Patients felt involved in their care and their physical needs were not the only consideration. Patients and relatives understood what their plan of care was and were able to be involved with this. All staff were committed to providing high quality patient focused care.

All patients told us that all staff delivered compassionate care, which was polite and respectful.

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

Compassionate care

- The percentage of patients who, according to the National Friends and Family test would recommend the services, was consistent with or higher than the national average for 2014-2015. Data showed an overall score at 97%.
- Wansbeck hospital showed in October 2015 a 62% response rate on ward 9 with 100% of patients recommending the hospital. Ward 8 showed a 15% response rate with a 100% recommendation rate.
- The trust's 2 minutes of your time patient satisfaction survey showed that 98% of patients would be extremely likely to recommend this service at this hospital. With the service scoring 9.92 out of 10 for being treated with kindness and compassion.
- We observed staff discussing patients care during the daily safety huddles and MDT meetings with care, respect and compassion.
- We spoke with 15 patients during our inspection; all were very complimentary of the care they were receiving. Patients said staff were very helpful and provided a high standard of care. The 2014 National Cancer Patient Experience Survey results showed that 95% of respondents rated their care excellent or very good in 2014, compared to the England average of 89%. Of the 70 questions, 41 of the 70 responses rated the trust as within the top 20% of trusts nationally. 1 out of the 70 scored within the lowest 20% of the trusts nationally. This related to asking patients about their involvement in cancer research.
- We observed nurses on all wards we visited, responding to patient call bells in a timely manner.

Understanding and involvement of patients and those close to them

- Patients and relatives said they felt involved in their care.
- They told us they had sufficient opportunities to speak with the consultant and other members of the multi-disciplinary team looking after them about their treatment goals. This enabled patients to make decisions about and be involved in their care.
- Patients told us that if they did not understand any aspects of their care that the medical, nursing or allied health professional staff would explain to them in a way that they could understand. One patient told us: 'I felt informed as to what was going on'.
- Wansbeck Hospital performed better than the recommended target of 9.62 in the real time patient feedback analysis. Data asking if nurses were answering questions in a way patients could understand scored 9.71 in October 2015.

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.

Are medical care services responsive?

Good

We rated responsive as good because:

There was service planning and delivery to meet the needs of the local population, research programmes were in place both at local and national levels to ensure continuous improvement of patient care and treatment.

Programmes were in place to provide specialist and supportive care to patients and their families.

There were processes to ensure patients were cared for in the right place at the right time. Patient flow was a priority, and the bed management team proactively managed this. The movement of patients during admission was monitored effectively.

Medical care (including older people's care)

There was openness and transparency in the management of complaints. Complaints and concerns were taken seriously and lessons were learnt.

Service planning and delivery to meet the needs of local people

- The development and subsequent opening of 'The Northumbria' in June 2015 followed several years of discussion, planning and widespread public engagement. The Northumbria is the first purpose built hospital of its kind in England dedicated to providing specialist emergency care. Although the impact of this resulted in the transfer of all emergency care services from Wansbeck Hospital, the opening of 'The Northumbria' replaces these services with a state of the art emergency care department in Cramlington.
- Projects were in place across the trust such as older people's health champion's programme, a living with dementia course, which offers 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.
- We spoke with the 'hospital to home team' which was a combined team consisting of social workers, occupational therapists, care managers and nurses. The aim of the team was to: ' provide safe prompt discharges and provide short and long term care packages in the community as well as signposting patients to other health services'.
- We saw ongoing engagement with external stakeholders such as local authorities, health and wellbeing boards, and clinical commissioning groups. We saw evidence of quarterly forum minutes and bulletins.

Access and flow

- Patients were usually admitted from NSECH following initial assessment. However, admissions were also accepted through GP and consultant referrals. The bed management team would transfer patients coming from NSECH and ward staff at Wansbeck hospital supplied with basic patient details in the first instance. We saw completed patient assessment documentation for patients who were admitted in this way.
- Data showed that bed occupancy in September 2015 was 90% in general medicine and 87% for cardiology. The national bed occupancy target is 95%.
- We asked the ward staff what plans were in place for escalation beds. Currently all beds on all of the wards we visited were full and therefore staff were unsure what escalation plan was in place particularly during winter pressures.
- Staff we spoke to told us that that delayed discharges were sometimes due to patients waiting for discharge medications.
- Staff told us that the referral process to specialist teams was 'simple' and 'straight forward' and staff felt they were able to access specialist help whenever they needed it.
- Deteriorating patients within endoscopy are transferred to NSECH in emergency situations.
- The 'Hospital to home team' provided integrated discharge planning and support within the hospital discharge model to ensure prompt safe and effective discharge planning. Patients identified as 'safe' for discharge and requiring on-going support at home or residential / nursing care were discussed with the hospital to home team. We saw effective patient handovers and responsive discharge planning.
- The 18-week referral to treatment performance between April 2013 and May 2015 was consistently better than the England average and above the national standard. For example, in May 2015 the England average rate was 94%, however the trust was below 98% for the same period.
- Teams worked to ensure patients avoided multiple moves during a stay. Patients admitted to the Wansbeck from N.S.E.C.H, followed clear pathways of care, and escalation pathways were in place.
- Medical boarders were identified clearly and staff were able to explain how the appropriate teams saw patients. Data provided by the trust showed figures for 2014 – 2015 as a total figure of 907 for the Wansbeck hospital. However, the number of patients boarding were reducing month on month during 2015 - 2016. For example, in April 2015, there were 68, May 54, June 30, July 11 and August 8 for this period. The trust defines boarders broadly as a medical patient on a surgical ward or surgical patient on a medical ward.
- The hospital has a dedicated bed management team. The matron's held the bleep for this and there were daily team telephone calls three times each day to look at pressures across the medical directorate. Bed data was

captured at 09.30 and 16.00 each day. The nurse practitioner within urgent care at NSECH had bed management responsibility out of hours. This arrangement was in place seven days a week.
- Staff felt the greatest challenge to timely discharge was the availability of ambulances. However, staff were clear that patients would not be discharged after 8 p.m unless there was patient insistence and it was safe to do so.
- There were 326 delayed discharges waiting over 4 hours for the period of 1st May 2015 to 31 October 2015.

Meeting people's individual needs

- A ward sister told us that one to one supervision or nursing within a high visibility area was available for high-risk patients. We saw this in place for patients who were at a high risk of falls.
- Nutritional assistants offered nutritional support to patients who required assistance with feeding and drinking. We saw these staff on many of the wards that we visited. Most worked across two busy meal times, to enhance the support provided by care assistants and nurses.
- There were adaptations made to many of the medical wards to ensure they were dementia friendly, such as clocks, coloured door signs and crockery. Day rooms had visibly been adapted and improved.
- Ward 8 had recently been nominated for an award as part of the 'shared purpose trails'. This was in recognition for the dementia friendly changes made to the ward.
- The shared purpose programme is funded by the Health foundation and is in partnership with Age UK. It is a commitment to improve the dignified, compassionate and safe care we provide for elderly patients.
- Ward 8 also developed the 'This is me' red personal file for all patients, which contained care planning and treatment information in a patient friendly format. We saw these files at the patient bedside.
- We asked about support for patients with a learning disability. We were shown a file containing relevant guidance and advised that there was a nurse contact that they could use if they needed advice.
- Access to an interpreting service was available for patients whose first language was not English. We saw the use of communication boards to enable patients to make appropriate nutritional choices.
- 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 inseveral languages.
- To support and promote patients individual religious and cultural needs there were relevant information sheets available within the clinical areas.
- Chaplaincy services were available 24hrs a day 7 days a week.
- Ward 9 domestic staff created a social dining area from a bay no longer in use to enable patients to dine together at mealtimes.
- We saw dementia champions on many of the wards who provided support and advice to staff and relatives.
- The service had implemented the 'This is me' tool which supports patients and their families with dementia (A tool for people with dementia to complete that lets health and social care professionals know about their needs, interests, preferences, likes and dislikes).

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 trust had a positive approach to adhering to the duty of candour regulations, although not all staff were familiar with the term.
- Staff followed the trust's complaints policy and provided examples of when they would resolve concerns locally. A ward sister gave us an example when they went out to a patients home to resolve a complaint. Staff felt that they did not receive many complaints.
- 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 at staff meetings, and on the intranet and performance display boards. We saw examples of learning from this feedback for example, 'My New Medicines form', which was being trailed on ward 8 and was developed to remind patients as to which new medications had been prescribed during their time on the ward.
- Matrons had an "open door policy" to support patients and discuss any concerns and had developed an open culture to discuss all concerns.

Medical care (including older people's care)

- We saw evidence of learning from complaints at all levels from local supervision to board level. We saw the introduction of the medication lists handed to patients prior to discharge in response to complaints about lack of medication information.

Are medical care services well-led?

Outstanding ☆

We rated well led as outstanding because:

An experienced and cohesive team who demonstrated a clear understanding of the challenges of providing high quality, safe care, managed the medical services. They had identified and implemented actions and strategies to manage this and this had been done with the involvement of frontline staff. This meant staff we spoke with felt valued and were engaged with the process. Staff felt valued and were encouraged to contribute to service development.

The directorate had a clear vision and business strategy. 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. Diabetes research, in particular the long term self-management of diabetes, was at the forefront of medical research within the medical directorate.

Vision and strategy for this service

- The opening of the Northumbria Specialist Emergency Care Hospital (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 Wansbeck General Hospital. There were short-term strategies to manage situations, which had arisen because of the changes, for example a safer staffing review and a focus on recruitment.
- 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 reviewed the nursing and midwifery strategy document for 2015-2017 which was based on the trust's five-core values and had clear methods of delivery. It focused on staff and service user involvement.
- 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'.

Governance, risk management and quality measurement

- 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.
- 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 and performance dashboards at ward and divisional level measured the quality of care; we observed these on all wards we visited.
- 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 in to elderly medicine.

- Most of the staff we spoke with could talk about the duty of candour and provide 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 clinical internal audit activity covering a wide range, including sepsis, hand hygiene and nutrition. Data was displayed in public areas and action plans made where improvement was required.

Leadership of service

- We saw evidence of strong leadership and clinical engagement. Leadership was encouraged at all levels and staff 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. The 2014 NHS staff survey results, which showed 76% of staff reporting they feel able to contribute to improvements at workis higher than the national average, which is 68%.
- 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 are visible and senior managers are 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. It's one of the best wards I have ever worked in' were made. This was reflected in the NHS 2014 staff survey results, which showed a score of 3.89 for staff supported by immediate managers; this was higher than the national averages, which were 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.

Culture within the service

- The senior management team told us 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 feel work is an environment which gives freedom to make decisions and all staff are 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 observed strong multidisciplinary team working which was patient focused. Staff of all grades told us they felt valued and respected, 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 raise 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.

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 collect 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, each was given a score out of ten. Data was reviewed from the medical business unit for Wansbeck General Hospital for October 2015 and scores were between 8.04 and 9.93. All the wards we spoke with said they scored lowest for medicines and that this was largely due to the types of patient they cared for. The questions asked were around understanding of medications patient had to take and some patients found it difficult to retain this type of

information and relied on relatives/carers. A staff nurse told us that work was in place to try to address this by involving relatives in discussion on medication and working with the pharmacy team.

- Two minutes of your time feedback was also collected on dischargeThis asked six key questions about the care patients received during their in-patient stay. The questions relate to the patients experience of respect and dignity, care and treatment, involvement, cleanliness, and kindness and compassion.
- The service actively promoted projects relating to patient experience. An example of this was the 15 steps challenge. This is a series of toolkits, which are part of the productive ward work stream. It was developed by various staff groups, patients, and volunteers to help capture what good quality care, looks, feels, and sounds like. We reviewed 15 steps analysis of one medical ward at Wansbeck General Hospital, which took place in August 2015. They used the Care Quality Commission's 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.
- A ward manager told us about quarterly engagement forums with voluntary and community groups.

Staff engagement

- 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.
- Wansbeck General Hospital and its staff had experienced significant change because of NSECH opening in June. Staff told us they had felt involved in discussions and were kept informed of any changes.
- A registered nurse on ward 6 told us that 'stress meetings' were arranged during the opening of the new hospital to support staff.

Innovation, improvement and sustainability

- The ward manager on ward 8 told us that they had introduced recreational activities for patients such as board games, electronic tablet entertainment and social events.
- Comfort care packs have been developed for relatives who are staying for long periods or visiting for prolonged periods.
- 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 trust, 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 an '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.
- Stroke services were under review to improve the pathway and develop.

Surgery

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

Information about the service

Surgical services at Wansbeck General Hospital were part of the wider hospital network, incorporating the Northumbria Specialist Emergency Care Hospital (NSECH) emergency care model. This allowed patients to access elective care at the hospital and ensured emergency support, using NSECH, was also available.

Following the opening of NSECH on 16 June 2015, all patients requiring specialist emergency care are admitted directly or transferred from Wansbeck General Hospital, one of the three 'base' hospitals. Planned surgery considered high-risk is also carried out at NSECH and patients are transferred from Wansbeck General Hospital when required.

Patients who no longer required emergency treatment at NSECH were discharged to home or to Wansbeck General Hospital for further rehabilitation, care and treatment. At the time of inspection the arrangements for transfer of patients between NSECH and the base hospitals was being managed flexibly by staff to accommodate patient need and assessment of risk.

Wansbeck General Hospital provides elective and non-elective treatments for breast surgery, colorectal surgery, upper gastrointestinal surgery, orthopaedics and urology.

During this inspection we visited surgical wards 7 (trauma and orthopaedics) and 10 (surgery) and Ward 15 (day surgery). We visited all theatres on site and observed care given and surgical procedures undertaken.

We spoke with 17 patients and relatives and 15 members of staff. We observed care and treatment and looked at care records for 11 people.

Surgery

Summary of findings

We rated surgery as outstanding because:

Senior managers had a clear vision and strategy for the division and are up to date with the new model of care. Staff spoke very positively of their management team and felt supported The trust had a commitment to a people centred approach, and staff in surgical departments at Wansbeck General Hospital were focused on delivering high quality care. The trust approach to governance was evident with robust structures in place and an approach used for continuous improvement. Staff told us they were encouraged to challenge existing practices, look for improvements and suggests ways to develop and introduce innovative practice. Strong leadership and visibility of senior staff was evident throughout the inspection and those staff we spoke with felt motivated and shared the trust's vision and values. The leadership team and approach in the organisation inspired and motivated staff and they told us repeatedly of being proud to work for the organisation.

The number of operations cancelled by the trust was consistently below the England average. The trust was meeting the NHS operational target of 92% of patients waiting less than 18 weeks for treatment. Six theatres were open at Wansbeck Hospital five days a week and regular weekend theatre sessions were provided. One example of innovative practice was demonstrated through the development of regional anaesthesia for patients, reducing the need for general anaesthetic, and improving recovery for many procedures. A dedicated 'block room' in the theatre suite had been created and patients were involved and fully informed of the benefits and risks of anaesthetic block. The development of a new care pathway in surgery and dedicated bone health clinics for women surviving breast cancer is delivering high quality care with the patient at the centre. At Wansbeck General Hospital an 'anti reflux service' was provided to patients as day case with evidence of reduced length of stay and less complications. Excellent multidisciplinary team work was demonstrated in order to deliver this service.

The services at Wansbeck General Hospital received consistent positive feedback scores and comments from patients through the NHS Friends and Family test, the local '2 minutes of your time' survey, a real-time feedback process and a social media feedback approach managed by the trust Communications and PALS team. We observed patients cared for with dignity, compassion and respect by all staff. Without exception, patients felt involved in their care and valued. All patients spoken to gave positive feedback about relationships with staff. Meeting people's emotional needs was embedded and documented in the care plans, with well-established and skilled staff providing post discharge support after surgery.

Wansbeck General Hospital had a good track record in regard to patient safety. The service had reported 4 serious incidents and no never events at the hospital. We saw governance processes in place to ensure that incidents were discussed, and lessons were learned and communicated to staff in order to improve services. Patients care and treatment is based on evidence based national guidance and the division took part in all the national clinical audits that they were eligible for.

Skilled, competent staff were available across site and staffing levels were appropriate for the service delivered and recruitment processes were in place to fill vacant posts. Mandatory training at the hospital was attended by all staff groups and overall compliance targets had been achieved. Local protocols had been developed to ensure consistent and effective handover of patients transferring to other hospital sites. The multidisciplinary team were involved in shift handovers and communicated clearly the needs and risks for patients. All staff were aware of the policy and processes around recognition of the deteriorating patient and escalation of the patients care to the emergency site when required.

Surgery

Are surgery services safe?

Good

We rated safe as good because:

Performance showed a good track record in regard to patient safety. The service had reported 4 serious incidents and no never events at the hospital. Clear information was displayed for staff and patients to show safety thermometer data and very low numbers of incidences of patient harm were recorded. Staff were confident in the reporting of incidents and felt supported in doing so. We saw governance processes in place to ensure that incidents were discussed; lessons were learned and communicated to staff in order to improve services.

Skilled, competent staff were available across site and staffing levels were appropriate for the service delivered and recruitment processes were in place to fill vacant posts. Handovers were well planned and managed to ensure that patient information was accurately passed on. There was a comprehensive understanding of patient risk and recognition of the deteriorating patient and staff understood the policy for escalation and transfer of patients.

Mandatory training at the hospital was attended by all staff groups and overall compliance targets had been achieved or had an action plan in place to achieve compliance by April 2016.

The hospital environment was clean and we saw evidence of regular audits with regard to infection control measures. Medicines were also stored and administered safely across the surgical departments inspected at Wansbeck General Hospital.

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.

The trust had a safeguarding strategy and policy and all staff were aware of their responsibilities in safeguarding vulnerable adults and children.

Incidents

- Staff at Wansbeck General Hospital 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. There was a consistent cross site approach.
- Between August 2014 and July 2015 the hospital recorded 4 serious incidents. A good reporting culture was in place and 800 incidents were recorded in that period, of which 564 caused 'no harm' to the patient.
- The trust published an 'Open and Honest Care' monthly report on its website which gave people information on: safety performance; patient experience; and details of improvement when lessons have been learnt from incidents together with stories of patient experience.
- Staff told us how they reported incidents through the electronic system. Learning was shared through meetings, communication books and team briefings.
- Ward 7 demonstrated learning from a patient that developed a new blood clot (venous thromboembolism or VTE) in November 2014. Since the incident, documentation has been improved and risk assessment with 100% compliance was evident and all patients at risk had received appropriate prophylaxis treatment.
- Staff explained the arrangements for clinical governance meetings, including monthly ward meetings on Ward 7 and 10 and theatres. A folder of incidents and minutes was kept at ward level and Ward Managers operated a signature 'sign-off' system for staff to acknowledge they had read updates.
- Staff had knowledge and experience of escalation and transfer of a sick patient to critical care at the NSECH site. The national early warning score (NEWS) system for observations was used and to aid communication of issues a situation, background, assessment and recommendation (SBAR) tool was also used.
- Technology was utilised in assessment and for cross-site communication and knowledgeable and skilled staff were available at all times. A retrieval team was available and patients were stabilised in theatre prior to transfer. Good practice and patient safety was prioritised.
- Staff, including nurse practitioners and members of the multidisciplinary team, were involved in and attended monthly mortality and morbidity case review meetings. Due to changes in job plans and team locations meetings had been reorganised and rescheduled.

During this period of change, interim measures were in place to review mortality and concerns in the absence of formal meetings. We were told during the inspection that the new meeting structure was in place in surgery.
- Staff on Ward 7 and 10 had attended training in duty of candour although, at the time of inspection, they could not share any experience or shared learning.

Safety thermometer

- Wards 7 and 10 participated in the NHS safety thermometer. This tool was used to measure, monitor and analyse patient 'harm free' care. To assure people using the service that the ward was improving practice based on experience and information, safety thermometer data was displayed.
- This information was displayed in ward 7 and 10's entrances and was easy to understand; staff had knowledge of the displayed information and ward performance.
- We saw information for the past year 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.
- Ward 7 had one new VTE in November 2014 and had since taken action to achieve 100% compliance and harm free care. Between October 2014 and October 2015, ward 7 reported no other harm free incidents. The matron we spoke with reported 242 days without hospital acquired pressure ulcers in orthopaedic care on ward 7.
- Ward 10 displayed safety thermometer data which showed 100% harm free care in October 2015. No falls or new urinary tract infections with a catheter were reported during the same period and no avoidable pressure ulcers were reported at Wansbeck General Hospital between April and June 2015.

Cleanliness, infection control and hygiene

- The trust had an infection surveillance programme and an infection control team. Policies were available, and had current review dates on both paper copies and on the trust intranet. Monthly reports were generated and reported on clostridium difficile infection (C. difficile), and methicillin resistant staphylococcus aureus (MRSA).
- No cases of MRSA or C. difficile were reported in surgery at Wansbeck General Hospital during the previous year.
- We saw infection control audit activity and results were good at Wansbeck General Hospital. Surgical wards achieved compliance against a trust target of 98%. Ward performance boards displayed the incidence of infection clearly to patients and visitors. Ward 7, 10, day case unit (15) and theatres had no incidence of UTI's, C. difficile or MRSA reported.
- Throughout all surgical areas the infection control and hand hygiene signage was good and we observed staff washing their hands. Patients told us that this was done without exception. Hand gel was available at the point of care and in compliance with trust policy, staff used personal protective equipment (PPE).
- Throughout surgical areas we observed clean equipment. Staff completed cleaning records and domestic cleaning schedules, and used a tape system to identify clean equipment. Clinical and domestic waste disposal and signage was good. Staff that we observed disposed of clinical waste appropriately.
- Trust policy for linen storage, segregation of soiled linen in sluice rooms and the disposal of sharps was followed by staff.
- 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 made 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. A key priority was to reduce sepsis related deaths by 30% over the previous two years by improving timely recognition and treatment.
- We observed signage for isolation of patients in single rooms that was clear. Isolation was available for people with identified infection or for those who required pre-operative screening for infection, such as for MRSA prior to surgery.
- This reduced risk of infection for elective patients. The matron for surgery told us that it was rare that they received non-elective admissions and that Ward 7 beds in orthopaedics were 'ring fenced' to reduce or stop non-elective admissions and to prevent infection.
- Staff told us of the system and policy to request terminal cleaning after discharge of patients with infection or during outbreaks and we saw the domestic team was accessible and good practice was demonstrated.

- The trust carried out quarterly audits of adherence to its antimicrobial prescribing care bundle. This included individual audits of eight elements identified in the care pack. Data from February 2014 to August 2015 showed routine compliance was 99% across the trust.
- The rate of deep surgical site infections between April and August 2015 was narrowly greater than the national target average for hip replacements (0.8% compared to 0.7%) and knee replacements (0.7% compare to 0.6%).
- The rate of surgical infection for fractured neck of femur was lower than the national average (1.3% compared to 1.4%).

Environment and equipment

- We inspected Wards 7, 10, the day case unit (Ward 15) and theatres. All areas appeared bright, uncluttered and in a good state of repair. Wards were spacious and did not have any storage or capacity issues. Equipment was stored appropriately.
- Trust environmental audit data showedsurgical areas achieved an average score of 98%.
- In the most recent Patient Led Assessment of the Care Environment (PLACE) audit (2014) Wansbeck General Hospital scored 97% for cleanliness, 97% for food, 97% for privacy and dignity, and 97% for condition. This was better overall than trust wide scores of 92% for food, 91% for privacy and dignity, and 96% for condition (although slightly worse than for cleanliness, which had a trust wide score of 99%). The trust performed better than the England average in all categories.
- Ward staff had attended medical device equipment training. However, not all staff groups in all surgical departments at Wansbeck General Hospital met the 85% target for completion of the self-assessment competency component to the module.
- We inspected resuscitation trolleys and suction equipment in all surgical departments wards and found all appropriately tested, clean, stocked and checked weekly as determined by policy.
- Both wards had appropriately equipped treatment rooms solely used for wound care (aseptic technique and dressing changes) in line with infection control good practice and policy. Nurse assessment of aseptic technique competence had been introduced and took place annually.
- Nursing staff on wards reported that these treatment rooms had been reinstated in surgical services at the trust as part of the strategy to improve Surgical Site Infection (SSI) rates.

Medicines

- In Ward 7, Ward 10, day case unit (Ward 15) and theatres, medicines were stored and locked away in line with policy. Clinical treatment rooms had locked keypads for secure staff access.
- Medicine prescription charts for individual patients were clearly written and medicines were prescribed and administered in line with trust policy and procedures, reducing the risk of errors.
- Medication rounds were observed to be conducted with good nursing practice principles and wards had dedicated support from pharmacy.
- Drug fridges were locked and daily fridge temperature was recorded at ward level by nursing staff. There was inconsistency in the daily recording and we spoke with staff who did not understand the process or significance of maximum and minimum temperature recording.
- One fridge on Ward 7 had a high temperature of 8.9 and this was not understood to be an exception but had been recorded. Staff were not sure of any assurance or audit provided by pharmacy staff through audit or checking processes.
- Medicines Management was part of mandatory training for clinical staff. Compliance across wards 7, 10, 15 and theatres was poor and significantly less than the department target of 85%.
- A plan was in place to achieve training targets by April 2016. Modules included: medication management; drug history compilation; reducing harm from medicines; and calculating drug doses for adults.
- Wansbeck General Hospital reported 80 medication incidents. All incidents were categorised as ‘no harm’ or ‘minor harm’. We spoke with ward sisters who had knowledge of numbers and types of incident in their wards and these are shared with staff at team meetings.
- In the absence of medical staff and prescribers on site, Nurse Practitioners had undertaken courses of study to obtain prescribing rights and further develop the role to support the patient and adopt new ways of working.

- Storage for intravenous therapy and associated single use equipment had been rationalised as part of the Well Organised Ward project (WOW). Staff felt that this system worked well and had improved practice and availability of essential equipment.

Records

- We looked at 11 sets of surgical patient medical records at Wansbeck General Hospital. We saw that they were mostly complete, legible and organised consistently but showed variable compliance with staff completing yellow alert forms in 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. Compliance with completion of this form was inconsistent across both wards. With only 6 complete from a possible 11 chosen at random.
- The risk register for surgery identified there were inconsistencies in staff completing yellow alert forms filed at the front of medical records.
- On wards 7 and 10 patient medical notes were stored in lockable notes trolleys. The notes for the current admission were kept in the trolleys on a lower shelf but without the facility to protect with a lock. 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 these notes.
- Daily entries of care and treatment plans were clearly documented by the team. With a small number of acceptable omissions for new admissions, care plans and charts reviewed had completed patient assessment, observation charts and evaluations.
- Two 'Do Not Attempt Cardiopulmonary Resuscitation' (DNACPR) were clearly written and care records had recorded discussions around decision making and patient and family involvement. Staff on Ward 10 confirmed that this was normal practice. The process for discharge of patients to home with their DNACPR record was understood by staff we spoke with.
- We observed one example of the Dementia Find, Assess and Investigate, Refer (FAIR) assessment. Nursing staff were able to discuss examples of good dementia care for patients in wards across the trust.

Safeguarding

- The trust had a 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 the trust. Local safeguarding leads had been appointed. This meeting provided a forum for staff to discuss safeguarding concerns and share learning across the trust.
- Staff had attended training and an on-going programme of sessions was available for staff to attend. The trust reported that 63% of staff had attended safeguarding training (September 2015) 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.
- On Ward 7, 81% of staff and on Ward 10, 94% of staff had attended level 1 safeguarding training for adults at the time of inspection.
- Staff we spoke with were knowledgeable about safeguarding principles and their responsibilities to vulnerable patients. Examples could not be given by the staff we spoke with at the time of inspection in surgical wards.
- To support staff in safeguarding decision making, safeguarding information folders were available for staff in surgical areas with current guidance, advice and details of contact leads.

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.
- The trust overall compliance with mandatory training attendance in 2014/2015 was good at 91%. Across all departments in Surgery 88% compliance was calculated for 1827 staff. Some wards in the data provided are now closed and staff had been redeployed across other hospital sites.
- At Wansbeck General Hospital, training data was reviewed for Wards 7, 10 and the day case unit (Ward 15), theatre staff, (under anaesthetics) and Ward 4 (as half of the staff from ward 4 were redeployed to posts on ward 10 as part of the reconfiguration of services).
- All areas had achieved induction for all staff groups of 100%.

- The safeguarding training strategy had ensured staff had received or were planned to attend level 1 safeguarding training in all departments, with additional attendance to level two training. Compliance was poor at the time of inspection.
- There was poor compliance with medical devices self-assessment and non-completion of the last module within the blood safety training sessions, which required competency assessment. We also found**,** and it was reported to us by staff, that there is an inconsistent compliance with basic life support training (BLS), especially for theatre staff.
- Staff told us they accessed mandatory training in a number of ways, such as online modules and eLearning, workbooks and through key trainer delivered sessions. Staff said they were supported with professional development through education.
- Staff spoke of a good induction and a preceptorship programme when joining the trust and attended local sessions and those provided at a trust level.

Assessing and responding to patient risk

- Trust data showed between April and July 2015, there was 100% compliance with the World Health Organisation (WHO) safer surgery checklist ('Safe surgery saved lives', 2008. 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 theatre and saw completed pre-operative checklists and consent documentation in patient notes.
- 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, which included any out of hours support for increased activity, patient acuity and staff shortages.
- 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.
- Staff were clear about the elective surgical programme at Wansbeck General Hospital and told us emergency patients and those assessed as higher risk were admitted to NSECH for access to critical care facilities and 24/7 surgical consultant cover.
- The strategy and processes for recognition and treatment of the deteriorating patient in surgery, including staff use of National Early Warning Scores (NEWS) was embedded. Staff gave examples where escalating a sick patient and transferring them safely to NSECH had worked well.
- The trust used a 'pick and retrieve' system, whereby an anaesthetist was on-call from NSECH and, in emergencies, was able to attend base site hospitals immediately to stabilise patients and transfer them to critical care facilities at NSECH**.**
- Care planning based on patients assessed risk was good. We saw evidence of risk assessment for nutrition using the Malnutrition Universal Screening Tool (MUST) which helped staff identify patient nutritional needs. Pain scores and diaries for patients were available for patients.
- Ward display boards had information against patients surnames to identify the risks to individual patients. This system was easy to understand for: falls risks; nutrition assistance; similar patient name alerts; and elevated early warning scores.
- Risk assessments, handover processes and safety briefs were observed and we saw all staff worked and communicated well as a team. We observed that ward staff used, on a daily basis, the 'risk approach' handover sheets. Also they used a trust developed document, called the Treatment Escalation Plan (TEP), to support effective decision making for those patients at risk of deteriorating.
- Patients at risk of falls were identified and assessed on admission and an individualised plan of care was put in place. We saw this planned care delivered, for example: one to one nurse to patient ratio; close observation; safety rails on beds; falls stockings; a nurse call system being in reach and to identify risk, the placing of stickers on display boards.
- Incidences and severity of falls were categorised in the electronic system as either: 'no harm', 'minor harm' or 'damage and moderate harm'. Serious harm that resulted in fractures or patient injury and fatalities were also recorded.
- Between August 2014 and July 2015 there had been 151 incidents reported as falls in surgery at Wansbeck General Hospital. Two falls with fractures were reported in surgery for this period at the hospital. The trust

reported that further work was planned, including the development of new nursing roles to improve risk assessment and prevent patient falls and reduce the incidence of harm related to falls.

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 the trust 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 in four wards.
- 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.
- Staffing overall in surgery was consistent with the SNCT. Recruitment challenges existed in Ward 7 and the senior team were aware of this. Sickness and absence was managed well with a policy in place. At the time of inspection ward 10 had issues with staff sickness and were managing to cover any shortfall on a daily basis through use of bank staff.
- On Ward 7 the staff on duty was displayed. Planned staffing levels were three RN's and two NA's on day shift and two RN's and one NA on night shift for a maximum of 21 patients. On the day of inspection there were three RN's and two NA's on day shift. Two RN's and one NA were expected to be on duty for the night shift. When needed the ward used hospital bank staff.
- Shortfalls in the 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.
- Ward staff told us that actual staffing levels were not always as planned and that they managed daily challenges to ensure safe staffing levels across sites. When shortages existed the escalation policy was followed. Visitors could see who was on duty and in charge of the ward.
- Recruitment to nursing assistant posts was less challenging than appointing registered nurses. Exit interviews had not identified any trend for action on ward 7. The executive team were aware and had identified recruitment plans to address this issue.
- A newly qualified member of staff said: "it was a really nice ward to work on" and she "had been very well supported with a good preceptorship programme".
- Two staff reported they were unhappy that they were moved to cover other wards across hospital sites at short notice.
- We spoke with a nurse practitioners (NP) on ward 7 and 10 and the role had been developed for some time and embedded into practice. The NP role supported patient pathways and was supported by Consultants at the Wansbeck site and across the trust. The service was provided 24/7.
- On Ward 10 the staff on duty was displayed. Planned staffing levels were three RNs and two NAs on day shift and two RNs and one NAs on night shift for a maximum of 22 patients. On the day of inspection actual numbers of staff were as planned. Senior nursing staff reported this was not always the case and the establishment that had been agreed for the setup of Ward 10 had made it difficult to achieve rota requirements.
- Two weeks before the inspection visit, two larger surgical wards had been joined to create Ward 10. This reduced capacity for elective women's health surgery and general surgery at the Wansbeck Hospital site as part of the reconfiguration of services. Staff were positive and motivated about the change and spoke with enthusiasm about the opportunities and teamwork on the ward.
- Staff that we spoke with told us staffing levels on day shift had been a challenge more on Ward 10, but that ward sisters organised staffing to manage shortfalls for sickness on a daily basis.
- Staff reported they were in a period of adjustment with the new emergency model of care. They felt that the Wansbeck hospital base site had not been able to fully anticipate the acuity of patients, the erratic activity and the frequency of patient transfers.
- Staff also reported that robust planning and a strategy was in place and there was no negative impact on performance or patient safety. In view of the recent changes staff said the two teams had come together 'exceptionally well'.

- Patients had not reported any issues caused by these changes directly to ward staff, the inspection team or through patient experience surveys.

Surgical staffing

- Consultants operated surgical lists from base sites at Wansbeck, Hexham and North Tyneside hospital for elective surgery and elective and emergency surgery at NSECH. Consultant Job Plans were altered to reduce travel so that most only work on a single site on any given day.
- Full day lists for surgeons and anaesthetic staff 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 and nurse practitioners were available for handovers, ward rounds and MDTs. Staff had good relationships with senior surgical doctors and consultants.
- Out of hours cover from senior medical staff was provided by NSECH. This included access to 24 hour 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 at the time of inspection.
- 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, in 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 Wansbeck General Hospital. We observed major incident policy folders in the ward managers' offices and these would be available to staff in the event of escalation.

Are surgery services effective?

Good

We rated effective as good because:

Patients receive treatment and care that is evidence based and staff are supported to implement national guidance and develop new innovative approaches to support patient pathways. The surgical business unit had a programme of clinical audit that identified local priorities and took part in all the national clinical audits that they were eligible for.

All patients reported their pain management needs had been met. Staff were in the process of training in the identification of pain in patients with dementia. The development of the theatre 'block room' for the administration of local anaesthetic, as an alternative to general anaesthetic for some procedures resulted in 98% of patients not feeling sick or nauseous and 89% of patients experiencing no pain after their procedure as reported in local audit.

Clinical staff were supported to deliver effective care and treatment through a consistent appraisal and revalidation process. Appraisal rates were above the trust target. All measures surveyed in the General Medical Council (GMC) national training scheme survey 2015 were within expected levels and junior medical staff did not identify any risks.

Staff can access information in a timely way at Wansbeck General Hospital. 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).

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, day of surgery admission and integration of pre-assessment had been introduced to reduce length of stay for patients particularly in colorectal and gynaecological surgery. A primary nurse would assess and review the patient throughout the care pathway providing an increased level of continuity of care. This included pre-operative assessments, perioperative admission and post-operative discharge and follow-up.
- Significant work and audit had been carried out to support evidence for implementing fast track treatment of patients and day case procedures that had previously

required an in-patient stay for upper gastrointestinal, colorectal, mastectomy and orthopaedic hip and knee surgery and this was evident at the Wansbeck General Hospital and across the trust.

- At Wansbeck General Hospital laparoscopic and reflux surgery was also developed as a day case procedure with significant impact on quality of life for patients with gastro oesophageal reflux disease.
- 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 and this was observed at Wansbeck Hospital. The surgery division took part in all the national clinical audits for which they were eligible. The division had a formal clinical audit programme where national guidance was audited and local priorities were identified. There was a breadth and depth to the publication of research and evidence based papers in national journals by medical and other clinical staff with particular reference to evidence of sharing best practice in trauma and orthopaedics.

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 patient pain levels. All patients we spoke with reported their pain management needs had been met.
- There was a pain assessment scale within the NEWS chart used throughout the hospital. NEWS audits were in place and the positive data produced from these was supported with patient feedback from the Friends and Family Test about their pain control. The audit showed 98% of NEWS charts had been correctly recorded within surgery (August 2015).
- Each ward had identified a pain link nurse and pre-planned pain relief was administered for patients on recovery pathways.
- 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 the anaesthetic 'block room' in theatre, for the administration of local anaesthetic to 'block' the nerve resulted in 89% of patients experiencing no pain while recovering after a procedure, according to recent trust audit. Patient outcomes had been monitored between November 2013 and November 2014. This showed that 96% of the patients questioned preferred the spinal block to a general anaesthetic. This information was being used to inform practice and patient care across surgery.

Nutrition and hydration

- Patients were screened using the Malnutrition Universal Screening Tool (MUST). Where necessary patients at risk of malnutrition were referred to the dietitian.
- 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.
- We reviewed 14 records and saw that nurses completed food charts for patients who were vulnerable or required nutritional supplements and support was provided by the dietetic department who also recorded assessments in the care record.
- A trust wide nutrition audit showed that between July and August 2015 an average of 96% of patients had received a nutritional assessment within 24 hours of admission. Records showed patients were advised as to what time they would need to fast from and daily fluid balance assessments were recorded.
- We observed protected patient mealtimes. Patients reported their meals to be very good, with a hot breakfast and good choice. Staff prioritised nutrition for surgical patients offering snacks and individualised choice for patients, both before and after surgical procedures.
- We were told of a 'nutritional nurse' initiative introduced across the service as part of enhanced recovery and shared purpose goals. This has resulted in improvements in practice which promoted recovery and the patient experience. This initiative and new role was yet to be rolled out at Wansbeck General Hospital although good practice from across the trust was being shared.

Patient outcomes

Surgery

- The average standardised relative re-admission rates (2014) for England is 100. The hospitals rates were lower for elective surgical patients for colorectal surgery, (84) and upper gastrointestinal surgery, (63) but higher for elective trauma and orthopaedics patients, (128).
- For non-elective surgical patients the standardised relative readmission rates (2014) were higher than the England average for general surgery (107), colorectal surgery (132) and trauma and orthopaedics (113).
- Adjusted mortality rates at 90 days were better than the England average (2.9, England average 3.9), and slightly worse at two years (24, England average 22).
- The National Bowel Cancer Audit (2014) showed better than England average results for multi-disciplinary team discussion, clinical nurse specialist involvement and scans undertaken; 68 % of patients undergoing major surgery stayed in the trust for an average of more than five days (lower than the England average of 69%).
- The Patient Reported Outcome Measures (PROMs) in the North East and North Cumbria 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' and were comparable to England averages in surgery.
- Results from the National Joint Registry (NJR) audit showed 100% of patients (benchmark 95%) had consent confirmed prior to procedure (January 2015). Revision rates for hip replacement were above the NJR total at one, three and five years; the revision rates for knee replacement were below the NJR total at one, three and five years.
- The rate of deep surgical site infections (June 2015) was in line with the national target for both hip replacements (0.8% compared to 0.7%) and knee replacements (0.7% compare to 0.6%).
- The rate of infection for fractured neck of femur surgery was lower than the national target (1.2% compared to 1.5%).
- The rate of all recorded surgical site infections during this period was below the national average.
- Following the opening of NSECH, theatre utilisation at the hospital varied between 32% and 74%.

Competent staff

- We spoke to staff and observed from the training matrix that appraisals were undertaken annually and all staff groups had achieved the trust target of 85% for staff appraisals. The majority of staff groups had achieved 100%.
- There were informal one to one meetings for staff should they request these and clinical supervision for nurses was available but not formally recorded. Monthly staff meetings were taking place.
- 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.
- Nursing staff were advised of the Nursing and Midwifery Council revalidation process through the trust intranet. New nursing staff underwent an induction programme and completed learning logs with a designated supervisor.
- Staff told us that the appraisal process was helpful and allowed them to discuss developmental objectives. These were agreed between staff and managers.
- Nurse practitioners had a designated consultant who provided clinical supervision and guidance.

Multidisciplinary working

- 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. Immediate telephone advice could be accessed but a face to face visit may take up to 24 hours at the Wansbeck General Hospital site.
- Protocols had been developed for the effective handover of patients to NSECH when needed. These involved the identification of bed availability, NEWS assessment and both verbal and written transfer of information using the Emergency Care Transfer Checklist.

- Therapists worked closely with the nursing teams on the ward where appropriate. Ward staff told us they had good access to physiotherapists and occupational therapists.
- There was pharmacy input on the wards during weekdays and dedicated pharmacy provision for each ward was planned.
- Staff explained to us the wards worked with local authority services as part of discharge planning and weekend discharges requiring support were identified at pre-assessment so that appropriate equipment and support could be arranged.
- Audit results (April 2015) showed theatre staff were aware of the morning conference call: this was established to help prepare and plan activity for the day and as a means to identify issues.

Seven-day services

- Elective surgery was provided at the hospital over a 5 day theatre programme running Monday to Friday. There was weekend theatre utilisation available. Ward 7 and 10 were established to run 24/7 to care for patients.
- Consultants were available on-call out of hours and would attend when required to see patients at weekends. A foundation level doctor and advanced nurse practitioners were on site at the hospital at all times. Middle grade doctors and Consultants were available on site Monday to Friday. Cover for emergencies and advice was provided by the NSECH site.
- A daily ward round reviewing all surgical patients is undertaken seven days a week and to facilitate appropriate discharge. The ward round was attended by nurse practitioners and medical staff.
- Access to essential diagnostic services was available seven days a week.
- Physiotherapy service was provided on site seven days a week. Other members of the healthcare team were accessible Monday to Friday and communication and planning of services for patients at weekends was reported to be good.
- The trust provided seven day services for all emergency attendances and admissions at NSECH. It met all ten national standards for seven day working. A comprehensive transfer plan was in place for deteriorating patients at base hospitals to access emergency care 24/7.

Access to information

- Risk assessments, care plans and test results were completed at appropriate times during patient care and treatment and we saw these were available to staff to support delivery of effective care and treatment.
- We reviewed discharge arrangements for patients and noted this process was started as soon as possible during admission. We saw discharge letters were completed appropriately and that relevant information was shared with the patients general practitioner.
- There were appropriate and effective systems in place to ensure patient information was co-ordinated between systems and accessible to staff.
- Ward nursing staff shared information around governance and clinical updates in a file in the ward office. A 'sign off' system was in place to assure that staff had read relevant updates and trust briefings.
- As part of the 'shared purpose' initiative, up to date information on ward performance against objectives was displayed at the entrance to the ward so staff, patients and visitors could see it.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- The trust had policies in place to inform and guide practice around Deprivation of Liberty Safeguards (DoLS) and the Mental Capacity Act (MCA). Staff were given information and guidance on terminology, issues surrounding capacity when taking patient consent and identifying trust leads for the escalation of issues.
- Staff we spoke with at Wansbeck General Hospital 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 patients care and Deprivation of Liberty Safeguards (DoLS) were referred to the trust's safeguarding team.

Surgery

- Consent, MCA and DoLS training was delivered as part of staff induction. The development of Advanced Nurse Practitioners had contributed to improvement in patients being consented in a timely manner and MCA and DoLS assessments were included in risk assessments.
- Deprivation of Liberty training was attended by staff in each department; 100% of nursing staff had attended training on Wards 7 and 10 and 100% nursing staff had attended Mental Capacity Act training on Wards 7 and 10.
- There was access to an independent mental capacity advocate (IMCA) for when best interest decision meetings were required.
- The trust had in place policies covering the 'Mental Capacity Act (2005) and Deprivation of Liberty Safeguards'.
- 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 being 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 with patients being provided with additional information (such as leaflets).
- The audit was discussed at the trust wide Surgical Integrated Governance Group, and staff were 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 11 records and observed that 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, before providing care, staff asked for their verbal consent.

Are surgery services caring?

Outstanding ☆

We rated caring as outstanding because:

The services at Wansbeck General Hospital received consistent positive feedback scores and comments from patients through the NHS Friends and Family test, the local '2 minutes of your time' survey, a real-time feedback process and a social media feedback approach managed by the trust Communications and PALS team. A patient reported to us that there was 'a real culture of caring' at Wansbeck General Hospital.

Throughout our inspection, in surgical wards and departments we observed patients cared for with dignity, compassion and respect. 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. Patients we spoke with confirmed that staff were caring, approachable and supportive of their individual needs.

We spoke with 17 patients in wards 7 and 10 and they reported, without exception, that they felt involved in their care, and felt valued. All patients spoken to gave positive feedback about relationships with staff. Meeting people's emotional needs was embedded and documented in the care plans, with well-established and skilled staff providing post discharge support after surgery.

Compassionate care

- We observed staff treating patients with kindness and respect. Staff took time to introduce themselves to patients and gave explanations for the treatment and care provided.
- We spoke to 17 patients and they told us, without exception, that staff were kind and caring, with patients stating that: 'there was an absolute culture of caring' and that they were: 'very impressed with the kindness of the staff'. We observed staff being friendly and professional, and they had a rapport with patients which was highly visible and valued as part of the culture.
- We spoke with 7 nursing staff and it was clear that the demonstration of a caring approach was a high priority to all staff. Without exception we observed good examples of caring behaviour in practice across the multidisciplinary team. Staff spoke to patients as

individuals and demonstrated they had knowledge about and relationships with the patients. In all staff interactions with patients and colleagues we observed kindness and professionalism.

- The trust performed a '2 minutes of your time' patient survey. Patients were given a short survey on discharge from hospital. Data from this survey was displayed prominently at entrances to wards. Out of a possible 10 (highest rating), Ward 7 achieved 9.7 and Ward 10 had achieved 9.9 in October 2015, which was reflective of previous scores.
- Satisfaction scores averaged 94% in the NHS Friends and Family Test (FFT) for the twelve months to July 2015 from a 22% response rate for surgical wards at the hospital. The trust average response rate was 23% and the England average 36%.
- A nursing assistant on Ward 10 spoke with confidence about caring for a patient with dementia on the surgical ward. She had attended dementia training and gave examples of using specific communication skills to help understand and support the patient in the ward environment. The use of bright cups, plates for nutritional support and consideration for the environment and the individual needs of the patient and family was said to be important to ward staff.
- On Ward 7 a newly qualified registered nurse was observed for 10 minutes taking time to talk with a patient at the bedside in a discreet and sensitive manner. Assessing that the patient was tearful the nurse was observed closing the bedside curtains after offering her privacy and asked the physiotherapist to delay her treatment at the bedside to a later time. It was noted that the nurse stayed behind the curtains with the patient and when spoken with she said she felt supported to talk to patients and spend time with them even during very busy shifts.

Understanding and involvement of patients and those close to them

- Patients and relatives felt involved in their care. Regular ward rounds with consultants, Advanced Nurse Practitioners and nursing staff gave patients the opportunity to ask questions and have their surgery and treatment explained to them. Quiet rooms were available to ensure privacy for patients was respected when needed. The use of curtains drawn around bed spaces was observed to be common practice and patients told us that this was normal practice.
- A system of pre-assessment for patients was well established and patients could watch DVD information about their procedure provided before surgery. The specialist nursing teams at Wansbeck General Hospital were skilled in providing support, advice and information for patients undergoing specific surgery in breast care, colorectal and orthopaedic. Each step of the surgical pathway was explained to the 17 patients with which we spoke across surgery.
- Patients and their families received information in a way they could understand and were knowledgeable about their treatment, progress and discharge plan. One patient reported that staff: 'explained everything about the pinning of her foot.' Another patient told us that: 'everything about the operation was explained', and that she 'understood what was going to happen'.
- Senior nursing staff were visible on the day of inspection and they reported to us the Ward Manager and Matron were available for patients and their relatives. It was made clear to patients and visitors to the ward who was on duty as this was displayed at the ward entrance.
- Ward 10 staff demonstrated adaptability to individual patient need and had introduced training for staff to better support female patients admitted for gynaecological procedures that required a heightened level of sensitivity from nursing staff. Staff we spoke with were knowledgeable about the proposals to better support female patients and the reasons for training.
- Rotas had been amended and staff training adapted and commenced to support patients undergoing termination of pregnancy and for women requiring surgical intervention after miscarriage. A training need had been recognised by the senior nursing staff that some staff had not had experience of caring for these patients before the joining of the two wards.

Emotional support

- 17 patients we spoke with at Wansbeck General Hospital did not raise any concerns during our inspection.
- Patients reported that staff spent time with them and nursing staff we spoke with also told us of the importance of having 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 all of the 11 case notes observed on Wards 7 and 10.

Surgery

- The Surgical Site Infection Surveillance Team (SSI team) offered a follow up service to all post-operative patients. Patients received a follow-up phone call at two and 30 days post discharge from hospital. Staff in the SSI team also reported that they receive very positive feedback from patients about their experiences with staff on the wards. This feedback was shared with the ward Matron.
- 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. Outside of these hours patients could call the ward when 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.
- A range of post-discharge follow-up methods was provided by clinical nurse specialists across the surgical specialities.

Are surgery services responsive?

Outstanding ☆

We rated responsive as outstanding because:

Surgical services at Wansbeck Hospital were part of the wider hospital network, incorporating the NSECH emergency care model. 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 General Hospital and ensured emergency support was also available 24/7.

The number of operations cancelled by the trust 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. The average length of stay for patients was below the national average and enhanced recovery programmes, fast track surgery initiatives and innovative approaches to pain control are making an impact on reducing length of stay across specialities.

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 Wansbeck General Hospital five days a week and the surgical elective programme also included regular weekend theatre sessions at the time of inspection.

The surgical services at Wansbeck General Hospital received a low number of formal complaints and staff we spoke with described the formal and informal process to resolve concerns and complaints with people using services.

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.

The commitment to post procedure follow up after patients are discharged home from hospital is excellent at Wansbeck General Hospital. 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. 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. Link nurses who provided advice and support with caring for patients with learning disabilities and dementia had been identified on ward 10 and 7.

Service planning and delivery to meet the needs of local people

- The hospital was part of a wider network that provided co-ordinated care since the opening of NSECH in June 2015. Care was planned to allow emergency and high risk patients to attend NSECH, while elective surgery for patients at lower risk was carried out at Wansbeck General Hospital.
- This allowed patients 24 hour access to consultant level emergency care using NSECH while also ensuring that elective work was available at a base hospital of the patients choice for most specialities.

Surgery

- 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.
- 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.
- The hospital had an escalation and surge policy and procedure to deal with busy times.
- Capacity bed meetings were held to monitor bed availability, review planned discharges and assess bed availability throughout the trust on a daily basis.
- The trust cancelled 344 operations between April 2014 and June 2015. The number of operations cancelled by the trust was consistently below the England average over the past 2 years.
- Of those cancelled between April 2014 and June 2015, six people were not treated within 28 days. This is below the England average.
- 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 and at the Wansbeck General.
- The Surgical Site Infection Surveillance Team (SSI) contacted patients after surgery at two and 30 days post discharge. The team identified how patients had settled back in to the home environment, their contact with social services where appropriate and any further needs.

Access and flow

- The trust had 33,909 surgical spells between January 2014 and December 2014. This was around the average for NHS trusts. Of these Wansbeck General Hospital had around 12,800 surgical spells during this period. The main specialty seen in 2014/15 at Wansbeck General Hospital at (40%) was trauma and orthopaedic surgery, with 20% upper gastrointestinal, 17% colorectal and 25% other surgery. 59% of patients had day case surgery.
- At the end of November 2015, the trust was meeting (93%) of the NHS operational referral to treatment target (RTT) of 92% of patients waiting less than 18 weeks for treatment.
- 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 86% (September 2015) to 87% (November 2015) and 92% of patients were waiting less than 21 weeks.
- The trust's performance against the NHS 18 week referral to treatment target had been above the England average since January 2014.
- Six theatres were open at Wansbeck Hospital on a three shift rota between 0800 and 2000, five days a week and also included regular weekend sessions; 45 weekend sessions had taken place between April 2015 and November 2015.
- 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 surgery and included a mobilisation of patients on day zero undergoing hip and knee replacement surgery. Staff worked closely with allied health staff to aid recovery and patients were routinely discharged within one to two days.
- A pre-assessment meeting was held with the patient before the surgery date and any issues concerning discharge planning or other patient needs were discussed. Patients requiring assistance from social services upon discharge were identified at pre-assessment and plans were continuously reviewed during the discharge planning process.
- Dedicated specialist nursing teams contacted patients by telephone following discharge to gather information about any immediate concerns the patient may have and provide advice and guidance. If they identified any concerns during the call, staff invited the patient to return to the hospital for assistance.

- The 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 Wansbeck. The breakdown of this information was not available at the time of inspection (November 2015).
- The average length of stay for elective patients was above the England average for breast surgery (2.8 days, England average 1.6 days) and colorectal surgery (6.1 days, England average 6.0 days) and below for urology (1.7 days, England average 2.2 days).
- Average length of stay for non-elective patients was above the England average for general surgery (8.8 days, England average 4.2 days) and colorectal surgery (6.0 days, England average 4.6 days) and below for orthopaedics (6.0 days, England average 8.5 days).
- The National Laparotomy Audit (2014) showed the hospital had 2.6 operating theatres and 2.9 gastro-intestinal care beds for 100 beds; these place the hospital in the highest group of hospitals for availability of theatres and care beds.

Meeting people's individual needs

- The service was responsive to the needs of patients living with dementia and learning disabilities. Link nurses who provided advice and support with caring for patients with learning disabilities and dementia had been identified. Training was a priority for clinical and non-clinical staff and there was good access to dementia awareness workbooks and sessions which were well attended.
- 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.
- A pre-assessment meeting was held with the patient before the surgery date and any issues concerning discharge planning or other patient needs were discussed. Patients requiring assistance from social services upon discharge were identified at pre-assessment and plans were continuously reviewed during the discharge planning process.
- Interpreter services were available to staff, both in person and on the telephone. Staff told us that any individual needs would routinely be picked up at pre-assessment and face to face service was normally booked for when a patient attended. We saw that the care of patients following surgery was particularly effective through the provision of ongoing physiotherapy services.

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.
- Complaints and concerns were proactively reviewed and discussed at monthly staff meetings where training needs and learning was identified as appropriate. Conflict resolution training had been identified as a means to deal with complaints at a local level and included as part of mandatory training for some staff groups.
- Surgical services at Wansbeck General Hospital had received 30 complaints since November 2014, this included complaints directed to surgical wards that have since closed as part of the change in services.No themes or trends were identified.
- We noted that processes and investigation of complaints was thorough, responses and apologies to people were appropriate and where learning could be shared with staff this was cascaded and practices changed when relevant.
- 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.
- Information was displayed on ward 7 and 10 to inform patients of the complaints process and patients we spoke with felt confident that they would know what to do to make a complaint if they needed to.
- 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.

Surgery

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 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.

Staff were proud of the organisation as a place to work and consistently spoke highly of their team and the culture. Senior managers had a shared, clear vision and strategy for the surgical division. This was consistently shared during the inspection of Wansbeck General Hospital and across the trust. There is an approach to innovation that is celebrated and encouraged and the new model of care has been embedded through a planned change in services, while supporting and motivating staff. Staff reflected on the strong leadership and visibility of senior members of the executive team and trust board.

Staff told us that challenge to existing practices from people is encouraged to support improvements to services. There was strong collaboration and support across teams. At ward and theatre levels we saw staff worked very well together and there was respect between specialities and across disciplines.

Governance and performance information was managed well and actively reviewed to promote best practice and manage any risk. The surgical team at Wansbeck General Hospital and across the trust used a range of methods to gather meaningful feedback from patients and staff. Information was used to make improvements in quality of care and peoples experiences. Experiences are shared at board and ward level and reporting is valued alongside a consistent range of performance data.

We saw constructive engagement with staff and managers at all levels, communicated in person to staff and through the weekly e-bulletin, team briefs, the staff magazine and internal campaigns. Staff had been engaged in deciding on annual priorities, the appointment of staff governor's; health and wellbeing advocates; sustainability champions; and had led and participated in staff road shows.

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 were encouraged to contribute to its development. During individual interviews staff were able to repeat this vision and discuss its meaning with us.
- The trust vision and strategy was clearly displayed in ward areas and staff were able to articulate these values to us. We noted that the trust's values and objectives were embedded 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. Staff said that at all times the division looked for patient improvements.

Governance, risk management and quality measurement

- Joint clinical governance and directorate meetings were held each month. Agendas and minutes showed audits, learning from complaints and PALS issues, learning from clinical risk management, peer review data, patient and

public information and involvement, infection control issues, alert notices, good practice, national service frameworks, clinical audits and research projects, were all discussed and action taken where required.

- The trust had 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. These were actively reviewed.
- An example of this related to a patient alert about the need to appoint medical device safety officers. The division decided to fund these posts for an initial six months to establish workload requirements and the reduction in risks associated with safety incidences.
- Surgical Business Unit 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 elements of action plans where appropriate. The risk register reflected newly identified and ongoing organisational risks and the progress made in addressing them.

Leadership of service

- 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.
- All staff we spoke with told us that service leads and managers were available, visible within the division and approachable. Leadership of the service ensured there was high staff morale and staff we spoke with felt supported at ward level. Clinical management meetings were held weekly and involved service leads and speciality managers.
- Monthly speciality meetings were held and discussed financial and clinical performance, patient safety and operational issues.
- Staff spoke positively about the service they provided for patients and emphasised quality and patient experience is a priority and everyone's responsibility.
- All staff explained that they would be happy to approach senior staff to raise concerns and they were confident issues were dealt with in a timely manner.
- Nursing staff stated that they were well supported by their managers and they were happy to challenge senior staff and raise concerns. Issues were said to be managed in a timely and responsive manner.
- Medical staff stated that they were supported by their consultants and confirmed they received feedback from governance and action planning meetings.
- Ward managers had dedicated management time when they were not expected to provide clinical care to patients. This allowed them to focus on management and administrative issues. Ward managers referred to having two administrative days each week.

Culture within the service

- At ward and theatre levels we saw staff worked very well together and there was respect between specialities and across disciplines. We saw examples of good team working on the wards between staff of different disciplines and grades.
- All staff we spoke with felt that they received appropriate support from management to allow them to complete their jobs effectively. Staff were well engaged with the rest of the hospital and reported an open and transparent culture on their individual wards and felt they were able to raise concerns.
- All junior staff we spoke with spoke positively about their line managers and felt that they provided excellent support and guidance. Staff described managers that carried out tasks to help support the team and ensure the effective running of the wards and departments.
- Patient and staff feedback consistently refers to provision of good care, positive experiences, and 'feeling valued'. A 'caring culture' was evident in Wansbeck General Hospital 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.
- Staff reflected on the strong leadership and visibility of senior members of the trust board. This motivated staff and staff felt that senior leadership reflected the vision and values that they shared with the organisation.

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 surgery services at Wansbeck General Hospital used various innovative ways to gather feedback from patients. This included the NHS Friends and Family test, the local '2 minutes of your time' survey, a real-time feedback process and a social media feedback approach managed by the trust Communications and PALS team.
- The trust used a '15 step challenge' approach 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 and services provided. An audit (April 2015) showed: staff were clear regarding their role; emphasised patient care; and ensured safety and well-being was paramount.
- Fifteen step challenge data from theatre and Ward 7 in May and August 2015 at Wansbeck General Hospital demonstrated that detailed assessments were carried out against the CQC's key lines of enquiry, (including case note audit) by a trust quality and audit team, including a public representative. Where issues were identified a comprehensive action plan was developed to resolve any issues. We saw that where issues required immediate action these had been resolved at the time of our visit.
- The hospital also received feedback through the in-patient survey (October 2015). Results showed 100% of patients were treated with respect and dignity, 98% of patients were involved in their care and 100% of patients said they were treated by 'good' doctors and nurses at this hospital.
- 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.
- Data collected by the Health and Social Care Information Centre (HSCIC) showed that the sickness absence rates for the trust have been 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. Based on staff survey results the trust was within the top 20% of trusts in England.
- Senior staff told us that they had been engaged by the trust to help to develop an e-prescribing system. This had included being shadowed by the team building the system to ensure they understood the needs of staff.
- We saw senior managers communicated to staff through the weekly e-bulletin, team briefs, the staff magazine and internal campaigns. Staff had been engaged in: deciding on annual priorities; the appointment of staff governors, health and wellbeing advocates, sustainability champions; and staff road shows.
- Staff had been involved and engaged with the development of the new model of emergency care and had undergone significant organisational change at the Wansbeck Hospital site and across the trust. Staff we spoke with 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 any necessary adjustments in surgical services.

Innovation, improvement and sustainability

- 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 7 and staff told us that they had embraced the day zero mobilisation programme.

- The development of the anaesthetic 'block room' in theatre, for the administration of local anaesthetic to 'block' the nerve resulted in 89% of patients experiencing no pain while recovering after a procedure, according to a recent trust audit. Patient outcomes had been monitored between November 2013 and November 2014. This showed that 96% of the patients questioned preferred the spinal block to a general anaesthetic. This information was being used to inform practice and patient care across surgery.
- The development and delivery of new care pathway in surgery at Wansbeck General Hospital in dedicated bone health clinics for women surviving breast cancer is delivering high quality care with the patient at the centre.
- At Wansbeck General Hospital an 'anti reflux service' was provided to patients as day case with evidence of reduced length of stay and less complications. Excellent multidisciplinary team work was demonstrated in order to deliver this service.
- The development of nurse practitioners had enabled the hospital to respond to patients appropriately and workforce planning had mitigated the potential recruitment difficulties of junior doctors.
- 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 and at the Wansbeck General Hospital.

Maternity and gynaecology

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

Information about the service

Up until June 2015, approximately 2000 babies were delivered each year at consultant-led maternity services at the Wansbeck General Hospital; however since June 2015 there were no delivery services provided from this location. The Wansbeck General Hospital offered a limited number of maternity services which included a pregnancy assessment unit, ante natal clinics and elective gynaecology. Community midwives did not have an allocated base at this location, however, would attend the unit for advice or to review one of their clients.

Miscarriage and termination of pregnancy was managed at Wansbeck. From April 2014 to March 2015, 193 medical and 113 surgical terminations were undertaken. All planned and routine gynaecology was undertaken on other sites within the Trust. Gynaecological oncology services were provided by neighbouring trusts.

We spoke with 18 members of staff from the maternity and gynaecology services and two women, one was an in-patient from gynaecology and one was visiting the pregnancy assessment unit.

Summary of findings

Overall we rated maternity services as good with the well-led domain rated as requires improvement because:

The service had effective systems in place for reporting, investigating and acting on serious adverse events. We saw that the supply of equipment, particularly in the antenatal clinics, was more than adequate. Medicines were stored and managed carefully and securely. The environment and equipment were clean and ready for use. Staff followed safety guidance for infection prevention and control. Staff planned care and treatment using strict admission criteria to support the assessment of patient risk so that complex births were handled by the consultant led unit at Northumbria Specialist Emergency Hospital (NSECH). Nurse and midwife staffing was appropriate. Medical staffing arrangements were such that they were available to attend as required which could lead to medical assessment and treatment being delayed.

The pregnancy assessment unit and gynaecology services provided effective care in accordance with recommended practice. Staff received the necessary training and assessment of competences so that they could respond appropriately to women's care and treatment. Midwives had supervision of their practice and opportunities for development.

The individual needs of women were taken into account in planning the level of support throughout pregnancy.

Maternity and gynaecology

Staff respected the privacy and dignity of women and their partners. There were no issues related to the demands on the service or fluctuation of workload. Women using the service could raise a concern and be confident this would be investigated and responded to. Formal complaints were dealt with according to the trust's policy.

However, 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. 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 maternity dashboard.

Are maternity and gynaecology services safe?

Good

We rated the safe domain as good because:

The service had effective systems in place for reporting, investigating and acting on serious adverse events. We saw that the supply of equipment, particularly in the antenatal clinics, was more than adequate.

Medicines were stored and managed carefully and securely. The environment and equipment were clean and ready for use. Safety issues were shared in meetings and reports and newsletters. For example, safety issues are discussed and shared in the Obstetrics and Gynaecology Governance Group and perinatal meetings for example.

Staff planned care and treatment using strict admission criteria to support the assessment of patient risk so that complex births were handled by the consultant led unit at Northumbria Specialist Emergency Hospital (NSECH). In this way staff provided care and treatment in a way that ensured women's safety and welfare. Staff followed safety guidance for infection prevention and control. Mandatory training was mostly up-to-date and, overall, compliance was good. Staff had completed their mandatory training or were on target to complete it, in areas relevant to the safety of women and their babies such as safeguarding, infection control and prevention.

Nurse and midwife staffing was appropriate. Medical staffing arrangements were such that they were available to attend as required which could lead to medical assessment and treatment being delayed.

Incidents

- The trust had policies for reporting incidents, near misses and adverse events. In addition, staff who spoke with us demonstrated their awareness of and use of the incident reporting system which was available in all clinical areas. We saw written evidence that incidents were reviewed and any learning shared, for example, in the obstetrics and gynaecology monthly newsletter for

all staff. Staff told us that communication briefs were handed over at the change of shifts and safety notices were cascaded so that all staff were aware of the current issues and guidance.

- Between January and July 2015 there were 231 incidents reported for the gynaecology and obstetrics unit at Wansbeck General Hospital prior to the move to NSECH. None were classed as 'major harm'. Four were classed as 'moderate harm', 93 as 'minor harm or damage' and 134 as 'no harm'. There were no themes.
- In 2015 there were no 'never events' reported. Never events are serious, wholly preventable incidents that should not occur if the available preventative measures have been implemented. Perinatal mortality and morbidity were monitored through monthly perinatal meetings, which were attended by 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.
- Staff were aware of the principles of duty of candour, and were able to provide us with verbal examples of where it had been applied.

Safety thermometer

- The unit used the NHS Safety Thermometer. This is a tool used by frontline healthcare professionals to measure a snapshot of harm once a month from pressure ulcers, falls, urinary infection in patients with catheters and treatment for VTE (venous thromboembolism).
- In the period October 2014 to September 2015, where data was available, the percentage of patients with harm free care (defined as the absence of pressure ulcers, harm from a fall, urine infection (in patients with a catheter) and new VTE) was at or around 100%. This data was displayed in the ward and unit areas.
- There was no maternity thermometer data specific to this location. 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.

Cleanliness, infection control and hygiene

- The service undertook PatientLed Assessments of the Care Environment (PLACE) across obstetrics and gynaecology services. We found all areas passed the assessments when they were conducted in September 2015.
- There were no cases of hospital-acquired Methicillin-Resistant Staphylococcus Aureus (MRSA) or Clostridium difficile (C. difficile) in 2014/15.
- We observed all areas of the hospital providing maternity and gynaecology services and we found them, overall, to be clean and tidy. For instance, in the antenatal clinic area we looked at the daily cleaning checks in the consulting rooms and found that the rooms were clean and were checked most days. Similarly, we found that most of the equipment was clean and ready for use, although one of the adult resuscitation trolleys was dusty. When we mentioned it to staff it was taken away for cleaning, but it had not been returned by the time we completed our inspection.
- There was access to hand gels on entry to all areas and also at the point of care. Staff were seen using the hand washing and drying facilities between the delivery of care activities. Staff also had access to, and were seen using, personal protective equipment, such as gloves and aprons. Staff were following the hospital dress code policy to be bare below the elbow.
- We saw that staff were required to attend prevention and infection control training (including hand hygiene) as a mandatory subject. Compliance with this training was an average of 78%, against a trust target of 85%.

Environment and equipment

- There was adequate equipment on the wards to ensure safe care. For example, there was a good supply of equipment including 16 hysteroscopy sets used to examine the inside of the uterus. There was cardiotography equipment available. There was a resuscitation trolley for emergency medication and equipment available in all clinical areas. There was no resuscitation equipment for babies. Staff we spoke with informed us they had requested a 'resuscitare' for the unit, but had been informed that they did not meet the criteria.
- There was a three bedded room available for clinical examination. There was also a two bedded room,

counselling room and a scanning room also used as the gynaecology assessment service. This room was big enough for scanning and consultation. There were fully equipped colposcopy and hysteroscopy suites available and a separate changing room. There were two obstetric ultrasound scanning rooms.

- There was good compliance with daily checking to ensure that all the necessary equipment was available and ready for use. We were informed by the midwife in charge that the pregnancy assessment unit was going to move from daily to weekly checking of resuscitation equipment. We saw that equipment trolleys were locked with breakable tamper proof tags. Portable electronic equipment, such as a blood pressure machine, had been tested and the next date for testing was clearly marked.
- We did see that some cleaning solutions, such as disinfectant, were being stored in unlocked cupboards or were left out on work surfaces and sink areas, but when we raised this with staffthey were locked away.

Medicines

- There were effective arrangements in place for storing medicines. We saw that medicine cupboards were locked and in a locked room. At the time of our visit, there were no controlled drugs stored in the cupboard. We saw that fridge temperatures were checked in the pregnancy assessment unit.

Records

- At the time of inspection antenatal records were completed electronically, and women who used the maternity services were given their own set of care notes which contained details of their antenatal checks, scans and screening tests. These notes were kept by the women and brought into the birthing unit where they were updated by the nurses and midwives. The trust also retained a separate set of records which could be delivered to Wansbeck General Hospital if needed.
- 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

- Staff we spoke with were aware of the safeguarding procedures. We were told if a woman came in at short notice and they did not have the notes they would look up the case on the safeguarding database. This was a service wide process that staff were aware of locally.
- Staff confirmed they were notified of any potential safeguarding concerns through a red form in the hospital records. This alert would usually come from the community midwifes.
- Staff we spoke with told us that safeguarding training was a mandatory subject for all staff in the department and they had received this training. We saw that training for safeguarding adults and children was being monitored. Broadly 76% of staff in the wards and units had completed the training against a trust target of 85% by 31 March 2016.
- 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.

Mandatory training

- We reviewed data supplied by the trust about mandatory training. For most modules, the trust target was for all staff to have completed training by 31 March 2016.
- The mandatory training for the antenatal clinical staff showed that training on basic life support, conflict resolution, essence of care, safeguarding and the Mental Capacity Act was fully up-to-date and ahead of the target for the year. The only area that was slightly behind the target was in mentorship with a completion rate of 80% against a trust target of 85%.
- The mandatory training data for community midwives showed for Safeguarding Adults – Level 2 only 6% of staff had completed this training but otherwise the data showed for Safeguarding Adults – Level 1 and Safeguarding Children & Young People – level 2 and 3, 76% and 100% respectively had completed the training. Also for Conflict Resolution and Tissue Viability - Pressure Ulcer Awareness, 88% and 76% respectively had completed training.
- The mandatory training data for gynaecology and obstetrics showed 75% of staff had completed mandatory training across most modules but in self assessments on medical devices it was 67%.

Assessing and responding to patient risk

- We observed staff on the pregnancy assessment unit under taking a detailed risk assessment and triage, on the telephone with mothers wishing to attend the unit. Staff used a situation, background, assessment and recommendation (SBAR) tool to assess the suitability of the unit in relation to the needs of the mother. We spoke with senior staff who explained that this was to ensure that women could be referred directly to the correct unit for treatment without delay.
- Safety issues are discussed and shared in the Obstetrics and Gynaecology Governance Group and perinatal meetings for example. There were also weekly communication safety briefings and information is passed on at handover sessions and using safety notices.

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 1:5 across both community and hospital staff which was better than the national recommended 1:28.
- We were advised that community midwifery caseloads were between1:90. However, they told us that the trust was in the process of recruiting more community midwives.
- We visited the pregnancy assessment unit where there were two midwives, a healthcare assistant and a ward clerk on duty. This level of staffing was appropriate. Planned and actual staffing was displayed and actual staff was as planned on the day of our visit.
- There were also plenty of nursing staff supporting the antenatal clinics with three nursing staff and two health care assistants. There was also a diabetes specialist midwife to support the diabetes clinic.
- Patients were on the mixed surgical ward where the nurses did not have a gynaecology background. The ward manager informed us that, some nurses, had expressed ethical concerns about looking after patients following the termination of pregnancy. Others were not familiar with gynaecology procedures such as the disposal of fetal remains.

Medical staffing

- There were consultant-led clinics howeverthere was no dedicated consultant presence for the pregnancy assessment unit or for gynaecology. Medical staff were accessible through an on-call system. Staff we spoke with on the pregnancy assessment unit told us that, if they needed the support of a consultant on the pregnancy assessment unit, they would contact the clinic. They said that, the consultant would come to the pregnancy assessment unit at the end of the clinic or, if the case was more urgent, would leave the clinic temporarily to attend. There were clinics running most days but concern was raised by nurses and midwives about the availability of doctors when clinics were not scheduled. On those occasions they would obtain medical advice from another unit or by using an on-call system. A midwife we spoke with in the pregnancy assessment unit said: 'sometimes it could be stressful'.

The midwife described an occasion where, although it was not an emergency, an anxious patient needed to see a consultant and the consultant could not attend for 30 minutes. We spoke with senior staff about the lack of consultant presence on the pregnancy assessment unit. We were told concerns had been escalated but that they expected the pregnancy assessment unit to move to NSECH but there was no confirmed date for the move.

- We were informed that most of the emergency gynaecology was conducted at NSECH but there was elective gynaecology surgery at Wansbeck General Hospital. All review, management and discharge of in-patients was conducted by a gynaecology nurse practitioner.

Major incident awareness and training

- We saw a copy of the incident and emergency response guides for incidents on the pregnancy assessment unit and antenatal and gynaecology outpatients.
- Senior staff we spoke with on the mixed surgical ward treating gynaecology patients informed us that there was a clear transfer policy to be used in the event of an emergency. So far, they said, the policy had not been used for gynaecology patients. These guides included key contacts and standard operating procedures in the event of loss of power, outbreaks of norovirus, fire and the need to evacuate a clinical area. These guides were in-date with clear version control and review dates.
- The obstetric escalation plan for short term staffing shortfalls and high activity had been implemented on three occasions during the first quarter of 2015, that is, April to June. Only one woman was affected but returned home as she was not in labour. The escalation plan has not been implemented between July and September 2015.

Are maternity and gynaecology services effective?

Good

We rated the effective domain 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, however, some nurses on the surgical ward did not have a gynaecology background and while waiting for formal training, were learning about the speciality 'on the job'. Training ensured medical and midwifery staff could carry out their roles effectively. Competencies and professional development were maintained through supervision.

Information was freely available in the form of leaflets, for instance, about pain relief. However, many were out of date. The trust informed us that it was unable to order new leaflets until the contact details for NSECH were known and as soon as this information was received new leaflets were ordered. In the meantime labels containing the new information were applied to the out of date leaflets. There was advice and support for women about nutrition and hydration during pregnancy.

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

Evidence-based care and treatment

- Policies and procedures were available to staff to guide and inform their practice during the provision of care. We also saw guidance available, for example, from the Royal College of Obstetricians and Gynaecologists on 'antenatal care: routine care for the healthy pregnant woman'.
- There was evidence available at antenatal clinics to demonstrate women using the services of the hospital were receiving care in line with the National Institute for Health Care Excellence. We saw the diabetes clinic used quality standards 63 on the management of diabetes and its complications from pre-conception to the postnatal period. There was also a midwife with specialist knowledge and experience of diabetes supporting the antenatal clinic when we visited.
- Clinical guidance for the management of induced abortion up to 17 weeks and 6 days of pregnancy was

available. This was based on the Abortion Act 1967 and the Human Tissue Authority's 'Code of Practice 5 on the disposal of human tissue' and Royal College of Obstetricians and Gynaecologists 'national evidence based clinical guideline number 7'. We found staff in the fertility control service adhered with the Abortion Act 1967 and Abortion Regulations 1991. This included the completion of the necessary forms (HSA1 and HSA4).

- Staff were informed of any relevant new and updated national or trust guidelines through the monthly newsletter. Governance Group meetings and audit days were also listed in this newsletter.

Pain relief

- Although no births took place at Wansbeck General Hospital, we saw a leaflet available for women on pain relief in labour. The leaflet was written by the Obstetric Anaesthetists' Association.
- During our inspection there were no gynaecology inpatients and therefore we were unable to assess pain relief provision, however, there was an anaesthetist and nurse practitioner on call to prescribe pain relief as required.

Nutrition and hydration

- 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.
- There was advice for women on nutrition and hydration during pregnancy, particularly women visiting the diabetes clinic.
- There was a midwife-led clinic on weight management in pregnancy.
- There were no maternity in-patients during our inspection and therefore we were unable to assess food provided.

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).
- Miscarriage and termination of pregnancy was managed at Wansbeck.

Competent staff

- We spoke with a midwife working on the pregnancy assessment unit. She said that her confidence had grown as she was dealing with more complex issues such as the reduction in foetal movements. She said that during her time in the unit she had become better able to assess risk and make decisions and understood her responsibility to exercise judgement. She said that it was reassuring to be able to consult with colleagues or contact the on-call midwife if necessary. This midwife said it would be helpful to have a dedicated consultant for the unit.
- The newly qualified midwife said that she had just had her annual appraisal. She said that the process had been supportive and helpful.
- We were informed that not all the nurses on the surgical ward had a gynaecology background and, in some instances, had expressed a lack of confidence in gynaecology nursing around the disposal of fetal remains, miscarriage and termination. We were told that specific training was being planned, but in the meantime the nurses were 'learning on the job'. We were told that this had not led to any incidents. We spoke with health care assistants working in the obstetrics and gynaecology clinics. They said that they were not trained to offer counselling for Down's Syndrome screening but would refer patients to the midwife sonographers or one of the midwives on the pregnancy assessment unit.
- As at 30 September 2015, 100% of staff in the antenatal clinic, 93% of community midwives, 75% of staff in obstetrics and gynaecology and the pregnancy assessment unit and 76% of staff on Ward 10, had received an appraisal against a trust target of 85% by 31 March 2016.
- The day surgery unit had good access to the main theatre block. This unit closed at 20:00.

Maternity and gynaecology

Multidisciplinary working

- We saw and were informed of the effective working relationships involving doctors, therapists, midwives and nurses from the pregnancy assessment unit, antenatal clinics and gynaecology.
- We were also told that community midwives would visit the unit to attend meetings or discuss issues with colleagues.

Seven-day services

- The pregnancy assessment unit was open from 08.30 to 17.30 Monday to Friday with the last booking at 16.30. 'Out of hours' services were directed to NSECH.
- Antenatal clinics were held daily and were open 08.30 – 17.30.
- Gynaecology patients were seen in the Day Surgery Unit which closed at 20.00 hours.Any patients who need to stay would be transferred to a surgical ward.

Access to information

- We found that there were a good range of helpful leaflets available. However, while we noticed that leaflets on anti-D prophylaxis and caesarean section had been updated old versions were in use as well.
- Some leaflets were significantly out of date but were still being used. These included a leaflet on ectopic pregnancy (which was due for review January 2010) and a leaflet on external cephalic version (a process by which a breech baby can sometimes be turned) (which expired in October 2009). We spoke with senior staff who confirmed these leaflets were still being given to women.
- For some of the leaflets that were in-date or had been updated recently, the telephone numbers did not reflect the new service at NSECH and still referred to services that were no longer available at Wansbeck. The trust informed us that it was unable to order new leaflets until the contact details for NSECH were known and as soon as this information was received new leaflets were ordered. In the meantime labels containing the new information were applied to the out of date leaflets.
- Staff we spoke with said that there was a reluctance to print new leaflets until the future of the maternity services were more certain. In the meantime, they had been given address labels to stick on the old leaflets before being handed to women.
- We found that HSA4 forms were completed electronically and in a timely manner.

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.
- Staff had a good understanding of mental capacity and described the process of caring for women who may lack capacity. 94% of staff had completed MCA level 1 training.

Are maternity and gynaecology services caring?

Good

We rated the caring domain as good because:

During our inspection we spoke with two women. We received feedback indicating that staff were caring and compassionate. In the pregnancy assessment unit we observed midwives respecting the privacy and dignity of women and their partners.

One woman we spoke with indicated that they would have benefited from seeing the same community midwife as this would have provided more continuity of care.

Compassionate care

- A woman we spoke with, who was a first time mum, said that the care she had received was good. She said that the midwives had enough time and were able to explain the care and treatment. She said that she had all the information she needed.
- There was no friends and family test data for this location due to the low number of responses, however, trust wide data showed 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.

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.
- We noted the rate of home births was low (below 1%).Records showed staff discussed birth options at booking and during the antenatal period. Supervisors of midwives, and the consultant team were 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

- Standard operating procedures were in place for the sensitive disposal of fetal/placental tissue, following early pregnancy loss.
- Each woman has a named community midwife. Women we spoke with said that they had seen a number of community midwives and that this affected the continuity of care and emotional support. They said they would have preferred to see the same community midwife as this would have enabled them to establish a relationship and not repeat their medical history each time. However, the trust told us the community midwifes work in small teams to provide cover for holidays and days off.
- 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.
- There was also a local charitable group called 'Teardrop' which worked with the bereavement midwives to provide support for women and their families following pregnancy loss.
- There was a separate room on the pregnancy assessment unit for counselling support.

Are maternity and gynaecology services responsive?

Good

We rated the responsive domain as good because:

There were no issues related to the demands on the service or fluctuation of workload.

Women using the service could raise a concern and be confident this would be investigated and responded to. Formal complaints were dealt with according to the trust's policy.

However, staff expressed the view that the pregnancy and gynaecology assessment units at Wansbeck would be in a position to respond to a greater number of patients and a broad range of individual needs if they were co-located with consultant led services. It was argued that this would improve access and flow.

Service planning and delivery to meet the needs of local people

- Women could contact the pregnancy unit and there was a telephone triage service. There was clear acceptance criteria, and those who did not meet this were referred to NSECH.
- The hospital is not overly busy and does not need to divert women to services elsewhere.
- We observed a woman waiting 20 minutes to speak to a consultant by telephone because there was no dedicated medical cover on the pregnancy assessment unit.
- Concern was expressed by staff about the current configuration of services at Wansbeck. Staff expressed the view that the pregnancy and gynaecology assessment units at Wansbeck would be in a position to

respond to a greater number of patients and a broad range of individual needs if they were co-located with consultant led services. It was argued that his would improve access and flow.

Access and flow

- All rostered antenatal clinics had a scanning service running in parallel.
- The pregnancy assessment unit was open from 08.30 to 17.30 Monday to Friday.
- Women would be referred to the pregnancy assessment unit by community midwives, general practitioners or women could self-refer.
- The day surgery unit had good access to the main theatre block. This unit closed at 20:00. If at that time there was a medical problem the staff on the unit contacted the anaesthetist and or nurse practitioner. There was no duty gynaecologist; however, if there was an emergency the Nurse practitioner could contact the on-call team at NSECH. Staff could not recall an occasion when this was required.
- Senior staff we spoke with told us that pressure for beds was low and that, in the summer, the ward had been so quiet some staff had feared for the continuation of their jobs. We were told activity had 'picked up' and staff were feeling more confident about the future of ward 10. When we visited the ward there were one gynaecology patient and plenty of empty beds.
- The elective surgical ward included elective gynaecology inpatients, miscarriages and terminations. This ward was not busy and had many empty beds.
-

Meeting people's individual needs

- We were informed that there was no fixed location for the emergency gynaecology clinic and it could be either in the gynaecology area or the pregnancy assessment unit. We found that sometimes an emergency gynaecology clinic was running alongside the pregnancy assessment unit. This meant that those women who may have lost a baby would be sitting alongside pregnant women. We were informed by the midwife that: 'we have had complaints about this but not many'. This was not sensitive to the individual needs following the loss of a pregnancy.
- There was a counselling room or multi-purpose room available on the pregnancy assessment unit. There was a bereavement co-ordinator and the service was supported by a local charity the tear drop group. There were a number of specialist midwives and nurses to meet the needs of vulnerable women, and women with diabetes.
- There are two individual side rooms on the surgical ward for miscarriages and terminations. 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

- There were 11 formal complaints about maternity services between April and September 2015. Of these seven involved the services offered at Wansbeck General Hospital obstetric unit prior to its move to NSECH.
- We found evidence demonstrating that all the complaints received were investigated. We were informed that all complaints were discussed at the monthly meeting of the obstetrics and gynaecology governance group and lessons learnt discussed with staff individually and at departmental meetings.
- Most of the issues raised in the complaints related to the attitude of individual members of staff, and the manner in which they communicated. One complaint, for example, related to the result of antenatal screening and the way in which it was perceived by a pregnant mother to be handled by a consultant. In several cases people complained that insufficient explanation was offered in relation to care and treatment. In all cases an apology was given and, where appropriate, a meeting was held with the complainant. The complaints were documented in the integrated governance quarterly report and learning shared with staff in meetings and through bulletins.
- There was one formal complaint received within the Gynaecology service between April and September 2015 and this related to poor care and treatment. The complainant said that her notes were not available, and no explanation was given about the procedure and the care lacked compassion.
- The quarterly governance report documented the outcomes from complaints including the learning for staff.

Maternity and gynaecology

Are maternity and gynaecology services well-led?

Requires improvement

We rated the well-led domain 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. 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 maternity dashboard. Risks were reported and monitored and action taken to improve quality.

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

Staff were positive about working at Wansbeck and professional about the services they offered. There was support for the local leadership.

At the same time, they were able to express their beliefs about the future and the overall configuration of maternity and gynaecology services following the opening of NSECH. Staff were engaged in the issues and keen to improve services for women and their families.

Vision and strategy for this service

- 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.
- We spoke with staff about the overall plan for the pregnancy assessment unit and gynaecology. The doctor said that the team had concerns about the lack of a resident consultant presence at the pregnancy and gynaecology assessment units at Wansbeck and questioned whether this 'compromised care' overall.
- The staff informed us that the issues had been escalated and they understood that there was a commitment to move both units to NSECH, although they did not know when or how this would happen.
- Senior staff we spoke with said that the move of maternity to NSECH had been an 'afterthought' and that, as a service, women's health appeared to be a lower priority. This consultant also described the emergency gynaecology at NSECH (a single room in the middle of an acute surgical ward) as 'inadequate'.
- Staff we spoke with said that they felt unsettled and that the pregnancy assessment unit would be relocated to NSECH. They also said that they felt that some things were not being done because of this such as, re-printing leaflets and adding a lock to the door of the clean utility cupboard. However, the trust told us that work on repairs at Wansbeck PAU had not been discouraged because there were no plans to move location and further leaflets were not re-ordered until the contact details for NSECH were known.

Governance, risk management and quality measurement

- We spoke with the Governance and Audit midwives. They were able to discuss the governance and risk management processes and showed us the dashboards, quarterly integrated governance report and newsletter. We also reviewed the services risk management strategy.
- They informed us that the highest risk for the department at this time was around the community midwives workload. They also said that there had been difficulties with backup notes not arriving in time for appointments. We saw that midwives had been reminded to request the backup notes without delay.
- Staff told us that communication briefs were handed over at the change of shifts and safety notices were cascaded so that all staff were aware of the current issues and guidance.
- 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. The risk management strategy had not been reviewed to reflect the current service provision.

- 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.
- 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 and also the gynaecology dashboards recommended by the Royal College of Obstetrics and Gynaecology RCOG. The dashboards showed clinical performance and governance scorecard and helped to identify patient safety issues in advance. There were no issues RAG rated red in the Gynaecology dashboard since June 2015. 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 and gynaecology 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 was no alignment between the risk register and the senior team worry list.Through discussion with the senior team there was concerns about relocation of pregnancy assessment services at NSECH. This was not documented on the directorate risk 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.
- Completion of HSA1 (grounds for carrying out an abortion) and HSA4 (abortion notification) forms were completed by two doctors who followed guidance and submitted the forms to the Department of Health as required.

Leadership of service

- The maternity and gynaecology service sat within the surgical business unit
- Senior staff in the pregnancy assessment unit, clinics and gynaecology were knowledgeable about their service and they were able to describe the patient pathway.
- Staff we spoke with were positive about the local leadership of the service.

Culture within the service

- All staff we spoke with were aware of the continuing changes taking place around the configuration of maternity and gynaecology services across the trust. They were aware of the growing pressures on NSECH and the need to make further changes to support those services. This was leading to some uncertainty about the future in Wansbeck and speculation about the likely changes ahead.
- Staff were uncomfortable about the uncertainty about the future of maternity services at Wansbeck.
- Staff sickness levels in Wansbeck maternity between June 2015 and August 2015 was 8%.This equated to 0.93% for community midwifery and 2.23% for obstetrics and gynaecology staff and 4.85% in antenatal

clinic. The overall trust sickness absence rate for Obstetrics and Gynaecology was 2.25%, against a trust target of 3.5%. Some of these related to long-term sickness.

Public engagement

- We saw that there was a recently established 'Maternity Service User' forum. We saw the minutes of the inaugural meeting and that the service was going to consider a reflective service for women to discuss their birth experience and peer support volunteers on the wards.

Staff engagement

- We observed that staff were fully engaged in issues affecting the services at Wansbeck Hospital. They were aware the service was likely to move to NSECH but that they were waiting for a suitable space. They had been engaged in the issues before and had argued in favour of a PAU at NSECH but felt the decision had already been made.
- 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 five being highly engaged and one being poorly engaged, the trust scored 3.93. This score placed the trust in the highest 20% of trusts compared to similar trusts.

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 reported good outcomes.
- 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, and 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 patient's experience of care and interactions with staff.

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 provides 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 team consists of a band seven specialist palliative care nurse and two palliative care nurses (Band 5 and Band 6). Their role is 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 involves 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 are 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 2,352 in-hospital deaths.

WGH had a 20 bed dedicated palliative care unit for patients with end of life and palliative care needs. Patients requiring end of life care would also be cared for in ward areas throughout the hospital with support from the hospital liaison palliative care team. 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 WGH consisted of two nurses, one band 7 specialist palliative care (SPC) clinical nurse specialist (CNS) and one band 5 palliative care nurse. There was a band 6 vacant palliative care nursing post that the trust was recruiting to.

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. During our inspection we spoke with staff based on the palliative care unit, members of the hospital liaison palliative care team, the wider integrated palliative care team, mortuary staff, chaplaincy staff and ministers, medical staff, palliative care consultants, medical director, specialist service managers, ward managers, nursing staff, health care assistants, allied healthcare professionals and student nurses. In total we spoke with 30 staff. We visited a number of wards and clinical areas across the hospital including palliative care, surgery, respiratory, acute medicine, elderly care, stroke care, and cardiology. We reviewed the records of eight patients at the end of life and reviewed Do Not Attempt Cardio Pulmonary Resuscitation (DNACPR) orders. We spoke with three patients and three relatives and we reviewed audits, surveys and feedback reports specific to end of life care.

End of life care

Summary of findings

We rated end of life care at WGH as outstanding because:

Leadership, governance and culture of the trust were designed to drive high quality end of life care services using an innovative model of working and effective partnership working. There had been significant investment in palliative and end of life care services and the trust was responsive to addressing the needs of the local population in the development of end of life care services across both acute and community. There was a clear vision, strategy and leadership at all levels of the organisation with a focus on good quality end of life care. 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.

There was a strong person-centred culture and we saw that staff were motivated and inspired to do more through a holistic approach to care and support. Examples included a trust wide emphasis on the assessment of spiritual, cultural and emotional needs and additional support to patients and families around discharge home where services crossed acute and community boundaries to ensure people received the support they needed. Information demonstrated that more patients were dying in their usual residence than there were five years before and we saw clear plans to continue this trend and ensure an emphasis on patients preferred place of care. The trust performed in the top ten NHS trusts in England in the 2014 National Cancer Patient Experience Programme national survey, with 95% of respondents rating the care as being excellent or very good.

We saw evidence of the use of national guidance and appropriate anticipatory prescribing of medicines at the end of life. There was a strong culture of multidisciplinary working across services within the hospital and the community. The use of a dedicated palliative care unit and hospital liaison meant that there was a culture of understanding of palliative and end of life care that was integrated across disciplines and with other services. Patients and their families were involved in care and we saw a number of initiatives in use and embedded to record patient wishes including advance care plans, emergency healthcare plans and treatment escalation plans.

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.

End of life care

Are end of life care services safe?

Good

We rated safe in end of life care services as good at this hospital because:

Staff understood their responsibilities to raise concerns and to record safety incidents. The manager of the PCU participated in hospital wide incident meetings where there were opportunities to share learning across departments and staff groups. 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 treatment escalation and emergency health care plans in ensuring that all patients had a plan in place should their condition deteriorate.

Appropriate equipment and medicines were available for the care and treatment of patients at the end of life. Staffing levels and skill mix were planned, implemented and reviewed to keep people safe at all times and we saw evidence of flexibility in staffing to ensure staffing levels were adequate.

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 on the PCU (palliative care unit) told us that the ward manager and matron would investigate any incidents that occurred. The ward manager or a representative from the ward attended weekly incident review meetings that were attended by staff from across the hospital and facilitated by clinical matrons. This enabled staff to discuss incidents outside of individual units and share learning across wards and clinical areas.
- We viewed minutes of clinical governance meetings where incidents were discussed, however the most recent minutes were from June 2015. The ward manager told us that meetings were not being held as regularly as planned due to recent staffing difficulties on the ward.
- We saw an example of learning from an incident which led to a change in working practices in the mortuary relating to two patients with the same name. Changes included additional checks to verify the patients identify. We saw evidence that the learning from this incident had been cascaded across all mortuary sites within the trust.
- We saw evidence that incidents were discussed by the palliative care steering group and at relevant ward based and team based meetings to share information and identify opportunities for learning.
- Staff we spoke with had an awareness of their responsibilities in relation to duty of candour.

Safety thermometer

- Safety thermometer information was visible on the wall in PCU. The NHS Safety Thermometer has been designed to be used by frontline healthcare professionals to measure a snapshot of harm once a month from pressure ulcers, falls, urinary infection in patients with catheters and treatment for VTE (venous thromboembolism).
- The safety thermometer dashboard between October 2014 and September 2015 showed that on average 94% of patients received harm free care. Harm free care is defined by the absence of pressure ulcers, harm from a fall, urine infection (in patients with a catheter) and new VTE.

Cleanliness, infection control and hygiene

- Clear guidance was available for staff to follow to reduce the risk of infection when providing end of life care. We observed staff using appropriate techniques to reduce the risk of infection including handwashing and the use of personal protective equipment (PPE) such as gloves and aprons.

- Mortuary procedures and protocols incorporated infection control mechanisms including daily monitoring and recording of the temperature of the mortuary fridges.
- The trust monitored compliance with infection control procedures through the use of the 15 steps Safety and Quality assessment. Specific observations included the general cleanliness of the ward, the use of PPE and the effective management of clinical waste.

Environment and Equipment

- The PCU was situated in a ward within the hospital. The environment was suitable with a combination of single bedded side rooms and four bedded bays.
- There was a body store at WGH. 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 mortuary fridges were temperature monitored and alarmed.
- We observed the use of McKinley syringe drivers on the wards and saw that regular administration safety checks were being recorded.
- Staff on the PCU and the specialist palliative care team told us that equipment was available when they needed it from the equipment library. None of the staff we spoke with had experienced any difficulty in accessing equipment when they needed it.
- We saw evidence of equipment having been safetytested and routinely maintained.

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. Controlled drugs were stored safely and correctly.
- A pharmacist visited the unit on a daily basis to reconcile medicines and carry out activity such as medicine audits.
- We viewed an August 2015 audit of omitted medication doses to ensure that critical medicines were administered as prescribed and saw an action plan for the pharmacist to work with ward staff to improve performance in this area.

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 eight 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 21 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 recorded in sufficient detail within the patients notes in all but one case.
- 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. At the time of our inspection administrative staff and some nursing staff had received training on the new system and we saw plans were in place for the remaining staff to attend training.

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 although this was below target for staff on the palliative care unit. 77% of nursing staff had attended safeguarding level one training against a target

of 85% and 69% had attended safeguarding children training against a target of 85%. There was a plan in place for all staff to complete their safeguarding training by the end of March 2015.

- 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.
- Records for the nurses on the palliative care unit showed that 100% had attended slips, trips and falls training against a target of 85%, 92% had undertaken a medical devices self assessment and 92% had undertaken care records management training. A number of areas of mandatory training were below target such as basic life support (23%) and conflict resolution (31%).There was a plan in place for all staff to complete their mandatory training by the end of March 2015.

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

- We viewed rotas and saw that the establishment was generally met using permanent and regular bank staff, with a minimal use of agency staff. However, staff told us that registered nurse vacancies (4) had impacted the unit and their ability to maintain certain aspects of work such as regular ward meetings and completion of mandatory training. At the time of our inspection all posts had been appointed to and we saw that post holders were due to start on an induction to the unit over the course of the coming weeks.
- Staff we spoke with on the PCU told us there was some flexibility with staff and that they were able to request additional staff if they had higher patient dependency levels. The ward manager and matron told us that they were awaiting the results of work on the nursing establishment using a safer nursing acuity tool.
- 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 WGH 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.
- 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.
- 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. One consultant took the lead for acute inpatient services including wards at WGH.

End of life care

- 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 were told that the specialist palliative care team regularly discuss 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 there was a business continuity plan in place relating to the body store/mortuary which included arrangements for times of increased mortality rates, for example in the winter months where capacity within the mortuary can be increased to meet demand. The plans included the use of the other 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 occurred.

Are end of life care services effective?

Outstanding ☆

We rated effective in end of life service 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 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.

Staff were proactively supported to acquire new skills and share best practice. The model of end of life care services saw that dedicated palliative care beds were operated alongside a specialist palliative in-reach service to general ward areas. This meant that specialist staff worked alongside general staff to deliver effective, coordinated care within a holistic approach. Staff, teams and services were committed to working collaboratively and found innovative and efficient ways to deliver more joined up care to people who use the service. This was demonstrated through services that worked across both acute and community settings with a strong multi-disciplinary ethos.

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. 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.
- 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 we spoke to told us that their pain was under control.We saw that pain relief was administered in a timely manner and we did not observe any patients in pain during our inspection.
- We viewed pain scales being used appropriately on the wards to assess patient 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.

End of life care

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 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.
- Healthcare assistants we spoke with told us they had received training in nutrition, hydration and mouth care for patients at the end of life and they understood their role in supporting patients in this way.
- The matron of the SPCT told us they had been approved funding for a nutritional support post on the PCU where the post holder would support patients in a variety of ways to meet their nutrition and hydration needs. Similar posts were also in place on other wards.
- 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 told us that the catering staff were flexible in ensuring that patients nutritional needs were met and in particular that patients at the end of life were able to choose the food they wanted. We were given examples of when staff had gone out of their way to ensure patients had the food they wanted, including situations where catering staff had made specific items requested such as bacon sandwiches.

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.
- We saw that the learning from the audit across the trust had been incorporated into all end of life care activity, including activity at WGH.
- The trust 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 CDP document had been audited in October 2014 following initial implementation in July 2014. Action had been taken to make changes in response to findings with the current iteration of the document having been implemented following changes made as a result of the audit.
- We viewed Commissioning for Quality and Innovation (CQUIN) goals that had been set around increasing the proportion of patients with cancer or end stage chronic disease with a recorded emergency healthcare plan (EHCP) in place and an increase in the percentage of patients with a DNACPR with an appropriate mental capacity assessment or best interest decision in place.
- We saw data that demonstrated an increase in the number of patients with an EHCP in place, for example in the six months between April and December 2014 there had been a 22% increase in the number of patients on the PCUs with one in place. We saw evidence of mental capacity assessments and best interest decisions in place.

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.

End of life care

- Members of the specialist palliative care team had specialist training in palliative care including degree modules.
- 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.
- Healthcare assistants we spoke with confirmed they had attended end of life care training with one telling us they had recently attended palliative care training as part of their induction.
- 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.
- Staff working on the PCU attended an annual palliative care training day where they would receive specific training updates to support the care of patients at the end of life. Staff we spoke with told us the training was helpful in keeping them up to date and an opportunity to learn from the specialist nurses and allied professionals who participated in the delivery of the training.
- 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. 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.
- 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.

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.
- 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, and physiotherapy and occupational therapy services.
- We observed multidisciplinary working on the PCU across disciplines such as nursing, medicine, pharmacy, physiotherapy, occupational therapy and social work. In particular we saw effective MDT working relating to rapid discharge into the community for patients at the end of life.
- The SPCT held a site specific MDT meeting at WGH every week and the team attended a SPCT MDT meeting on a weekly basis that was attended by SPCT staff 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.
- 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.
- Staff we spoke with across the hospital consistently demonstrated a commitment to collaborative working across multi-disciplinary teams so as to provide high quality holistic care to patients in a way that involved them and their families as much as possible. We saw this commitment reflected in the structure of services and the management plans for future service development.

Seven-day services

- Inpatients at WGH 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.
- Patients nursed on the PCU received care from staff trained in palliative and end of life care.
- Face to face specialist nursing input was available Monday to Friday using the hospital liaison team although telephone advice was available to ward staff from the palliative care inpatient unit and 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 was in the process of implementing 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 WGH 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 WGH. 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 patient 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 directives, the use of independent mental capacity advocates (IMCAs) and the use of mental capacity assessments.
- We viewed records where mental capacity assessments and best interest meetings had been undertaken. We

viewed a record of an application for a Deprivation of Liberty Safeguard (DoLS) for one patient. Records relating to capacity assessments and recording of consent were seen to be completed correctly, accurately and in a timely way.

- 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 five patients who had been identified as lacking mental capacity. We saw in two cases that discussions had been held with individuals identified as having power of attorney. We viewed one example where discussions with the patient or relatives was not adequately recorded and we saw two examples where consideration of the persons ability to consent or be involved in discussions had been recorded in line with mental capacity assessment processes. We saw examples where clear assessment of mental capacity recorded and best interest decisions had been made with the involvement of those close to the individual patients.
- 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 or other representatives.

Are end of life care services caring?

Outstanding ☆

We rated caring as outstanding in end of life services because:

Staff at WGH provided compassionate care to patients and their families. We saw that 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 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.

Feedback from patients and relatives was consistently positive and 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. The trust performed in the top ten NHS trusts in England in the 2014 National Cancer Patient Experience Programme national survey, with 95% of respondents rating the care as being excellent or very good. Staff provided additional support at a time when both patients and their families were likely to feel concerned about what to expect.Examples included where staff had stayed beyond the end of their shift to ensure patients had the support they needed.

Compassionate care

- During our inspection we saw that patients were treated with compassion, dignity and respect on the palliative care unit and in all other patient areas we visited in the wider hospital.
- 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.
- Patient experience surveys demonstrated a consistently high score on patient feedback regarding the palliative care service in Northumberland. For example, in 2 minutes of your time feedback data for the quarter period from April to June 2015, 100% of patients said they had been treated with dignity and respect and 100% felt satisfied overall with the care they had received. At the time of our visit current overall satisfaction scores were displayed on the wall on the PCU, the score was 9.8 out of 10.
- The trust performed in the top ten NHS trusts in England in the 2014 National Cancer Patient Experience Programme national survey, with 95% of respondents rating the care as being excellent or very good.
- Patients and relatives we spoke with told us they were extremely satisfied with the quality of care they received. One relative told us that staff were always

willing to help and that they created a calm and soothing environment. A patient we spoke with told us they felt safe, comfortable and that the care could not be better.
- Staff told us of a couple who were married on the PCU where they bought flowers for the ceremony.
- We were told of a lady who was upset because she wasn't able to go out and buy her daughter a birthday card or present so staff went and bought a card and chocolates for her to give.
- Another patient only wanted to eat a specific cake so staff went and found one for them. Staff baked cheese scones for another patient as that was what they wanted to eat.
- Staff were taught basic principles of hand massage as an intervention to provide support and comfort to patients.
- 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.
- Patient privacy and dignity was respected. We observed staff caring for patients in a way that demonstrated an awareness of privacy and dignity.

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. The patient experience team visited the PCU on a monthly basis and spoke with patients and relatives to ask for feedback on their care. We viewed feedback on the wall in the unit and saw that the trust clearly recorded both positive and negative feedback and actions taken to improve patient experience.
- 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.
- A healthcare assistant on one of the wards told us how they had encouraged a family to help care for their loved one and how they routinely took time to do this as it was best for the patient and their family. The staff member told us: 'we can't do this without them'. We saw an example of a relative helping to support a patient nutritionally. The relative told us that staff took the time to involve them.

Emotional support

- Patient 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 from many faiths which 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.

End of life care

- 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.
- 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.
- Volunteers worked with ministers to provide listening for patients who wanted to talk.
- A bereavement service was available across the trust for the families of patients who had died and dedicated bereavement support staff were based at WGH. Staff told us they used special tote bags for the property of patients who had died rather than standard hospital plastic property bags. They also gave relatives a packet of forget me not seeds when they came to collect a death certificate.
- Members of the palliative care team had attended training in advanced communication skills. Additional support was provided to patients by a psychologist who worked as part of the MDT.

Are end of life care services responsive?

Outstanding ☆

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

End of life care services was 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. Through the development of dedicated palliative care beds and a hospital liaison palliative care service that supported patients being cared for in non-palliative care beds the trust had adopted an innovative approach to providing an integrated person-centred pathway of care. The trust worked 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.

Service planning and delivery to meet the needs of local people

- The palliative care inpatient unit at WGH had been opened in 2011 following the successful implementation of a similar unit at North Tyneside General Hospital (NTGH) in 2009. The aim of the unit was to provide dedicated inpatient beds for patients at the end of life. The trust told us they had decided to open dedicated palliative care units after reviewing place of death data that showed the trust had a higher than national percentage of patients dying in acute hospital beds and a lower than national percentage of patients dying in hospice beds.
- The palliative care hospital liaison service was widely embedded throughout clinical areas in the hospital and worked across sites at the other acute hospitals in the trust, including the emergency hospital at Cramlington.
- 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 a significantly greater number of patients.
- The hospital liaison team model was one that had been developed jointly with Marie Curie and with resources invested by both the charity and the trust to create joint posts and collaborative working to meet the holistic needs of patients in both hospital and community environments.
- Total referrals to palliative care went from 2013/14 (1024) to 2014/15 (2142). This increase included the hospital liaison team.

End of life care

- Work had been undertaken to increase specialist palliative care support to patients with non-malignant disease. This had increased across the trust by more than 200% 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%.
- 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.
- 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% to 50% in 2014 compared to the national average of 44%. 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

- On the PCU patients were cared for in shared bays or 5 individual side rooms and in other ward areas in the hospital patients at the end of life had access to side rooms where possible.
- Personalised individual care plans ensured that care was tailored to meet the needs of the patient at the end of life. An end of life care pack was available in all clinical areas and 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.
- 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 and staff gave us examples of when they had used this information to support families in the care of patients with a variety of religious or cultural beliefs.

End of life care

- 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 quiet room with prayer mats available for patients, staff and visitors. The chapel was suitably designed to meet the needs of people with a variety of faiths.
- 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. An 'Oasis' room was available for relatives of patients at the end of life. The room was a spacious, calm and peaceful space for relatives to rest and reflect when staying at the hospital with a loved one at the end of life. The room had a self-contained kitchen that was stocked with drinks and snacks that were regularly replenished by volunteer staff using charitable funds. Toiletries and other items designed to improve comfort were also available.

Access and flow

- Patients at the end of life at WGH were cared for on the palliative care unit with specially trained staff available twenty four hours a day, seven days a week. Patients at the end of life who were unable to be cared for on the PCU were cared for on general hospital wards with support from the palliative care liaison service.
- 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 commence on the CDP document the team would be alerted straight away.
- It was the aim of the palliative care service to see patients urgently 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.
- There was a waiting list for admission to the PCU. Staff told us that the criteria for admission was based on individual patient need. Staff told us that patients in the community would generally take precedence over a patient already in a hospital bed elsewhere in the trust because admission was based on patient need.
- 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.
- 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 hospital liaison team meeting, with learning used to develop practice.

End of life care

- There were very few complaints relating to end of life care. We viewed evidence of learning, including staff receiving training in communication skills relating to supporting patients and their relatives at the end of life and the language used.
- We saw that when a complaint was made they were taken seriously and that action was taken as a result.
- 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 as outstanding in end of life services 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 WGH with the use of a dedicated palliative care unit and a specialist palliative liaison service to support patients being cared for in non-palliative care beds. 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.
- 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.
- 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.
- 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 WGH 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 development of a palliative care inpatient service and a hospital liaison service in collaboration with Marie Curie. Staff we spoke to at WGH 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 sits within the directorate structure of community and social care.

End of life 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, recognising the Palliative Care Units (at Wansbeck and North Tyneside hospitals) and 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.We saw also 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 matron's 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.

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.

End of life 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 and those working on the PCU had received an annual appraisal and a personal development plan as a result.

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. A band 7 specialist nurse was available 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.
- 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 direct questions in a more straightforward way so as to ensure patients understood.
- 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.
- 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

Wansbeck General Hospital provided a range of clinics covering the majority of clinical specialities, including general surgery, orthopaedics, urology, oncology and cardiology. The department had around 40 consulting rooms including private consulting and treatment rooms. The clinics were allocated into four separate waiting areas supported by a team of qualified and unqualified nurses.

Outpatient services were part of the trust's Emergency Surgery and Elective Care Business Unit. The business unit director with support from a deputy director and a number of general and operational service managers, specialist clinical leads, and support services such as human resources, finance, information and administrative support led the unit.

From January to December 2014 Wansbeck General Hospital undertook 125,021 outpatient appointments. Outpatient opening times were from 8.30am to 6pm Monday to Friday and 8.30am to 12.30pm on Saturdays. Staff from Wansbeck General Hospital were responsible for covering the trauma clinics at the Northumbria Specialist Emergency Care Hospital seven days a week.

The main reception was at the entrance to the main outpatients department. Three medical records clerks/ receptionists staffed it. Patients were booked in on arrival for their appointment and directed to the appropriate sub-waiting areas within the main department.

Radiology services were part of the Clinical Support Business Unit. The business unit director led the department with support from a deputy director, an operational service manager, trust lead radiographer, and lead consultant radiologist with a site lead radiographer at Wansbeck.

Diagnostic imaging services were open for 24 hours a day, seven days a week. The department offered several imaging techniques including plain x-ray, CT scanning (CT head scans only out of hours), diagnostic ultrasound from 8am to 6pm Monday to Friday, and theatre fluoroscopy(A computerised tomography (CT) scan which 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. Diagnostic ultrasound, also called sonography, which is an imaging method that uses high-frequency sound waves to produce images of structures within the body. Fluoroscopy is an x-ray technique that enables a doctor to watch a medical procedure or look at an area of the body in detail. A dye is often injected to help provide a more detailed picture, and an X-ray or CT scan is taken to see the path of the dye).

A private company managed the MRI scanning department independently from 8am to 5pm seven days a week. Trust radiologists provided reports for MRI scans (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).

The X-ray department provided four general x-ray rooms, two CT scanners, three ultrasound rooms, three mobile x-ray machines and three image intensifiers in theatre as well as mammography facilities.

Outpatients and diagnostic imaging

During the course of our visit we observed outpatients clinics. We spoke with 17 patients and one relative and with 21 members of staff including, consultants, qualified and unqualified nursing staff, radiographers, porters, clinical specialists, medical records clerks, and receptionists.

Summary of findings

Overall, we rated Wansbeck General Hospital outpatients and diagnostic imaging services as outstanding because:

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.

Outpatient 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. Waiting times for all types of appointments consistently met national targets. Some specialties had experienced capacity and performance difficulties these had been well managed and resolved. All appointments were booked within acceptable timescales. Prior to emergency services moving to NSECH in June 2015, the radiology department had developed trauma image reporting, which was swift with an emphasis on “results within minutes” for emergency patients. This was the process that had been adopted at the new NSECH hospital and enabled medical teams to complete assessments and manage risks quickly. A radiographer discharge programme facilitated the discharge of patients having soft tissue injuries directly from radiology by suitably

Outpatients and diagnostic imaging

trained radiographers. The departments for outpatients and diagnostic imaging learned from complaints and incidents, and developed systems to stop them happening again. The departments delivered services to respond to patient needs and ensured that departments worked efficiently.

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.

Patients were happy with the care they received and found it to be caring and compassionate. Staff worked within nationally agreed guidance to ensure that patients received the most appropriate care and treatment. Trust policies protected patients from the risk of harm by making sure they met any individual support needs. Staff demonstrated understanding of these policies and followed them.

Are outpatient and diagnostic imaging services safe?

Good

We rated safe in outpatient and diagnostic imaging services as good because:

Staff were knowledgeable about the process for reporting and investigating incidents and shared lessons learned with staff. Performance data and minutes of trust meetings are widely communicated. There was a good reporting and feedback culture.

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

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.

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

The overall nurse staffing number for the department had recently increased with the redeployment of 12 staff from the amalgamation of two surgical inpatient wards. Changes to the consultant job plans and on call arrangements were still ongoing following the opening of the new hospital.

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.

Outpatients and diagnostic imaging

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 over the past 12 months.
- 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. Outpatients had recorded 22 incidents in the last year. Each incident was categorised by theme and the trust had assessed the majority of the outpatient department reports as causing no harm, only 4 incidents had been assessed as causing minor harm. The manager told us that they discussed incidents and brought them to the attention of the team at morning staff meetings, known as "huddle" meetings.
- Staff could give examples of incidents that had occurred and investigations that had resulted in positive changes in practice. The operational service manager monitored incidents on a daily basis and actioned them immediately. Staff told us that they were encouraged to report any incidents using the electronic incident reporting system and were fully aware of the procedure to do so. Staff discussed incident follow up at the daily huddles. We saw from meeting minutes that staff also reviewed incidents at weekly ward and department governance meetings within the emergency surgery and elective care business unit, at monthly trust wide outpatient department meetings and at the individual departmental meetings.
- Staff could discuss specific incidents on an individual basis to support greater understanding and support reflective learning.
- The majority of incident reports were related to delays in clinic waiting times. Managers had introduced waiting time escalation plans with actions attached for staff to follow in the event of clinic delays. If the delay was between 0 to 15 minutes: the nurse in charge would provide a visible presence and monitor the situation, 15 to 30 minutes: staff review, discuss with medical staff, and inform patients. 30 minutes and above: review medical staffing, escalate to senior managers, offer patients refreshments, and record as an incident.
- Staff discussed recent learning from an incident that had resulted in effective actions taken to address the issues identified.
- 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. Staff were aware of the need to be open and honest when dealing with patients concerns and the manager told us that the duty of candour principles were discussed at staff meetings.

Diagnostic Imaging:

- There had been two radiological incidents reported by the trust under Ionising Radiation (Medical Exposure) Regulations (IR (ME) R) 2000 in the previous year. These were low level and included scanning the incorrect patient and one incident where the incorrect body part was scanned. Trusts must report to the Care Quality Commission (CQC) any unnecessary exposure of radiation to patients. There was evidence staff had checked these, taken actions, and produced action plans 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.
- The x-ray department displayed details of general incidents and feedback. There were a low number of general incidents within radiology and staff had reported 21 in the last year, only four of which had resulted in minor harm. There were no never events or serious untoward incidents.
- 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.

Cleanliness, infection control and hygiene

- Staff undertook hand hygiene and 'Saving Lives' audits (reducing infection, delivering clean and safe care in the NHS), 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 sawthat staff washed their hands regularly before attending to each patient. Patients we spoke to confirmed this. Departments provided hand gel stations 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.
- 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.
- During the inspection, we observed a very thorough clean of an x-ray room following patient use. General observation of the whole department found it to be clean and uncluttered.
- All patient waiting areas, consultation and treatment rooms, and private changing rooms were 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 departments 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

- All areas we inspected were clean, well kept and patient areas were spacious and bright. Staff ensured that consulting, treatment and testing rooms, store rooms and the plaster room were well stocked. All staff followed the standard operating procedure for cleanliness and infection control. We observed no obvious environmental hazards during our inspection.
- Staff had completed risk assessments in March 2015 for the control of substances hazardous to health (COSHH), manual handling, caring for patients in beds, on trolleys and chairs and safe systems of work. Staff had submitted the assessments to the health and safety risk officer for patient services for review and they had recommended no further actions.
- Treatment and store rooms were clear of clutter, appeared clean, tidy and consumables were all in date.
- The trust provided dedicated safe areas for children to play and the cleaning schedules for the play equipment and toys were up to date.
- We found that resuscitation trolleys and equipment including suction and oxygen lines were 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.
- 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 also saw a range of clinical equipment had been serviced such as blood pressure monitors.
- 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 rectified them quickly or escalated them to the department manager.

Diagnostic imaging:

- The design of the environment within diagnostic imaging kept people safe. Waiting and clinical areas were clean. 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. Radiology staff collected dosimeters and sent them for testing every month. Results were all within the safe range.

- 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. We saw reviews against IR(ME)R and learning shared to staff through team meetings and training.
- 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. All x-ray equipment had been measured by the regional medical physics advisor and had been found to be safe.
- 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. They 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 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.
- Internal prescriptions were provided to medical staff. The register of FP10s was seen, and these prescriptions were monitored.
- Patient group directions which include written instructions for the supply or administration of medicines for use in the outpatient's clinics, radiological contrasts and drugs used in CT had been completed and reviewed.

Records

- 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 tracking the movement of patient notes throughout all of the trusts locations.
- The clinic reception/administration staff were part of the medical records team. Staff assured us that it was rare for notes not to be available and the majority of notes were available at the time of the patients appointment. The annual audit report on the notes availability for the department at year ending March 2015 showed that 99% of the notes were available for the outpatient clinics.
- If patient notes were physically unavailable, we were assured that sufficient clinical information was available to the clinician to see the patient as records were accessible electronically. The electronic records included doctors' letters, x-rays, MRI, CT and pathology results. However, a doctor told us that the notes were 'always available' and they couldn't remember the 'last occasion when the notes weren't available'.
- Records contained patient specific information which included the patients previous medical history, presenting condition, personal information such as name, address and date of birth, medical, nursing, and allied healthcare professional interventions. We observed staff checking patient identification against their medical notes when booking in for their appointments in clinics.
- We reviewed six patient records which were completed with no obvious omissions. All contained patient demographics and contact telephone numbers.
- We reviewed six electronic record referrals in the x-ray department. Five of the six sets contained full and complete patient demographics, relevant clinical information, appropriate test results and detailed the investigation requested. The remaining record had an

incorrect user code which meant that the x-ray staff were unable to ascertain which clinician had requested the test. The CRIS system generated an on-screen error which would not allow the referral to be progressed until this had been corrected. Staff immediately identified and rectified this by contacting the department where the referral came from and obtaining the correct user code. This allowed the completed test report to be sent back to the right clinician first time and in a timely manner therefore not delaying reporting and proposed treatments for the benefit of the patient.

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. Nurses carried out assessments of blood pressure, weight, height, and pulse for patients according to clinical needs. We saw staff undertaking these checks during our inspection.
- Patient information, diagnostic images and reports were stored electronically and available to doctors using Picture Archiving and Communications System (PACS), and Clinical Radiology Information System (CRIS). Pathology reports were available to view 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 four electronic patient records in diagnostic imaging. Staff referred patients into diagnostic imaging electronically and radiology staff viewed details on the CRIS system.
- All notes 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 at the time of our inspection were up to date with both adult and children safeguarding training level 1 and 2. They knew how to escalate concerns and we saw from the department's monthly training report September 2015 showed that staff had completed safeguarding training.
- For patients attending the x-ray department who may be vulnearable, the trust provided a designated waiting area.

Mandatory training

- 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. The overall departmental compliance score was at 95% against a trust target of 85%.
- The monthly training report for September 2015 showed that 87% of staff had received induction. The manager had questioned this figure with staff development as local records indicated that all of the staff had received induction. Senior staff told us that 12 staff had recently transferred from the surgical unit to the outpatients department and their information had not yet been assimilated into the department's training figures.
- 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

- The trust had clear policies and guidance in place for managing medical emergencies. Staff received basic life support training as a minimum.
- If a patient were to deteriorate on site, subject to the circumstances, the emergency crash team would be called using '2222' or the CCOT (Critical Care Outreach Team) would be called on '7777'. There was an anaesthetist on site. Should the patient require further care, staff would arrange an ambulance to convey them to the Northumbria Specialist Emergency Care Hospital (NSECH).
- Staff knew what 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.
- We saw from the department training report basic life support training was above the trust target at 88% to date.
- Staff completed risk assessments including National Early Warning Score (NEWS), pre-assessment for procedures and pain assessments. Nurses and radiographers recorded these in patient records and escalated any concerns to medical staff.

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.
- 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.
- All radiology equipment had been risk assessed and safetytested to ensure the safety of staff and patients. Specific testing and reporting on equipment included radiographic tubes and generators, ultrasound, CT and image intensifiers.
- 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. Staff followed 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 and screening departments used adaptations of the WHO safer surgical checklist for all interventional procedures. Staff audited checklists for compliance and quality.

Nursing and allied health professional staffing

- Senior nursing staff told us that managers had undertaken a comprehensive review of staffing that involved a review on the number of clinics, tasks, and chaperone requirements. The outcomes from this review were not completed at the time of our visit. However, the overall staffing number for the department had recently increased with the redeployment of 12 staff from the amalgamation of two surgical inpatient wards. The increase in staff took into account the rotational cover of staff to the trauma clinics at the Northumbria Specialist Emergency Care Hospital. Mentors had been allocated for all of the redeployed staff.
- The overall staffing numbers for the department included the nurse manager band, nine qualified nurses, and 26 nursing assistants along with three plaster room technicians. Each of the four areas had a minimum of one qualified nurse to two nursing assistants on duty and staff worked flexibly to cover planned and unplanned absences. Agency staff were used to cover the plaster room.
- The trust had recently allocated a Matron specifically attached to outpatient's services across the trust. They had also recently recruited two new outpatient sisters to share the four main outpatient hospital sites.
- 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.
- 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. However, rotation of radiology staff to the new hospital and departmental changes had caused some attrition.

Diagnostic Imaging:

Outpatients and diagnostic imaging

- Recruitment in radiology 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.
- There is a site lead radiographer based permanently at the diagnostic imaging department at Wansbeck General Hospital. Radiographers worked on a rotational basis to staff the Northumbria Specialist Emergency Care Hospital and retain their range of skills.
- Managers told us they monitored staff sickness and rates were consistently low.

Medical staffing

- 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 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 visit.
- A new consultant had recently been appointed to oral surgery and the managers were confident this would serve to assist the trust to meet the referral to treatment (RTT) 18 week target in this speciality.

Diagnostic imaging:

- There was a national shortage of radiologists. The trust had four vacancies and the trust radiology lead 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.
- All medical staff completed a full trust induction and we saw the programme for the newly appointed locum was underway.
- The sickness rate for radiologists in the previous year was 1.95%.
- Two consultant radiologists were based at NSECH and provided cover to staff at all sites from 8am and 8pm seven days a week. A team of consultants were on duty during weekdays at Wansbeck between 9am and 5pm.
- Two radiology specialist registrars were supernumerary in order to facilitate their training on Mondays to Fridays. Registrars told us that the trust provided them with good working experience and radiologists and the department as a whole supported them. The trust had secured funding for additional specialist registrar posts.
- 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.

Major incident awareness and training

- We saw the major incident policies along with the business contingency plans were available and staff told us they had recently updated and reissued them. The manager told us that they would discuss the plans at the next staff meeting. It was not clear from the training records we looked at as to whether staff had received training.
- 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 during our inspection we observed the following:

The trust 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 trust 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 all 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

- The trust provided some specialities such as cardiology with rapid access chest pain clinics. They provided one stop multi-disciplinary breast service clinics including bone health assessments and screening.
- 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 National Institute for Health and Care Excellence and other specialist guidance that affected their practice. Specialties were responsible for compliance with National Institute for Health and Care Excellence guidelines, Public Health England directives, and specialty specific guidance such as Royal Colleges at national, regional, and local levels. All policies and guidelines were stored on the trust intranet. As staff received new guidance and directives, the department managers ensured updates to clinical practice.
- The departments were adhering to local policies and procedures.
- Staff followed standard operating procedures in line with best practice guidelines to determine each patients referral and ongoing treatment pathways based upon the diagnosis. Staff understood the impact they had on patient care.

Diagnostic Imaging:

- Staff were following procedures regarding National Institute for Health and Care Excellence guidance to prevent contrast induced acute kidney injury and completed evidence based documentation before, during and after interventional procedures.
- The diagnostic imaging department carried out quality control checks on images to ensure the service met expected standards.
- We saw reviews against IR(ME)R and learning shared with staff through team meetings and training.
- The trust had a radiation safety policy which met with national guidance and legislation. The purpose of the policy was to set down the responsibilities and duties of designated committees and individuals. This was to ensure the work with Ionising Radiation undertaken in the trust was safe 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.

Pain relief

- Pain relief advice was included as part of the patients outpatient consultation and ongoing treatment plans.
- The trust provided specific clinics for pain management.

Nutrition and hydration

- 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

- The trust report from February to July 2015 showed that for all clinical specialties over 86% of patients were seen within 15 minutes of their appointment times. This figure excluded patients who arrived late for their appointment or where time seen was not recorded. The trust reported overall that the percentage of patients waiting over 30 minutes to see a clinician was (5.85%).
- Waiting times within the clinic were monitored and there was a clear escalation plan 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.
- The trust had a working group reviewing bariatric out-patient care for the previous 7 years and totalling in the region of 1,000 patients to inform future practice and service development. The bariatric consultant shared his “society produced data” with trust governance for quality improvement performance.
- The trust participated in local and national audits of patient outcomes and had implemented the ’15 Steps’ programme which, supported by the NHS Institute for

Innovation and Improvement, looks at care through the eyes of patients to help capture what good quality care looks, sounds and feels like. The x-ray department were involved in this process and had received feedback from the '15 Steps' team visit. The departments received feedback on the day of the visit followed by a report which detailed wider findings. Managers shared the report findings at team meetings and followed up highlighted actions at manager and staff meetings.

Diagnostic imaging:

- The x-ray department were actively involved in local and national audit; they displayed the results of some of these initiatives in the patient waiting area. We observed a published '15 steps' report (a NHS Innovation and Improvement initiative that captures data from the perspective of the patient to see what good quality care looks, sounds and feels like) in the patient waiting area.
- 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.
- All diagnostic images were quality checked by radiographers before patients left the department. Staff followed national audit requirements and quality standards for radiology activity and compliance levels were consistently high.
- 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.
- 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 except ultrasound met national standards. Ultrasound results had affected the overall trust operational standard target for two months only and had improved significantly as additional staff was recruited.
- 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 told us that they had received appraisals. The 2015/16 trust wide appraisal report showed that the majority of the outpatient's staff were up to date with their appraisals. Managers discussed staff training needs at annual appraisals and staff told us opportunities to develop and receive trust support was available. Staff were encouraged to attend courses to update their skills and knowledge.
- The trust had agreed all local protocols and competencies. Staff were encouraged to question practice if they had any concerns. Senior staff checked and documented staff competencies and medical devices training in all departments.
- Staff were actively encouraged to develop. One consultant stated that the trust supported their teaching and non-clinical duties, allowing them to continue with national and international research opportunities.
- Students were welcomed in all departments and students told us they felt supported and encouraged to develop when working within the departments. Several staff had chosen to work at the trust following student placements.
- The trust carried out medical revalidation for all consultants.

Diagnostic Imaging:

- Managers had created eight reporting radiographer posts and four trainee sonographer positions to train existing staff and improve skills pathways. The posts were introduced to improve ultrasound capacity, plain x-ray reporting levels and in response to the national shortage of radiologists.
- Consultant radiologists had annual appraisals with a named appraiser. They had dedicated SPA (supporting professional activities) time, study leave allowance and funding.
- 47% of radiographers had completed appraisals to date for the year 2015 to 2016. The manager was aware of this and provided support for the lead radiographer to ensure they planned appraisals for all staff to be completed by the year end.

Outpatients and diagnostic imaging

- Nominated key staff led on specialist information and guidance in radiology on areas such as radiation protection and education for referrers. Radiation protection supervisors undertook annual training updates.
- Radiographers followed the trust competency framework where staff must perform a number of observed procedures to gain competency in that particular area. Designated supervisors approved and signed off the competency framework.
- 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 the department 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.
- One radiography student told us the department had offered them good opportunities to achieve the required learning for their placement. A designated educational lead for radiology supported all radiography students.

Multidisciplinary working

- The trust provided one stop multi-disciplinary breast service clinics including bone health assessments and screening.
- There was evidence of multidisciplinary (MDT) working in all departments we visited. In the outpatient clinics the onward management of the patients treatment could involve intervention from physiotherapy, radiography, plaster room technicians, and occupational therapy. Staff maintained 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:

- Radiography staff rotated to other trust sites therefore gaining exposure to wider work experiences and MDT working. One staff member stated that they found this very stimulating, motivating and a way to keep upskilled.
- 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.

Seven-day services

- 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.
- Outpatients managers had not fully developed seven day working within the outpatients setting as they had judged there was currently no demand for this service. The majority of staff were employed with seven-day working terms and conditions. The department supported the delivery of outpatients clinics over a six-day service including Saturday and evenings when demand occurred. Such demand was mostly for extra capacity to support Waiting List Initiatives requested by specialties to help address shortfalls in capacity.

Diagnostic imaging:

- Diagnostic imaging provided services seven days a week. The trust provided a 24 hours a day, seven days a week service for emergency plain x-ray imaging, emergency CT, heads only during the night, and out of hours portable images. Staff also provided radiology services to GP patients from Monday to Friday. A team of consultants were on duty on weekdays between 9am to 5pm.
- The diagnostic imaging department provided general radiography, CT and ultrasound scanning, theatre fluoroscopy and mammography for all patients every day. There was a rota to cover evenings and weekends so inpatients and emergency care patients could use diagnostic imaging services when they needed to.
- An external company provided MRI but the trust had secured a managed seven-day service. They held 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 8am to 5pm 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

- The clinicians had access to a range of clinical information accessed electronically which was securely protected such as x-ray, MRI, CT, and pathology results.
- The department had a dedicated appointment service for patients to arrange their radiological scans.
- 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.
- 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. Clinicians 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 identified patients with learning difficulties, memory impairment, or safeguarding concerns during their attendance at the emergency department and urgent care centres. Staff documented and escalated concerns at this point to the medical and safeguarding teams in compliance with trust policy
- 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.
- Staff obtained consent for any interventional procedures in writing according to the pre-assessment policy before attending departments for 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. We saw from the department's training reports that learning disabilities, mental capacity level 1 and 2 training was included. The overall outpatients compliance score was 95% for level 1 training and 90% for level 2. The trust standard was 85%.
- 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 told us if they had concerns about a patients capacity they would refer to the trust independent mental capacity advocate (IMCA). Staff confirmed that they held informal confidential discussions; particularly at pre-assessment stage should capacity or consent be raised as a concern.
- Although 93% of staff in radiology had completed level 1 mental capacity training, only 50% of medical staff had completed mental capacity level 2 training. The trust standard was 85%. Managers had action plans in place to ensure all staff achieved the required level for their role by the end of the year.

Are outpatient and diagnostic imaging services caring?

Good

We rated caring as good because:

Outpatients and diagnostic imaging

Staff respected patient privacy, dignity, and confidentiality at all times. Patients told us, and we confirmed during our inspection, that staff treated them in a kind consistently caring and compassionate way at every stage of their care and treatment. Staff spent time with patients and those attending with 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 undertook training 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 care which allowed patients to make informed decisions about the treatment they received.

Compassionate care

- We observed staff speaking to patients in a polite manner. Reception staff respected patient privacy when they were checking personal details on arrival for their appointments.
- Staff interactions with patients in all areas we inspected were polite, courteous, and respectful. We heard staff introducing themselves when dealing with patients and relatives. Staff greeted patients in a kind and friendly manner.
- Reception staff respected patient privacy when they were checking personal details on arrival for their appointments.
- We spoke with 17 patients and one relative and all said that staff were friendly with a caring attitude. There were no negative aspects highlighted to us.
- The patients and their relatives told us staff had treated them with dignity and respect and overall they were happy with the service provided. They also told us that the staff were friendly, and professional. We observed two nursing assistants showing care and concern for two disabled patients. They ensured the patients were seated safely and close to the nursing station so they could maintain observations.
- Staff confirmed that the patient would have a chaperone made available when intimate examinations were performed or at any time on their request.
- 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.
- The trust used the Friends and Family Test (FFT) to obtain information from outpatients on their experience. Results demonstrated that staff were caring and 87% of people would recommend the outpatients service to others between April and October 2015 (slightly worse than the England average of 92%) and 3% of patients or those close to them would not recommend it (the same as or slightly better than the England average of 3%).
- An extensive multi-faceted patient experience programme assisted the trust to obtain and gain a broad and deeper understanding of patient experiences. The 2014/15 outpatient experience results continued to be outstanding. The department achieved an overall average score of 88% with the score for the top 20% in England standing at 84%. Results from quarter one, April to June 2015, showed the department had further improved its average score to 89%.
- Scores also showed that 90% of patients would recommend the trust and 98% of patients rated the trust as excellent, very good or good. There were variations between the specialties with scores ranging from the lowest at 83% to the highest at 96%.

Diagnostic imaging:

- Staff respected patient 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 in x-ray informed us that they spent the time necessary with patients to ensure they informed, supported, and reassured them about the procedure to be undertaken.

Understanding and involvement of patients and those close to them

- 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 consented.
- Patients and their families were given time to ask questions.
- Staff in x-ray informed us that they spent whatever time necessary to ensure that the patient understood and consented to the procedure. Staff also confirmed that should they have any concerns about a patient who did not fully understand what their care entailed then they could delay or cancel the procedure to suit the patient.

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.

Are outpatient and diagnostic imaging services responsive?

Outstanding ☆

We rated responsive as outstanding because:

The trust had worked with the local population, primary care, and commissioners to plan a new model of emergency care and had successfully reconfigured outpatients and diagnostic imaging services at Wansbeck General Hospital to ensure that the service met people's needs.

Outpatient 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.

Waiting times for all types of appointments consistently met national targets. Some specialties had experienced capacity and performance difficulties and these had been well managed and resolved. All appointments were booked within acceptable timescales.

Prior to emergency services moving to NSECH in June 2015, the radiology department had developed trauma image reporting, which was swift with an emphasis on "results within minutes" for emergency patients. This was the process that had been adopted at the new NSECH hospital and enabled medical teams to complete assessments and manage risks quickly.

A radiographer discharge programme facilitated the discharge of patients having soft tissue injuries directly from radiology by suitably trained radiographers.

Staff made sure services could meet patients individual needs, such as dementia, learning or physical disabilities, or those whose first language was not English. 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.

The departments recorded concerns and complaints, which they reviewed and acted on to improve patient experience. 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 trust provided a shuttle bus service running between Wansbeck and North Tyneside General and NSECH hospitals for patients and relatives to use.
- 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. Some of the patients we spoke with were not happy about car parking arrangements and not all of them were aware of the signs that parking charges could be waived if their appointment times were delayed.
- 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 trust reported from July 2014 to August 2015 short notice clinic cancellations within six weeks was low (1%) and the percentage cancelled over six weeks was 11%. Some of the main reasons clinics were cancelled was due to annual leave, on call commitments, sickness, clinical and business meetings, training and study leave.
- Patients told us that they received appointment letters in a timely manner and provided the necessary information following referral; and the trust offered choice and times for follow up appointments.
- Senior managers told us that changes to the consultant job plans and on call arrangements were still ongoing following the opening of the new NSECH hospital. The trust had 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.
- A new consultant had recently been appointed to oral surgery and the managers were confident this would serve to assist the trust to meet the RTT 18 week target in this speciality.
- Pathology staff provided a Point of Care Team (POCT) which was clinical pathology accredited for each blood test carried out.
- The trust had recently installed new nurses' stations to improve the welcoming of patients to the department and to also provide a base and improve accessibility of staff. The stations provided a safe temporary area for notes and clinic lists with patient identifiable information as well as an appropriate area to request X-Rays and blood tests.

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.
- The radiology department provided a workflow coordinator on each shift to assess activity and schedule procedures according to patient needs.
- Diagnostic imaging reporting and record keeping was electronic and the department used paperless methods to reduce time and administration.
- Turnaround times for urgent radiology reports were 24 hours, two weeks for general scans and 30 minutes for urgent images such as those for suspected stroke patients. Management of routine radiology reports ensured completion within national target times.

Access and flow

- We observed that seating in the main and sub-waiting areas was sufficient to meet the demand of the patients attending appointments. Staff informed patients of any delays to appointment times.
- Patients attending the hearing aid drop in service were experiencing significant delays. Patients attending the clinic took a numbered ticket and the last number called was displayed so patients were aware of the number of patients before them but not of the estimated time to their appointment.
- The trust had a low level of patients who failed to attend with a 'Did Not Attend' (DNA) rate (6%) which was lower than the 7% national average. Managers monitored this continually to enable adaptations and staff told us that the rate had improved since the onset of the automated voice system to remind patients seven days and again one day before attendance of their appointments. Clinicians made all decisions and actions for patients who DNA based upon the care they felt the patient needed.
- The trust's new to follow up ratios were similar to the rates of the majority of trusts at 1:2.2.
- The percentage of appointments cancelled by the trust within 6 weeks of an appointment date was consistently low with an average over the previous 12 months of 1% which was much better than the England average of 6%. The main reasons given for cancellations were medical staff annual leave, on-call commitments, attendance at clinical and business meetings, study leave, research, training, and sickness.
- The percentage of patients waiting for over 30 minutes to see a clinician in outpatients across the trust was 5%. There were no delays during our inspection at this site.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.

Outpatients and diagnostic imaging

- Staff followed waiting time escalation plans taking appropriate action when there were clinic delays. The 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. There were no extended delays during our inspection.
- The monthly National Statistics on NHS Consultant led Referral to Treatment (RTT) waiting times April 2013 to May 2015 showed that the trust consistently performed at or above the national average of 95% of (non-admitted patients) starting treatment within 18 weeks and above the national average of 92% for patients waiting to start treatment (incomplete pathways).
- The trust performed continually better than the England average in all three measures for cancer targets. Where individual speciality targets dipped below the national standard operational service managers were proactive in working with specialist teams to meet capacity and demand for patient referrals.
- The trust had missed the national 62 day target for upper gastrointestinal (GI) for June, August, September, November and December. Senior managers told us this was due to capacity problems caused by a sudden increase of patients through choose and book from another local area. Managers monitored all targets and reported to the trust board through their overall performance reports. These were escalated to the surgical risk register and actions assigned to improve the target. They did achieve100% in July 2015 and had continued to achieve this to date.
- The percentage of non-admitted patients seen within 18 weeks of referral over the previous 12 months ranged between 95% and 97% and was continually higher (better) than the operational standard of 95% and the England average (apart from September 2015 when it was 93%). However, for the period between April and August 2015, general surgery, urology, Trauma and orthopaedics, oral surgery and plastic surgery was the only specialty at this hospital where results dipped just below the national standard (95%) at 94%.
- The percentage of patients with incomplete care pathways who had started their consultant-led treatment ranged between 92% and 93%. The operational standard in England is 92%. In oral surgery, an increasing pattern showed percentages slowly rising from 66% to 89%. A newly appointed oral surgeon was in post and patient waiting times were reducing. However, results for trauma and orthopaedics had declined from 91 to 85%. Managers had recorded these as a governance risk. Outpatient staff had checked the results and found there were no delays in the appointment systems and this target was failing further along the patient pathways for treatment.
-

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.
- 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 reported within 48 hours. Staff reported 97% of emergency and head injury images within an hour. Reporting was routinely outsourced and at night emergency images were reported within one and a half hours.
- There was a very low DNA rate in x-ray. The average rates for the previous 6 months were CT: 3.3%, plain x-rays: 1.9% and ultrasound: 7.5%. The ultrasound DNA rate had peaked in July to September 2015 which staff believed were due to longer waiting times. However the rate had reduced to 5% as waiting times improved in October 2015.

Meeting people's individual needs

- The reception staff along with the nursing teams were currently trialling discreet identification cards attached to the patient notes that had any disability, sight, or hearing difficulties or needed extra assistance. The reception staff then provided the staff with the detail and handed over the notes with the appropriate card attached as a constant reminder to all staff of the patient needs. We observed receptionists handing the notes with the cards attached and they provided the nursing staff with the relevant details.

Outpatients and diagnostic imaging

- Patients attending appointments with memory impairment and learning difficulties were identified through the 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. The reception staff informed the nursing teams if patients had any additional needs.
- 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.
- The reception staff organised interpreter services for patients who did not speak or understand English. Staff told us they did not have trouble in booking interpreters. 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.
- Staff used private areas to hold confidential conversations with patients and receptionists told staff quickly if patients had difficulties with speaking, listening, understanding, or needed extra assistance.
- 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.
- The trust provided good quality patient information leaflets, condition specific information, health promotion information and trust information in all patient areas. The information was easily accessible to all visitors and patients to the respective departments and staff could provide it in several different languages when needed.
- 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.
- 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). Staff selected x-ray equipment as it was replaced to enable access for larger and heavier patients.
- Staff confirmed that relatives or carers would be encouraged to remain with a patient throughout their clinic appointment or procedure to minimise any distress the process may cause.
- Television screens provided information for patients and general health advice.
- The X-ray department had a large formal reception area with a spacious waiting area. There was a children's play area with clean equipment. The waiting area was clean and well maintained, provided comfortable seating, a water cooler, patient information leaflets and was within clear sight of reception staff. Radiographers greeted patients in the waiting room and escorted them to the procedure rooms and changing areas. An additional waiting area was provided in CT.
- Dedicated porters transported patients from wards to the department and returned them after their procedures.
- Posters and information in the waiting areas reinforced common patient, relative and carer concerns such as chaperones, privacy and dignity with the use of gowns .An information poster about a 'day in the life of a radiographer' giving a behind the scenes overview of the journey through x-ray was also on public display.
- The departments were accessible for people with limited mobility and people who used a wheelchair. The reception area had a designated hearing loop.
- The staff in the outpatients department supported outreach clinic services at HMP Northumberland.
- The outpatients department was well signposted. The reception area was bright and modern and designed to promote private conversation at the desk area.

Outpatients and diagnostic imaging

- Three receptionists received patients and they managed the flow through the department efficiently as they directed patients to the relevant sub-waiting areas once checked in for their appointments.
- Information was available and displayed publicly in relation to hand hygiene audit results, departmental ratings and patient experience results.
- Sub-waiting areas provided adequate seating arrangements and a quiet room was available for use by patients and relatives.
- Where clinics were delayed staff would provide pagers to patients so they could visit refreshment facilities without missing their appointments.
- Patients attending outpatients had access to coffee and snack facilities. We saw the local hospital volunteer service brought a trolley to the department for patients to obtain drinks.
- All departments were well signposted and provided plentiful comfortable seating and areas for children.
- Disabled toilets were available in all departments.
- Patient toilets (including disabled facilities and baby changing) were all easily accessible. Outpatients provided a specific toilet and hand basin especially for children.

Learning from complaints and concerns

- 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 provided its complaints policy on the trust web site.
- Staff understood the local complaints procedure and took a proactive approach to dealing with any patient concerns or complaints. Their aim was to resolve concerns or informal complaints immediately and they 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 patient advice and liaison service (PALS). Department managers kept logs of actions taken and shared lessons learned from complaints and concerns with their teams.
- The trust complaints report from September 2014 to August 2015 showed patients made eight formal complaints in outpatients. The majority of complaints attributed directly to outpatient services were about appointment delays.
- 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 managers discussed complaints with staff during these meetings. 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:

- There had been only two formal complaints directly attributed to diagnostic imaging; one patient had moved house and had not received their appointment letter and another had to wait for a joint injection because the consultant was on sick leave.
- Staff managed complaints in diagnostic imaging and showed us logs of actions they had taken to address concerns and their outcomes. The trust put processes in place to prevent recurrence of both types of problems.

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.

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

- The trust in October 2015 launched 'The Northumbria Way' which linked together a number of existing key programmes of work that contribute to improving quality and delivery of high quality care. This information was publicly displayed throughout the hospital and available through the trust intranet and extrnet.
- Staff were aware of the trusts values and knew how to access this information from the intranet. Staff showed us the quality strategy 2014 to 2016 outlining the aims and key objectives of the strategy which included 'The Northumbria Way' and how it linked to departmental objectives.
- The Emergency Surgery and Elective Care Business Unit Annual Plan (2015-2016) set out clear and realistic aims for quality, safety, patient centred care, efficiency, and growth. The strategy was able to show that from the patient experience data the trust had consistently performed higher than the top 20% of trusts.
- Teams were motivated and had been involved in planning and preparation for new departments and services in preparation for and following the opening of the new hospital, NSECH. They evaluated their performance continually against the plans and were preparing for the year ahead.
- All departments we inspected had good leadership and management and staff told us managers involved them in strategic working and planning.
- Staff were proud to work in the 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, driven by the hospital, directorates, department leadership, and staff.
- 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.
- 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:

- Radiology had presented a business case to provide a new service for small bowel radiology.
- 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. They had employed eight assistant practitioners. Operating department practitioners had taken on extended roles and radiographers were providing the relevant training.

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 groups all reporting to the governance group then to the assurance committee and onwards to the board.
- 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. 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 managed each risk and they gave descriptions of key controls to mitigate risks.
- Managers shared learning from incidents across the organisation using regular directorate and operational service manager meetings, and staff emails.
- The business unit took part in the trust wide auditing programme and monthly performance against targets.
- The 15 Steps Challenge is a toolkit with a series of questions and prompts in order to obtain first impressions of a ward or department. The challenge assists trusts to gain an understanding of how patients feel about the care provided and helps the trust to identify the key components of high quality care that are important to patients and carers from their first contact with the department. We looked at the results from the 29 April 2014 and the more recent 30 March 2015 outcomes. The outcome assessment report in March demonstrated that the outpatients department had significantly improved in all of the five domains. Staff rated safe, effective, and caring as good. Responsive and well-led required improvement. We saw from the April 2015 action plan that all of the required actions from the last assessment were completed. A number of staff told us that they were initially disappointed with the outcomes but had learned from the assessment and had pulled together as a team to improve the quality of service offered to the patient.

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

- Staff told us that the Chief Executive Officer was known to staff and had visited the department. Staff knew the executive team, who invited and listened to new ideas for change and sent out regular messages to staff.
- There were clear lines of management support and accountability for the business unit as a whole.
- The trust had strengthened nursing leadership of the outpatient's service with the recent allocation of a Matron and the appointment of two band 7 nurses to share the four main hospital sites.
- 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 managers listened to their views. Local departmental leadership was reported to be positive and supportive. Staff told us they knew what managers expected of them and of the departments. Staff felt line managers communicated well with them and kept them up to date about the day-to-day running of the departments, their expectations of staff and the departments. Managers had planned some positive changes and some had already taken place.
- There was confidence and respect in the management. We saw good, positive, and friendly interactions between staff and local managers. Staff told us they were proud to work in the hospital and integrated teamwork was evident in all departments.
- 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.

Outpatients and diagnostic imaging

- 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.

Diagnostic imaging:

- Managers supported staff to carry out continuous professional development activities, complete mandatory training, and appraisal, and complete specific modality training, medical devices training, and competencies.

Culture within the service

- Staff said the culture was "open, approachable, and receptive, all the way to the top".
- Staff stated that they felt supported by the trust and wanted to stay to progress.
- Managers asked staff for their ideas on how to improve their services practice and overall the majority of the staff felt supported by their local managers.
- 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 changing 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.
- 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 and practice.
- 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.

Public engagement

- The outpatient patient perspective survey results for the quarter April to June 2015 continued to show the service as being extremely good. On average the trust is in the top 20% of all Trusts in England. It is in the top 20% for 19 of the 20 most important questions to patients and in the middle 20% for the other one.
- The trust website enabled patients and the public to comment on the care they had received. Departments displayed compliments and complaints received.
- Outpatient staff told us of a recent survey undertaken in consultation with patients with regards to the use of televisions within the waiting areas. The survey was completed but they had not collated the results at the time of our inspection.
- The trust had well embedded systems and processes for gathering and responding to patient experiences and the results were well publicised throughout the hospital. Staff collated the data collected from the 'real-time' feedback and provided results to each department as a means to inform practice and the development of service provision.
- The trust used a combination of methods as an approach to understanding the experience of patients including national patient experience surveys and a questionnaire found throughout the hospital called "Two minutes of your time". Staff encouraged patients to use the comments boxes situated in out-patients and the results were well publicised throughout the hospital.

Diagnostic Imaging:

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

Staff engagement

- The trust had a number of internal communication and engagements with staff. They included, for example, weekly staff updates through e-bulletins to all

employees;monthly team briefs cascaded to staff from executive management and a quarterly staff magazine. Staff were aware of how to access all of this information from the intranet and extranet.

- Staff told us the executive team undertook road shows across the trust to update staff working at all units on major developments and to encourage them to ask questions. The trust posted outcome notes from road shows on the intranet.
- The trust held business unit governance meetings weekly and local departmental 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, 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 managers listened to their views and they had opportunities to contribute towards the development of their departments, the configuration of services and resource planning.

Diagnostic Imaging:

- Radiology staff contributed in the writing of standard operating procedures (SOPs) across the department and invited theatre staff to provide input into procedures involving their practice.
- 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.

Innovation, improvement and sustainability

- The trust displayed the top five achievements the outpatient service had accomplished across all of the main outpatient locations. These included: privacy and dignity with the installation of new nurses' stations at two locations used for secure confidential areas for patient information, the virtual trauma clinic, charitable monies obtained to buy new toys and refurbish audiology, a staff ideas forum, and displayed waiting times.
- The service also had a top five list to inform patients and relatives of what they were going to achieve. These included: provision of chaperones for procedures including phlebotomy, sharing feedback from audits with service users, escalation plans for delay times, learning from incidents to improve patient pathways, and working towards a Dementia Alliance approved environment and a staff photograph board.
- Staff told us that management consistently asked for their input into new ideas and service improvement initiatives.
- 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.

Diagnostic Imaging:

- Staff in x-ray had developed their own departmental patient satisfaction survey. This project was supported by local and trust management, the patient safety team and the trust communications group. They shared data collated from the surveys with wider trust projects to assist in the development and improvement of service provision.
- The radiology team had received the Health Education North East Allied Health Professional Service Improvement Award for their radiographer reporting service project.
- 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 the department planned to reintroduce it as systems and processes settled at the Northumbria Specialist Emergency Care Hospital.

- In 2014, the trust was awarded the HENE Certificate (Health Education North East) for the 'Reporting Radiographers of the Year'.
- X-ray staff were completing an audit of WHO Safer Surgery Checklist usage across all sites with an aim to standardise the checklist used for the benefit of all staff and patient safety. Initial feedback suggested the trust should develop a new WHO compliant checklist/ consent form and the team would complete this.

Outstanding practice and areas for improvement

Outstanding practice

In surgical services:

- The development of the 'block room' had resulted in a streamlined approach to the recovery of patients following surgery.
- Guidelines for oncoplastic breast reduction and guidelines for best practice in reducing surgical site infections had been developed.
- 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.

In end of life care:

- The model of end of life care services at this hospital saw that dedicated palliative care beds were operated alongside a specialist palliative in-reach service to general ward areas. This meant that specialist staff worked alongside general staff to deliver effective, coordinated care within a holistic approach.
- Services worked across both acute and community settings with a strong multi-disciplinary ethos.
- An Oasis room was available for relatives of patients at the end of life where they could rest or take time to themselves. The room was stocked with drinks, snacks and toiletries by volunteers using funds that were dedicated for this purpose.
- 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.
- 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.
- 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.
- The Palliative Care service had won the Quality Award for 2014 for their commitment to improvement and the excellent patient experience feedback received.

Areas for improvement

Action the hospital MUST take to improve

- The service must complete a comprehensive gap analysis against the recommendation made for the University Hospitals of Morecambe Bay NHS Foundation Trust.

The service must ensure that the maternity and gynaecology dashboard is fit for purpose, robust and open to scrutiny.

Outstanding practice and areas for improvement

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 care centre:

- Consider circulating guidance to staff about when to stop using the 'see and treat' model when the department is busy and revert to the triage model, to ensure patient safety and improve responsiveness.
- Consider training for reception staff to help identify patients who may need to be brought to the attention of clinical staff more quickly.
- Consider increasing the number of independent nurse prescribers to enable more flexibility in prescribing of medication in the ECC when there are no doctors available.

In Medical Care services:

- Ensure that resuscitation equipment is checked consistently, in line with trust procedures, on all medical wards.
- Ensure that fridge temperatures are checked consistently, in line with trust procedures.

In maternity and gynaecology:

- 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.

In outpatient's and diagnostic imaging:

- Ensure waiting time targets in ultrasound continue to improve as more staff are appointed.

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.