

North Tees and Hartlepool NHS Foundation Trust University Hospital of Hartlepool

Quality Report

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

Ratings

Overall rating for this hospital	Requires improvement 
Medical care	Requires improvement 
Surgery	Good 
Maternity and gynaecology	Requires improvement 
Services for children and young people	Good 
Outpatients and diagnostic imaging	Good 

Summary of findings

Letter from the Chief Inspector of Hospitals

The University Hospital of Hartlepool is part of North Tees and Hartlepool NHS Foundation Trust and has 88 beds. It provides a wide range of diagnostic services, outpatient clinics, maternity services and day case and low risk surgery,

The trust gained foundation status in 2007. It has a workforce of approximately 4660 staff and serves a population of around 400,000 in Hartlepool, Stockton and parts of County Durham. The trust also provides services in a number of community facilities across the areas supported, including Peterlee Community Hospital and the One Life Centre, Hartlepool.

We inspected University Hospital Hartlepool as part of the comprehensive inspection of North Tees and Hartlepool NHS Foundation Trust and inspected University Hospital Hartlepool on 7-10 July and 29 July 2015.

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

We rated surgical services, children's and young people services and outpatient and diagnostic imaging services as good and medical care and maternity and gynaecology services as requires improvement.

Our key findings were as follows:

- Arrangements were in place to manage and monitor the prevention and control of infection. There was a dedicated infection control team to support staff and ensure policies and procedures were implemented and adhered to. We found that areas we visited were clean. On Holdforth Unit we saw that infection control procedures were not always being followed.
- There were low rates of infection in the hospital, with no confirmed MRSA infections, two confirmed cases of Clostridium Difficile and one confirmed case of Escherichia Coli (E. Coli).
- Patients were able to access suitable nutrition and hydration, including special diets and they reported that they were content with the quality and quantity of food.
- There were staffing shortages with one ward unable to meet the safer staffing requirements. The trust used NHS Professionals or agency nurses to address the staffing requirements. We discussed this concern with the trust and we noted that beds had been closed on the ward to improve staffing ratios on our follow-up unannounced inspection.
- We reviewed a significant number of policies on the intranet for medicine and maternity services that were out of date and required updating.
- There were processes in place for the reporting of incidents and there was evidence of learning from incidents. However, governance processes were not fully developed or embedded and there were concerns in some areas regarding the maintenance and use of risk registers.
- There were concerns regarding leadership of Holdforth Unit however the trust had addressed these concerns in part by the time of the unannounced inspection.

We saw several areas of good practice including:

- The development of advanced nurse practitioners had enabled the hospital to respond to patients' needs appropriately and mitigated difficulties in recruiting junior doctors.
- The bariatric service had been developed as part of a consortium arrangement with neighbouring NHS trusts to ensure the local population had access to this service.
- Staff had produced posters and delivered presentations at the International Society of Orthopaedic and Trauma Nursing international conference on the development of virtual fracture clinics and on the roles of speciality nurses.
- The trust told us that a number of staff within the departments had completed modules on service improvement and that one current project was working to improve the staff engagement and sustainability in clinical supervision.

Summary of findings

- A project in conjunction with Hartlepool Council was initiated to improve health care for people living with learning disabilities. When a patient with learning disabilities was admitted to the hospital, an alert was generated and they were admitted to a virtual ward managed by the learning disabilities lead nurse. This ensured that the trust was able to respond to their needs in an appropriate and timely manner.

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

Importantly, the hospital must:

- Ensure there are systems and processes in place to minimise the likelihood of risks by completing the 5 Steps to Safer Surgery checklist.
- Ensure staff follow trust policies and procedures for managing medicines, including controlled drugs.
- Ensure that risk assessments are documented along with personal care and support needs and evidence that a capacity assessment has been carried out where required.
- Ensure effective systems are in place which enable staff to assess, monitor and mitigate risks relating to the health, safety and welfare of people who use the service.
- Ensure that all policies and procedures in the In-Hospital Care directorate are reviewed and brought up to date.
- Ensure midwifery policies, guidelines and procedural documents are up to date and evidence based.
- Ensure there are always sufficient numbers of suitably qualified, skilled and experienced staff to deliver safe care in a timely manner.
- Ensure that all annual reviews for midwives take place on a timely basis.
- Ensure all staff attend the relevant resuscitation training.

In addition, the hospital should:

- Ensure the processes and documentation used for appraisal of non-medical staff meets their personal development needs in children and young people services.
- Ensure that formal drugs audits and stock checks are carried out regularly in outpatients.
- Ensure that clinic planning, room utilisation and staffing is effectively managed and controlled for outpatient clinics including those hosted by the trust.
- Ensure that established models of regular nursing clinical supervision are implemented for all staff involved in patient care.
- Ensure that strategy and management plans regarding transforming the outpatients departments are communicated to all staff.
- Have a competency based framework in place for all grades of midwives.
- Have systems in place to achieve the nationally recommended ratio of 1:15 for supervision of midwives.
- Indicate benchmark data on the maternity performance dashboard to measure performance.
- Ensure the availability of a diabetes specialist midwife.
- Provide simulation training to prevent the abduction of an infant.

Professor Sir Mike Richards

Chief Inspector of Hospitals

Professor Sir Mike Richards
Chief Inspector of Hospitals

Summary of findings

Our judgements about each of the main services

Service

Medical care

Requires improvement

Rating



Why have we given this rating?

We rated the medical services provision at the University Hospital of Hartlepool as requires improvement. There was a lack of clarity around the purpose of Holdforth Unit and there were concerns about the leadership capacity, staffing levels, nursing standards and quality of care on the unit. Holdforth Unit was transferred from the In-Hospital Care directorate to the Out-of-Hospital Care directorate in May 2014. However there was confusion about where the unit sat in the hospital structure. The overarching plan for the unit was to become a nurse led community rehabilitation ward, but there was no evidence of progress towards this goal and the plans were not documented in the form of a strategy.

Incident reporting systems were embedded but there was also a lack of assurance on the effective management of the Out of Hospital care directorate risk register. Of 53 medical policies, 40 were out of date. Nursing staff were responsible for ensuring patients received their medicines in a timely and consistent way. On Holdforth Unit, we found there was a risk pain medicines might not be given at the correct intervals. Pain was well-managed on the medical rehabilitation day unit and in endoscopy. There was no formal process for clinical supervision but 88% of staff had received an appraisal within the last 12 months. A multidisciplinary team met weekly to discuss the patients on Holdforth Unit but outcomes were not recorded in the patients' health care record. At the time of our inspection the trust had no formal processes to audit mental capacity and best interests assessments. The trust operated a system of virtual wards. These were described as wards or groups of patients with similar characteristics. For example the dementia specialist nurse had a virtual ward of patients assigned of patients formally diagnosed with dementia and those patients who showed possible signs of dementia but with no formal diagnosis.

We spoke with 14 patients and seven relatives on Holdforth Unit who reported mixed experiences of the care they received; however the results of the

Summary of findings

NHS friends and family test for Holdforth Unit between April and June 2015 showed that 98% of patients would recommend the care they received; this is higher than the England average of 95%. The Staff and Patient Experience and Quality Standards (SPEQS) reports between April and June 2015 identified that 97% of the patients were happy with their experience. We observed an inconsistent approach to ensuring the call bells were within reach of patients.

The trust responded immediately to the concerns raised during inspection and developed an action plan to manage the identified risks. We went back to the unit unannounced to check that improvements had been made. There had been a change in ward leadership and measures were in place to improve the quality of care. For example beds had closed, staffing levels had improved and all Mental Capacity Act and Deprivation of Liberty Safeguards documentation had been audited. We were provided with assurance that the new unit leadership had introduced a system of “intentional rounding” to ensure patients’ needs were monitored effectively. The trust patient safety team planned to support the unit to audit compliance with this.

Staff on endoscopy and the medical rehabilitation day unit had a clear vision for their services and felt their managers were accessible. Staff we spoke with were aware of the corporate vision of the trust. We found the culture of care delivered by staff across all the medical services was open, dedicated, and compassionate and was strongly supported at divisional and ward

Surgery

Good



Overall we rated safe, effective, caring, responsive and well-led as good.

We observed patients being treated with compassion, dignity and respect throughout our inspection at this hospital. Patients commented positively on the dedication and professionalism of staff and the quality of care and treatment received. Staff were familiar with the process for reporting incidents using systems and staff confirmed themes from incidents were discussed to promote shared learning.

Summary of findings

Care pathways were in use including enhanced recovery pathways and we saw all wards completed appropriate risk assessments. Risk assessments, care plans and test results were completed at appropriate times during a patient's care and treatment. All wards used an early warning scoring system for the management of deteriorating patients. We looked at clinical records and observed that all patients had been consented appropriately. The development of the advanced nurse practitioner's role had enabled patients to be consented in a timely manner.

We found that staffing levels were compliant with the required establishment and skill mix. Difficulties in the recruitment of junior doctors had been covered through the use of locum medical staffing and the development of advanced surgical care nurse practitioners and advanced trauma and emergency surgery nurse practitioners. Therapists worked closely with the nursing teams on the ward and daily handovers were carried out with members of the multidisciplinary team. The trauma and orthopaedics and surgery and urology directorates delivered consultant led seven day services.

The service was responsive to the needs of patients living with dementia and learning disabilities. A dedicated 'Homeward' team had been developed to ensure the arrangements for the discharge of patients was co-ordinated between all agencies and families. 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.

Senior managers had a clear vision and strategy for the division and staff were able to repeat this vision and discuss its meaning with us during individual interviews. Staff spoke positively about the service they provided for patients and emphasised quality and patient experience. We saw staff worked well together and there was respect between specialities and across disciplines. We saw examples of good team working on the wards between staff of different disciplines and grades.

Summary of findings

Maternity and gynaecology

Requires improvement



Overall we rated the maternity services as requires improvement at University Hospital of Hartlepool. This was due to concerns in the areas of effective and well led. We rated safe and responsive as good and we were unable to rate services for caring as no patients were present at the time of our inspection. We rated effective as requires improvement as there was no competency framework in place to support the development of band six midwives and this was a concern. Managers told us a competency based framework was under development and it was hoped this would be completed by September 2015. The recommended midwife to supervisor of midwives ratio was not being met. The recommendation is a ratio of 1:15 and at the time of inspection the ratio was 1:18. 27% of the trust midwifery staff had not received an annual review. Guidelines that were out of date when we conducted the comprehensive inspection were updated by the time of the unannounced inspection; however, we were not assured that systems were in place to monitor and maintain this position. Referral times for termination of pregnancy and the full completion of the required documentation was an area for improvement. Plans had been put in place and required further audit to monitor and evidence progress.

We rated well-led as requires improvement as the maternity services risk register contained many generic risks and identifying risks specific to the services at Hartlepool was difficult. The lack of a rating system to measure performance on the maternity dashboard was also a concern. There were concerns about maternity leadership capacity as the senior operational role had a wide remit and was seen to be challenging. The midwifery management structure was flat with no additional support between the Head of Midwifery and the band seven midwives.

We found incident reporting was embedded within the service and noted examples of shared learning from incidents. Mandatory training participation rates were good and staff could articulate how they would manage safeguarding concerns.

We did find there was good local leadership and staff were engaged and committed to the service. Staff were not based in the birthing unit, but they

Summary of findings

were available when the unit needed to open and individual needs of patients were a focus. The environment was welcoming and efforts had been made to make it less clinical. Although we were unable to rate caring, the staff we spoke with were clearly dedicated and passionate about the care and services they provided.

Services for children and young people

Good



Overall, we rated safe, effective, caring and responsive as good and well led as required improvement. The overall rating for the service was good.

The management team were committed to the vision and strategy for the children's service and feedback from staff about the culture within the service, teamwork, staff support and morale was positive. However, systems and processes for risk management within the service were not effective and timely. We saw a number of high-level risks had been on the service's joint risk register for up to nine years. Staff received appropriate professional development, including an annual appraisal. However, the documentation and format of the appraisal process for non-medical staff required further development

Processes and documentation relating to pain relief for children and young people required improvement; evidence showed systems and processes for pain management within the service were not well embedded. We found all clinical areas visibly clean, child-friendly and well maintained. Medicines and patient records were handled safely and there were sufficient numbers of suitably qualified staff to meet the needs of the children and young people using the service. Staff received appropriate training, which included training in safeguarding and manual handling.

There was good evidence of multidisciplinary working within and between teams and children and families using the service were provided with appropriate information. Consent procedures were in place and followed. Relatives we spoke with told us they were very happy with the care received. They said the staff were supportive and communication and involvement was good. The children's service was responsive to the individual

Summary of findings

needs of the children and young people who used it and there were effective systems and processes in place for dealing with complaints from people using the service.

Outpatients and diagnostic imaging

Good



Overall we rated the care and treatment received by patients in the University Hospital of Hartlepool outpatient and diagnostic imaging departments as good for safe, caring and responsive. We rated well-led as requires improvement. Patients were very 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 for their conditions. Patients were protected from the risk of harm because there were policies in place to make sure that any additional support needs were met. Staff were aware of these policies and how to follow them. However no nursing and midwifery registered staff or additional clinical services staff in women's outpatients at University Hospital of Hartlepool had attended Level 2 or 3 safeguarding children training. The departments learned from complaints and incidents and put systems in place to avoid recurrences.

There were some areas that needed improvement within the outpatients department. These included the systems in place for utilising clinic rooms effectively and communication of the departmental strategy to all levels of staff. The diagnostic imaging departments were well led, proactive and staff worked as a team across all sites towards continuous improvement for good patient care.

University Hospital of Hartlepool

Detailed findings

Services we looked at

Medical care (including older people's care); Surgery; Maternity and gynaecology; Services for children and young people; Outpatients and diagnostic imaging

Detailed findings

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Background to University Hospital of Hartlepool

The University Hospital of Hartlepool is part of North Tees and Hartlepool NHS Foundation Trust and has 88 beds. It provides a wide range of diagnostic services, outpatient clinics, maternity services and day case and low risk surgery,

The trust gained foundation status in 2007. It has a workforce of approximately 4660 staff and serves a population of around 400,000 in Hartlepool, Stockton and parts of County Durham. The trust also provides services in a number of community facilities across the areas supported, including Peterlee Community Hospital and the One Life Centre, Hartlepool.

We inspected University Hospital Hartlepool on 7-10 July and 29 July 2015, as part of the comprehensive inspection of North Tees and Hartlepool NHS Foundation Trust.

The North Tees and Hartlepool NHS Foundation Trust provides medical care including older peoples care at the University Hospital of Hartlepool (UHH) in Hartlepool. There were 10,4000 spells of medical treatment in 2013-2014 of which 21% were emergency admissions, 2% elective admissions and 78% day case admissions. Of these spells, 53% were medical, 19% clinical oncology, 16% clinical haematology and 11% 'other'.

The 30-bedded community inpatients ward (Holdforth Unit) transferred from the In-Hospital Care directorate to the Out-of-Hospital Care directorate in May 2014 and provided intermediate care. The management of Holdforth Unit was unclear as the unit was allocated to

the Out-of-Hospital Care directorate; however, the bed base remained in the In-Hospital Care directorate and received transferred patients from the medical wards at University Hospital North Tees during periods of bed pressures. On this basis, the service provided on that unit has been included in this report as a medical service. There was also an endoscopy unit and a medical rehabilitation day unit at the hospital managed by the In-Hospital Care directorate.

We visited the medical rehabilitation day unit, endoscopy unit and Holdforth Unit and looked at seven care records and six medication administration records. We spoke with 15 patients, 7 relatives and 18 staff, including doctors, nurses, therapists, pharmacists and managers. Before the inspection, we reviewed performance information from and about the trust.

The hospital provides elective and non-elective surgical treatments for trauma and orthopaedics, general surgery and urology. During this inspection we visited the surgical ward as well all theatres and recovery areas on site. We also observed care being given and surgical procedures being undertaken.

University Hospital of Hartlepool has a birthing team who provide care for women and families in the Hartlepool area. The service is for low risk women and entirely midwife-led, with no medical cover. The maternity service at University Hospital of Hartlepool delivered 109 babies between April 2014 and March 2015.

Detailed findings

There is an antenatal day assessment unit and a birthing centre with four delivery rooms, a pregnancy advisory service and an early pregnancy service. Post-natal care is also provided at children's centres throughout Hartlepool. The birthing centre had to be opened for our inspection as there were no mothers on the unit that day. We also visited the day assessment unit, the pregnancy advisory centre and the early pregnancy assessment clinic.

The women and children's services directorate at the Hartlepool site provided a nurse-led paediatric day unit, day-case facilities and a children's outpatient department. The paediatric day unit had six beds in one bay and two individual cubicles/side rooms. The children's outpatient department was immediately adjacent to the paediatric day unit and patients and staff had to walk through the children's outpatient department waiting area to access the paediatric day unit. The paediatric day unit was open for day case surgery (for children aged 2 to 16) on Thursdays and Fridays from 8am – 4pm. Orthopaedic surgery was carried out on Thursdays and urology and general surgery on Fridays. The children's and young people's service at the Hartlepool site did not deal with any trauma cases.

There were 82 children's admissions at the Hartlepool site between July 2013 and June 2014. Of these 90% were day cases, 9% were emergencies and 1% were elective. There were 3856 outpatient attendances at the Hartlepool site between April 2014 and March 2015. Staff worked at both hospital sites and there was a hospital shuttle available for staff to travel between the North Tees and Hartlepool

hospital sites. We inspected this service on a Friday morning and visited all of the clinical areas where children and young people were admitted or which they attended on an outpatient basis. This comprised of the eight-bedded paediatric day unit, the children's outpatients department and the operating theatres.

The University Hospital of Hartlepool outpatients department and diagnostic imaging department were situated on the main hospital site in Hartlepool. There were a total of 92,780 outpatient appointments and 48,994 attendances for diagnostic imaging procedures between April 2014 and March 2015 at University Hospital of Hartlepool. The DNA rate (percentage of patients who did not attend an outpatient appointment) at Hartlepool was 8% which is slightly higher (worse) than average when compared to other Trusts in England.

Outpatient clinics were held in different locations within the University Hospital of Hartlepool site across specialties including, medical clinics: respiratory, diabetes, rheumatology, gastrointestinal, haematology, cardiology, chemical pathology, and nephrology. Surgical clinics including orthopaedics, urology, colorectal, upper gastrointestinal, thyroid, vascular, bariatric and pain services. Visiting consultants from neighbouring trusts provided clinics for oncology, ophthalmology, ear, nose and throat, dermatology and oral surgery. There was a separate women's outpatients department which included gynaecology services. A mobile breast screening service was provided on weekdays and one Saturday per month.

Our inspection team

Our inspection team was led by:

Chair: Helen Bellairs, Non-Executive Director, 5 Boroughs Partnership NHS Foundation Trust

Head of Hospital Inspections: Amanda Stanford, Care Quality Commission

The team included CQC inspectors and a variety of specialists: a consultant in diabetology, a consultant in

palliative care, a consultant paediatrician, a consultant general surgeon, a professor of gynaecological research, a junior doctor, a student nurse, senior midwives, matrons, senior nurses and three experts by experience.

Experts by experience are people who use hospital services, or have relatives who have used hospital care, and have first-hand experience of using acute care 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 clinical commissioning groups, local area team, Monitor, Health Education England, NHS England, General Medical Council, Nursing and Midwifery Council, Royal College of Nursing, NHS Litigation Authority and the local Healthwatch.

We held a listening event on 6 July 2015 in Hartlepool to hear people's views about care and treatment received at the hospital. 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 event.

We carried out the announced visit between 7 and 10 July 2015. During the visit, we talked with patients and staff from all areas of the hospital, including from the wards, theatres, outpatients and maternity departments. We observed how people were being cared for, talked with carers and family members and reviewed patients' personal care or treatment records.

We completed an unannounced visit on 29 July 2015.

Facts and data about University Hospital of Hartlepool

University Hospital Hartlepool is located in Hartlepool and provides a range of services to a resident population of 400,000 people in Hartlepool, Stockton and parts of County Durham.

During 2014-2015, the hospital had 17,826 admissions, 92,780 outpatient attendances, 109 births and 37 deaths.

- The health of people in Hartlepool is generally worse than the England average. Deprivation is higher than average and about 29.8% (5,300) children live in poverty. Life expectancy for both men and women is lower than the England average.

- Life expectancy is 10.8 years lower for men and 8.6 years lower for women in the most deprived areas of Hartlepool than in the least deprived areas.
- Estimated levels of adult excess weight, smoking and physical activity are worse than the England average.
- In Year 6, 24.4% (245) of children are classified as obese, worse than the average for England. The rate of alcohol-specific hospital stays among those under 18 was 54.2. This represents 12 stays per year.
- Levels of teenage pregnancy, breastfeeding and smoking at time of delivery are worse than the England average.

Our ratings for this hospital

Our ratings for this hospital are:

Detailed findings

	Safe	Effective	Caring	Responsive	Well-led	Overall
Medical care	Requires improvement	Requires improvement	Requires improvement	Requires improvement	Inadequate	Requires improvement
Surgery	Good	Good	Good	Good	Good	Good
Maternity and gynaecology	Good	Requires improvement	N/A	Good	Requires improvement	Requires improvement
Services for children and young people	Good	Good	Good	Good	Requires improvement	Good
Outpatients and diagnostic imaging	Good	N/A	Good	Good	Requires improvement	Good
Overall	Good	Requires improvement	Good	Good	Requires improvement	Requires improvement

Notes

1. There were no patients present in the Birthing Centre so we were unable to rate the caring domain for Maternity and Gynaecology.
2. We are currently not confident that we are collecting sufficient evidence to rate effectiveness for Outpatients & Diagnostic Imaging

Medical care (including older people's care)

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

Information about the service

The North Tees and Hartlepool NHS Foundation Trust provides medical care including older peoples care at the University Hospital of Hartlepool (UHH) in Hartlepool. There were 10,4000 spells of medical treatment in 2013-2014 of which 21% were emergency admissions, 2% elective admissions and 78% day case admissions. Of these spells, 53% were medical, 19% clinical oncology, 16% clinical haematology and 11% 'other'.

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There was also an endoscopy unit and a medical rehabilitation day unit at the hospital managed by the In-Hospital Care directorate.

We visited the medical rehabilitation day unit, endoscopy unit and Holdforth Unit and looked at seven care records and six medication administration records. We spoke with 15 patients, 7 relatives and 18 staff, including doctors, nurses, therapists, pharmacists and managers. Before the inspection, we reviewed performance information from and about the trust.

Summary of findings

We rated the medical services provision at the University Hospital of Hartlepool as requires improvement with specific reference to findings on Holdforth Unit.

There was a lack of clarity around the purpose of Holdforth Unit and there were concerns about the leadership capacity, staffing levels, nursing standards and quality of care on the unit. Holdforth Unit transferred from the In-Hospital Care directorate to the Out-of-Hospital Care directorate in May 2014. However there was confusion amongst leads where the unit sat in the hospital structure. The overarching plan for the unit was to become a nurse led community rehabilitation ward; however, there was no evidence of progress towards this goal and plans to achieve this were not documented in the form of a strategy.

Incident reporting systems were embedded but there was also a lack of assurance on the effective management of the Out of Hospital Care directorate risk register. Of 53 medical policies, 40 were out of date. Nursing staff were responsible for ensuring patients received their medicines in a timely and consistent way. On Holdforth Unit, we found there was a risk pain medicines might not be given at the correct intervals. Pain was well-managed on the medical rehabilitation day unit and in endoscopy.

There was no formal process for clinical supervision but 88% of staff had received an appraisal within the last 12 months. A multidisciplinary team met weekly to discuss

Medical care (including older people's care)

the patients on Holdforth Unit but outcomes were not recorded in the patients' health care record. At the time of our inspection the trust had no formal processes to audit mental capacity and best interests assessments. The trust operated a system of virtual wards. These were described as wards or groups of patients with similar characteristics. For example the dementia specialist nurse had a virtual ward of patients assigned of patients formally diagnosed with dementia and those patients who showed possible signs of dementia but with no formal diagnosis.

We spoke with 14 patients and seven relatives on Holdforth Unit who reported mixed experiences of the care they received; however the results of the NHS friends and family test for Holdforth Unit between April and June 2015 showed that 98% of patients would recommend the care they received; this is higher than the England average of 95%. The Staff and Patient Experience and Quality Standards (SPEQS) reports between April and June 2015 identified that 97% of the patients were happy with their experience. We observed an inconsistent approach to ensuring the call bells were within reach of patients.

The trust responded immediately to the concerns raised during inspection and developed an action plan to manage the identified risks. We went back to the unit unannounced to check that improvements had been made. We found there had been a change in ward leadership and measures were in place to improve the quality of care. For example beds had closed and staffing levels had improved. We were provided with assurance that the new unit leadership had introduced a system of "intentional rounding" to ensure patients' needs were monitored effectively. The trust patient safety team planned to support the unit to audit compliance with this.

Staff on endoscopy and the medical rehabilitation day unit had a clear vision for their services and felt their managers were accessible. Staff in these areas were managed centrally from University Hospital North Tees and were aware of the corporate vision of the trust. We found the culture of care delivered by staff across all the medical services was open, dedicated, and compassionate and was strongly supported at divisional and ward level.

Are medical care services safe?

Requires improvement



We rated medical services required improvement for safe.

During our announced inspection and specifically related to Holdforth Unit, we were concerned about staffing levels, leadership capacity, the standard of medicines management, gaps in effective care planning and risk assessing and the lack of involvement of the patients and relatives in agreeing rehabilitation goals. There was a lack of evidence that relatives were always consulted in relation to mental capacity assessments and best interest assessments. At the time of this inspection, an improvement plan was developed and implemented immediately and direct action was taken on Holdforth Unit. During our unannounced inspection, we saw that four beds were closed, services had improved and positive changes were taking place.

Incidents

- There were no never events reported between April 2014 and March 2015. Never Events are a particular type of serious incident that are wholly preventable.
- There were 18 incidents reported by the medical rehabilitation day unit and endoscopy unit between April 2014 and March 2015. These were not site specific; themes were identified as communication errors and slips trips and falls and unable to carry out procedure due to equipment not being available or computer systems down. Actions and lessons learnt were documented, for example when the reporting system was unavailable, hand written reports were completed at the time of the procedure to be inputted to the computer at a later time. We were advised of an incident where a patient had fallen and sustained a hip fracture; however, this incident was not reported through Reporting of Injuries, Diseases and Dangerous Occurrences Regulations 2013 (RIDDOR). During our unannounced inspection we were provided with assurance that this case had been discussed and an action plan was in place to address reporting expectations.

Medical care (including older people's care)

- The trust held a centralised weekly Mortality and Morbidity meeting to review cases from the previous week using a national assessment tool to evaluate cases.
- Staff were able to inform of us of the principles of the duty of candour and we reviewed evidence where this was used in practice.

Holdforth Unit

- There were 161 incidents reported between April 2014 and March 2015. Of these 42% (67) were categorised as slips, trips, falls and collisions and 16% (25) were categorised as pressure ulcers. Of these incidents 64% (103) were categorised as harm not caused by care delivery; 30% (48) were categorised as no harm, 0.5% (8) were categorised as low harm and 0% (2) were categorised as moderate harm which required further treatment.
- Staff were able to inform of us of the principles of the duty of candour and we reviewed evidence where this was used in practice.

Safety thermometer

Holdforth Unit

- The NHS Safety Thermometer is a tool designed to be used by frontline healthcare professionals to measure the number of harms such as falls, pressure ulcers and catheter acquired infections once a month. The Holdforth Unit displayed the results of these audits at the entrance to the unit on the ward board.
- The results between May 2014 and May 2015 fluctuated between 100% harm free care in May 2014 and a low of 72% in January 2015. This meant that 28% of patients in January had suffered some form of harm; the data informed us that this harm could be attributed to pressure ulcers.

Cleanliness, infection control and hygiene

- The endoscopy and medical rehabilitation day unit were clean when we inspected them. There were cleaning schedules in place and levels of cleanliness were audited regularly.
- Hand towel and soap dispensers were adequately stocked. There was a sufficient number of hand wash sinks and hand gels.

- The handling and cleaning of all endoscopy scopes and equipment were in line with Joint Advisory Group (JAG) guidelines.

Holdforth Unit

- During our inspection we noted that some areas of the ward were unclean, for example the shower drain was dirty.
- We observed the unit had toilet brushes in the toilets and plugs were still in use in patient sinks. These are not recommended for use as they may be a focus for infection.
- We reviewed equipment on the unit and there were no cleaning labels, which were signed or dated; we observed that the hoist was labelled as last cleaned in March 2015.
- We reviewed infection control data which identified that between April 2014 and March 2015 Holdforth Unit had no confirmed MRSA infections, two confirmed cases of Clostridium Difficile and one confirmed case of Escherichia Coli (E. Coli).
- Hand hygiene audits conducted by the trust identified 100% compliance with hand hygiene procedures; however, we observed a staff member not cleaning their hands after taking a bed pan to the dirty utility room and removing their apron and gloves.
- During our unannounced inspection we noted that infection prevention and control procedures had improved,

Environment and equipment

- We reviewed a sample of equipment on each unit we visited and not all equipment had a valid service sticker on them. In-house service documentation was reviewed and we were assured that the trust had robust systems in place to monitor equipment. Staff told us that the medical devices department coordinated servicing of equipment and calibration of scales and this was done yearly.

Holdforth Unit

- Staff on all wards told us that equipment including falls sensors was readily available however; the unit only had four on the ward and had to borrow from another ward.
- We observed records that emergency equipment was checked daily and that fridge temperatures were checked daily, however, maximum and minimum temperature was not recorded.

Medical care (including older people's care)

- The day room on the ward was not used and was poorly equipped. During our unannounced inspection we observed the day room had been cleared and patients were being encouraged to eat their lunch together in that room.

Medicines

- Medicines were stored safely and securely in the endoscopy and medical rehabilitation day units.

Holdforth Unit

- We observed drug rounds on the Holdforth Unit and saw that these took a significant amount of time, for example the 08.00am drug round concluded at 11.00am. Staff signed medication records following administration; however, we observed a patient was left with their drugs whilst a staff member left to get more medication from the clinical room.
- We saw staff sign off the administration of a controlled drug in the controlled drug register prior to the administration of the medication. This was not in line with Nursing and Midwifery Council (NMC) guidance (2010).
- Nursing staff were responsible for ensuring patients received their medicines in a timely and consistent way. We found there was a risk some medicines that were time sensitive might not be given correctly because medication records did not always direct the right time to administer them. For example, staff were not administering medication for the treatment of Parkinson's Disease at the correct times. These medicines were prescribed to be given 'am' and 'pm' rather than at specific intervals which is best practise for this type of medication to maintain its effectiveness.
- We checked six patients' prescription charts on the Holdforth Unit and found 23 gaps where nursing staff had not signed to record a medicine had been administered. These errors had not been identified and investigated. Trust policy was that all medicines errors should be reported but this was not being followed on Holdforth Unit. One patient was prescribed a medicine to be taken once weekly, but missed five weekly doses over the previous two months. This was not identified or investigated.
- We found audits of prescription charts were limited and clinical staff including nurses, doctors and pharmacy

staff had not identified administration errors. A recent audit of the unit in April 2015 concluded 'There were very few incidents reported regarding medication in the last 6 months and no trend identified'.

- Medicines were securely stored in a suitable room. However the medicines fridge was not properly monitored because the daily maximum and minimum temperatures were not recorded. Insulin was not safely stored and managed because it was not dated upon opening and not correctly stored once opened. We also found insulin pens for individual patient use were being used incorrectly as stock.
- Following our unannounced inspection we received evidence that an audit of medicines management had been undertaken; the outcomes of the audit were added to the Holdforth Unit performance dashboard for monitoring. We were also informed that medication rounds were now protected to reduce the risk of disruption which could cause delay.

Records

- Physiotherapy records were stored on the electronic patient record system (SystemOne) and a 'share point' had been created for sharing of information.
- The endoscopy unit recorded information on another electronic reporting system (Unisoft); however, we saw evidence that this system was occasionally unavailable.

Holdforth Unit

- There were paper based records on the Holdforth Unit; all members of the multidisciplinary team completed these records.
- During our announced inspection we reviewed seven care records. We found incomplete risk assessments and there was no evidence of effective care planning in the nursing records.
- Staff recorded multidisciplinary team reviews on the electronic ward board. Staff we spoke with informed us that this board did not have a 'back-up' facility and was, therefore, not available the following day. The outcomes of these meetings were not documented in the patient record.
- During our announced inspection patient records were stored in designated lockable trolleys which were kept outside of the bays. We observed that one of the trolleys had a broken lock. Staff we spoke with informed us that this had been reported, however, no interim measures were in place to secure the records.

Medical care (including older people's care)

- The unit undertook monthly health care record audits. We reviewed evidence between September 2014 and February 2015 that identified that the unit needed to improve on completing the audit in the first instance. However, there were areas identified for improvement including all entries to have a legibly printed name; all entries made by a doctor to include a GMC number; all entries to be timed and deletions or alterations to be timed.
- During our unannounced inspection we reviewed eight care records and found they had been completed appropriately. We spoke with the senior clinical lead and nurse lead who told us following the announced inspection, there had been a review of all patients on the unit and care plans had been updated. We found that all the appropriate assessments and care plans had been completed for each patient in the records we reviewed.

Safeguarding

- There was a system in place for raising safeguarding concerns. Staff were aware of the process and could explain what was meant by abuse and neglect. This process was supported by staff training.
- 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 this was corroborated by data provided by the trust that 95% of staff had been trained in safeguarding. All clinical areas we visited had an adult safeguarding pathway displayed in the clinical area.

Holdforth Unit

- Staff we spoke with informed us that safeguarding issues were fully investigated and lessons shared; however, we were not given any information to support this. The unit was supported by the adult safeguarding team based at the University Hospital of North Tees, and staff knew how to contact them if required.

Mandatory training

- Levels of mandatory training within the In-Hospital Care directorate were positive, with very few areas where training levels were below the trust targets with the exception of resuscitation training (52% - trust target 80%), blood transfusion competencies: collection (76%), preparation and administration (79% - trust target 80%).

We were told that simulation training was currently being rolled out across the trust, however, this was dependant on capacity within the ward and patient numbers.

Holdforth Unit

- Levels of mandatory training in the Holdforth Unit were variable; we reviewed data that identified 18% of nursing staff had completed resuscitation training and 64% completed venous blood transfusion training. The remaining mandatory training levels were above the trust targets.
- The mandatory training levels for administration and clerical staff showed that none had completed dementia level one, fire training or incidents, complaints and claims training; however, the remainder of the training levels were above the trust target.
- Mandatory training for staff categorised in additional clinical services, for example health care support workers showed that 65% had completed resuscitation training; however, the remainder of the mandatory training was above the trust targets.

Assessing and responding to patient risk

- Staff used the National Early Warning Score (NEWS) which was designed to identify patients whose condition was deteriorating. Staff were prompted when to call for appropriate support for patients at the UHH site including transfer via ambulance to the University Hospital North Tees site for critical care. We found that that staff understood the tool and escalated changes in the patient's condition appropriately.

Holdforth Unit

- Staff we spoke with informed us of the process of implementing the NEWS score. We were informed that should the patient require acute treatment, an emergency ambulance was called to transfer the patient to the University Hospital North Tees. However, staff informed us that the hospital was seen as a place of safety and it could take up to two hours for an ambulance to arrive which could delay the specialist treatment a deteriorating patient may need.

Nursing staffing

- There were no nurse vacancies or staffing issues on the medical rehabilitation day unit and endoscopy unit.

Medical care (including older people's care)

Holdforth Unit

- Planned and actual staffing levels were displayed on a board in the entrance to the unit. We saw on the day of our inspection, there were three registered nurses on duty which included the ward manager. The ward manager told us she was supporting the other nurses on duty and was not in charge of a team of patients. This meant the nurse to patient ratio was one nurse to 15 patients.
- There was no use of a recognised nurse staffing tool evident. Senior leads were unable to identify the establishment for the unit and therefore could not identify the current vacancy rate, apart from budget constraints.
- We spoke with the ward manager who told us the unit should have four trained staff on duty with three registered nurses to care for patients and a nurse in charge. Staff told us this rarely happened and the nurse in charge often had a team of patients or had to support staff with the workload. The ward manager completed a daily sitrep which detailed the nurse staffing on the unit each day and sent this to senior management staff.
- We reviewed information in the standard operating procedure for the unit (March 2015) and saw it detailed in the appendix a draft seven day rota and the number of nursing staff for each shift. For example between 7am to 3.15pm there should be one band 6 registered nurse, three band 5 registered nurses and three band 2 health care assistants. The band 7 ward manager worked between 9am to 5pm.
- Staff informed us that they were unable to plan their diary as the nursing rota was often published very late and they did not know what shifts they would be working the week after of our inspection.
- We saw information on the unit risk register which highlighted the unit was unable to maintain adequate staffing levels due to vacancies. Senior managers told us they were actively recruiting to vacancies on the unit.
- During our unannounced inspection we were provided with assurance that staffing on the Holdforth Unit was a priority and informed that the bed base had been reduced to from 30 to 26 to ensure safer staffing levels. Staff also told us the nursing rota was now published in a timely manner.

Medical staffing

- The endoscopy and medical rehabilitation units were both nurse led units. However, staff were able to contact the medical team if required.

Holdforth Unit

- Medical cover on the Holdforth Unit consisted of two consultant physician sessions a week and a foundation year two (FY2) doctor and junior doctor presence during the day. A resident medical officer (RMO) provided medical cover at night for University Hospital of Hartlepool (UHH). The consultant rota was accessible to staff and patients.
- During our announced inspection, the consultant physician was on leave; however, nursing staff could not inform us which consultant was covering during their absence. We spoke with staff who told us only one junior medical professional was covering the ward during this inspection.
- We were informed that the medical team would write instructions for the weekend medical cover in health care record; however, when we reviewed the records, no detailed plan of care for the weekend could be identified. One example was “aim for discharge”; but no further detail was documented.

Major incident awareness and training

- There was a major incident plan in place and staff we spoke with were aware of this.
- The trust and regional partners had escalation/resilience plans and implemented these when required. For example, if bed capacity was reduced, the North East Escalation Plan (NEEP) was activated. This was graded one (normal) to four (severe pressure). During our inspection, the trust was at a NEEP level 3 (increased pressure).

Are medical care services effective?

Requires improvement



We rated effective as requires improvement.

Staff used a combination of National Institute for Health and Care Excellence (NICE), and Royal Colleges' guidelines to determine the treatment they provided; however 40 out of 53 local policies were out of date. Hospital Standardised Mortality Ratio (HSMR) compares the number of deaths in a trust with the number

Medical care (including older people's care)

expected given age and sex distribution. HSMR adjusts for a number of other contextual factors and is usually expressed using '100' as the expected figure based on national rates. In 2014/15 the Trust had an increased HSMR of 124.5 (year to May 2015); this was higher than expected. The Summary Hospital-level Mortality Indicator (SHMI) is the ratio between the actual number of patients who die following hospitalisation at the trust and the number that would be expected to die on the basis of average England figures, given the characteristics of the patients treated there. The SHMI was 123.5 (year to May 2015) which remained higher than expected; the trust was reported in July 2015 (health and Social Care Information Centre) as among the 11 worst performing trusts in England for mortality performance. The trust had implemented action plans to improve the trust position in both indicators and had been open to expert scrutiny.

Nursing staff were responsible for ensuring patients received their medicines in a timely and consistent way. On Holdforth Unit, we found there was a risk pain medicines might not be given at the correct intervals. Pain was well-managed on the medical rehabilitation day unit and in endoscopy. A multidisciplinary team met weekly to discuss the patients on Holdforth Unit but outcomes were not recorded in the patients' health care record. At the time of our inspection the trust had no formal processes to audit mental capacity and best interests assessments. Senior staff we spoke with were unable to identify which patients had been assessed as lacking capacity.

On the unannounced inspection, we received evidence that medication rounds were protected to reduce the risk of disruption which could cause delay to administering medications. We were also provided with information that all mental capacity and best interest assessment documentation had been audited. We reviewed three records and appropriate assessments had been completed with the support from the trust adult safeguarding team. There was no formal process for clinical supervision but 88% of Holdforth Unit staff had received an appraisal within the last 12 months.

Evidence-based care and treatment

- Staff used a combination of National Institute for Health and Care Excellence (NICE), and Royal Colleges' guidelines to determine the treatment they provided.

Local policies were written in line with these and had been updated periodically our review of 53 policies demonstrated that only 25% (13) were within date and 30% (16) had not been approved.

- The endoscopy unit had a Joint Advisory Group (JAG) accreditation. JAG accreditation is the formal recognition that an endoscopy service has demonstrated that it has the competence to deliver against the measures in the endoscopy Global Rating Scale standards.
- All policies and procedures were available to staff to access from the intranet.

Pain relief

- On the medical rehabilitation day unit and endoscopy unit, pain relief was provided as prescribed. Patient records indicated that pain relief was incorporated into their elements of care; this supported the management of people's pain and checks were recorded as required. Patients told us they were asked about their pain and if they required any pain relief. Patients we spoke with had no concerns about how their pain was managed.

Holdforth Unit

- Two patients on the unit were prescribed regular pain relief that was prescribed at 12 hourly intervals but we saw this was not always effectively managed. We reviewed the controlled drugs register and found that one patient had their 12.00 medication dispensed at 11.00, however their previous dose was administered at 09.15. We also identified that there were delays of up to two hours in the administration of controlled drugs.
- Following our unannounced inspection we received evidence that medication rounds were protected to reduce the risk of disruption which could cause delay to administering medications.

Nutrition and hydration

Holdforth Unit

- The Malnutrition Universal Screening Tool (MUST) was in use and patient weights were recorded twice weekly. However, relatives we spoke with and evidence we reviewed identified that high risk patients were not always provided with appropriate dietary supplementation.

Medical care (including older people's care)

- Relatives informed us that staff did not always support patients at mealtimes and so they visited at mealtimes to ensure their relative was fed.
- During our unannounced inspection, we were provided with assurance that MUST assessments were being completed weekly which was confirmed during our case note review. Staff were provided with relevant training if required.

Patient outcomes

- The average length of stay for elective admissions in the UHH was equal to the England average at four days. The average length of stay in general medicine was 14 days; this was worse than the England average of five days; 13 days for rheumatology (England average four days), and one day for cardiology (England average two days).
- The average length of stay for non-elective admissions to the hospital was ten days, this was worse than the England average of seven days. The average length of stay in general medicine was ten days which was worse than the England average of six days, the average length of stay for respiratory medicine was 13 days which was worse than the England average of seven days, however, the average length of stay in clinical haematology was six days which was equal to the England average
- A standardised relative readmission rate for elective medical patients in the UHH (85) was better than the England average (100) for clinical oncology (97), clinical haematology (69) and general medicine (76). For non-elective patients, standardised relative readmission rates for UHH (98) ran better than the England average (100) for general medicine (9) and clinical Haematology (41), however, the rates for clinical oncology (129) were worse than the England average.
- There were 37 deaths at University Hospital Hartlepool in 2014-15.
- Hospital Standardised Mortality Ratio (HSMR) compares the number of deaths in a trust with the number expected, given age and sex distribution. HSMR adjusts for a number of other factors including deprivation, palliative care and case mix. HSMRs are usually expressed using '100' as the expected figure based on national rates.
- In 2014/15 the Trust had an elevated HSMR of 128, this was an increase from the previous year at 112. The Summary Hospital-level Mortality Indicator (SHMI) for 1-July 2013 to 30 June 2014 was 119, which was an

increase from the previous year of 113. The trust had introduced centralised weekly mortality and morbidity meetings and has an action plan in place to improve this position.

Holdforth Unit

- Patients were not involved in planning their own discharge. A predicted date of discharge was set on admission to the unit; however, this was always set at two weeks. We did not see evidence which showed that discharge dates were discussed and agreed according to individual need.
- We reviewed Staff and Patient Experience and Quality Standards (SPEQS) data between April and June 2015. This was an audit of the unit environment. The Holdforth unit scored 100% for first impressions, 97% for patient experience, 87% for nursing evidence and 100% for staff involvement. The overall score for the Holdforth Unit for the three months prior to our announced inspection was 95%.
- The average length of stay was 17 days but this had increased to 20 days due to the time patients were awaiting placement in residential and nursing care.

Competent staff

- We reviewed appraisal data provided by the trust; at the time of the inspection 88% of staff had received an appraisal within the last 12 months.
- Figures from the 2014 NHS staff survey indicated that 70% of staff in the medical divisions had in the last 12 months, had an appraisal. The same survey identified that 81% of staff had received job-relevant training, learning or development in the last 12 months.
- Student nurses told us they were supported by a university educator; they also told us they received good support from their ward based mentors and received a good balance of practical skills and theoretical knowledge. All students had been through a 360 degree feedback process whilst on the wards to appraise their performance; this included feedback from staff, patients and their relatives.
- Allied health professionals and support staff who spoke with us reported they were supported to participate in external training relevant to their role.

Medical care (including older people's care)

- Some non-registered staff told us there were opportunities for development. We were given examples of staff being supported with the leadership programme and feeling that this empowered them to bring about positive change in their own work place.
- During our unannounced inspection we were provided with assurance that a training needs analysis had been undertaken and processes were in place to respond to skills gaps.

Holdforth Unit

- We reviewed appraisal data provided by the trust; at the time of the inspection 91% of nursing staff and 76% of those working within additional clinical services received an appraisal between April 14 and March 2015.
- There was no formal process for clinical supervision; however, senior staff informed us that it was held on a drop-in basis. This was not in line with trust policy, which states that it was a minimum mandatory requirement that clinical supervision was no less than a minimum of one hour every three months. We also observed posters displaying the dates and times of supervision.

Multidisciplinary working

- The medical rehabilitation day unit was a Multidisciplinary unit and we observed Allied Health professionals (Occupational Therapists and Physiotherapists) working alongside nurses.

Holdforth Unit

- We were informed that there were weekly multidisciplinary team (MDT) meetings led by the medical team, the outcomes of which were documented on the electronic ward board. Staff informed us that the outcomes were not documented in the medical notes and the information was not backed up or saved on the ward board for future reference.
- The unit was staffed using an integrated multidisciplinary care team, this comprised of registered nurses, physiotherapists, occupational therapists, social workers, clinical support workers and pharmacists.
- The Holdforth Unit was supported by specialist nurses for example, we saw evidence that patients were reviewed by the psychiatric liaison nurse. Staff we spoke with informed us they were supported by the discharge liaison nurse and the dementia specialist nurse.

- We observed a daily board meeting held at the ward desk, confidentiality was maintained by closing the doors to the ward bays having allocated staff to observe the patients. We were informed by staff that this was common practice.
- During our unannounced inspection we were provided with assurance that MDT meeting outcomes were now documented in the patient record and informed discharge planning. These plans were observed in the patient records that we reviewed.

Seven-day services

- The medical rehabilitation day unit and endoscopy unit were open Monday to Friday 9am to 5pm. Staff we spoke with informed us there was access to on call physiotherapists, radiology, chaplaincy and catering services.

Holdforth Unit

- Medical cover was provided by an resident medical officer (RMO) out of hours and also Senior Clinical Out of Hours Matron (SCHMO). There was also a Nurse Practitioner available on site.

Access to information

- Guidelines were stored on the trust intranet pages, however, doctors informed us that the trust guidelines were difficult to find and use.
- The adult safeguarding pathway was displayed in all wards we visited.
- Information was communicated throughout the In-Hospital Care directorate through monthly bulletins,

Holdforth Unit

- Each patient had an information board at the head of the bed, this was updated each shift. This detailed the patients' consultant and nurse responsible for their care during that shift; however, during our announced inspection this was not up to date on all beds.
- Staff we spoke with felt involved and were encouraged to give feedback on patient care both informally and at handovers. Therapy staff were included in patient handovers at shift changes and reported information back to the therapy teams.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

Holdforth Unit

Medical care (including older people's care)

- We reviewed Mental Capacity Act (MCA) documentation in three health care records during our announced inspection; these were not fully completed regarding the capacity and best interest assessments. Relatives were not always consulted in relation to mental capacity and best interests assessments.
- At the time of our inspection the trust had no formal processes to audit MCA and best interest assessments. Senior staff we spoke with were unable to identify which patients had been assessed as lacking capacity.
- During our unannounced inspection we were provided with information that all MCA and DoLs documentation had been audited. Staff had received additional training and the unit was adopting the use of the yellow symbol on the white board, to identify patients living with dementia more easily. We reviewed three records and appropriate assessments had been completed with support from the trust adult safeguarding team.
- The NHS Friends and Family test results (FFT) results between December 2013 and November 2014 indicated the response rate (29.1%) was comparable to the England average (30.1%). The percentage of patients who would recommend the services was consistent with, or better than, the national average during this time.
- The trust performed around the same as other trusts in relevant questions in the 2014 CQC inpatient survey such as nurses answering questions in a way patients could understand.

Holdforth Unit

- We spoke with 14 patients and seven relatives who reported mixed experiences of the care they received on the unit. Not all patients were aware of their named nurse for the shift. Patients we spoke with informed us that one named nurse introduced themselves at the beginning of the shift; however another did not.
- The results of the NHS friends and family test for Holdforth Unit between April and June 2015 showed that 98% of patients would recommend the care they received; this is higher than the England average of 95%.
- The Staff and Patient Experience and Quality Standards reports between April and June 2015 identified that 97% of the patients were happy with their experience.
- During our inspection we observed that call bells were not answered in a timely manner. We timed how long three call bells were ringing. One call bell was ringing for three minutes and the other two call bells were ringing for two minutes. We observed staff walk past the cubicles where the bell was sounding, however, they did not check on the patient.
- A patient informed us that he were unable to hold his call bell as the coiled cord would spring out of reach. We discussed this issue with staff but it was unclear if any action was taken. We observed an inconsistent approach to ensuring the call bells were within reach of patients.
- During our unannounced inspection, we were provided with assurance that the new unit leadership had just introduced a system of "intentional rounding" to ensure that patients received the care they needed. The trust patient safety team planned to support the unit to audit compliance with this.

Are medical care services caring?

Requires improvement



We rated caring as requires improvement.

We spoke with 14 patients and seven relatives on Holdforth Unit who reported mixed experiences of the care they received; however the results of the NHS friends and family test for Holdforth Unit between April and June 2015 showed that 98% of patients would recommend the care they received; this is higher than the England average of 95%. The Staff and Patient Experience and Quality Standards (SPEQS) reports between April and June 2015 identified that 97% of the patients were happy with their experience.

We observed an inconsistent approach to ensuring the call bells were within reach of patients. We also observed that there was little involvement of the patients and families in the discharge process. During our unannounced inspection, we were provided with assurance that the new unit leadership had just introduced a system of "intentional rounding" to ensure that patients received the care they needed. The trust patient safety team planned to support the unit to audit compliance with this.

Compassionate care

Understanding and involvement of patients and those close to them

Medical care (including older people's care)

Holdforth Unit

- Staff we spoke with informed us that they did not use "This is me" a universal tool for support patients with dementia. We were informed that patients sometimes came in with a "This is me" document; however, they were not used on the ward.
- Patients we spoke with were not aware of a planned timescale for their discharge and there were patients who were not aware of their care plans. One patient we spoke with was aware of her care plan but was unsure if it was from a current or previous admission.
- During our inspection we spoke with one relative who expressed concern that their relative was being discharged and felt that this had been arranged without their input. We corroborated this by reviewing the patient's record and the relative was not marked as present at the discharge planning meeting.

Emotional support

Holdforth Unit

- Staff provided emotional support when patients displayed anxiety during rehabilitation activities. We noted that staff were using dementia friendly techniques to support confused patients.
- Therapists listened to patients' concerns and explained what they planned to achieve.

Are medical care services responsive?

Requires improvement 

We rated responsive as requires improvement.

Admission criteria and a screening process were in place for access to the unit; this was to ensure the right patients were admitted for intermediate care; however during our inspection we noted that there were some patients who were not medically fit or ready for that level of care. The discharge liaison team worked with Holdforth Unit to support the process of patient flow; this included transfer of patients from the University Hospital of North Tees through to discharge to home, residential or nursing care. However, the discharge process was observed to be

disjointed and disorganised with lack of clear plans, timescales and patient involvement, causing delays in the discharge process. Data demonstrated that there was an average of six days delay for discharges.

The trust operated a system of virtual wards to meet the needs of groups of patients with similar characteristics. For example the dementia specialist nurse had a virtual ward of patients assigned of patients formally diagnosed with dementia and those patients who showed possible signs of dementia but with no formal diagnosis. Nurse led endoscopy services and medical rehabilitation services were provided from the University Hospital of Hartlepool to meet the needs of the local community.

Service planning and delivery to meet the needs of local people

- Nurse led endoscopy services and medical rehabilitation services were provided from the University Hospital of Hartlepool to meet the needs of the local community.

Holdforth Unit

- Patients who lived in Hartlepool were transferred from the University Hospital of North Tees to the University Hospital Hartlepool for rehabilitation nearer their home. These transfers were coordinated through the therapy teams, medical team and the patient flow team based at the University Hospital of North Tees.
- We were provided with evidence that the preferred place of care is discussed with patients and relatives; however, we did not see evidence of this in practice when we reviewed seven patient records

Access and flow

Holdforth Unit

- Admission criteria and a screening process were in place for access to the unit; this was to ensure the right patients were admitted; however during our inspection we noted that there were some patients who were not medically fit or ready for rehabilitation. There were also patients who were waiting for placement in social care.
- We reviewed evidence which showed that patient stays on the unit were between three and 93 days. The average stay was 19 days between November 2014 and July 2015. The Holdforth Unit measured when patients were functionally fit and medically fit for discharge from March 2015. This data showed that the average length of

Medical care (including older people's care)

time for patients to be functionally fit was nine days and medically fit for discharge in 12 days; however the average length of stay was 18 days. This identifies that there was an average delay of 6 days in the discharge process. Staff from all disciplines told us that patients who were admitted from nursing homes in Hartlepool required a full reassessment prior to discharge and this could delay discharge up to three days. We were told that this process was undertaken for all continuing healthcare patients in Hartlepool and was not dependant to the length of the admission.

- The discharge liaison team worked with the unit to support the process of flow in the unit; this included transfer of patients from the University Hospital of North Tees through to discharge to home, residential or nursing care. However the process appeared to be disjointed and disorganised with lack of clear plans, timescales and patient involvement. During our unannounced inspection we were provided with assurance that plans were in place to improve the discharge process. These included documented aims and objectives for patients and liaising with local authority partners.

Meeting people's individual needs

- Staff could access interpreter services if required for patients whose first language was not English.

Holdforth Unit

- The trust operated a system of virtual wards. These were described as wards or groups of patients with similar characteristics. For example the dementia specialist nurse had a virtual ward of patients assigned of patients formally diagnosed with dementia and those patients who showed possible signs of dementia but with no formal diagnosis.
- We were also informed of a project in conjunction with Hartlepool Council to improve health care for people living with learning disabilities. When a patient with learning disabilities was admitted to the hospital, an alert was generated and they were automatically admitted to a virtual ward which was owned by the learning disabilities lead nurse. The unit was also supported by the specialist psychiatric nurse. This ensured that the trust was able to respond to patients' needs in an appropriate and timely manner. Outcomes of reviews and evidence in patient notes corroborated this.

- Staff we spoke with were able to use language line if interpreting services were required.

Learning from complaints and concerns

- Staff followed the trust's complaints policy and provided examples of when they would resolve concerns locally such as complaints about ward moves, treatment plans or lost property and how to advise patients to escalate more serious concerns when required.

Holdforth Unit

- We saw information provided by the trust which showed at the end of May, the unit had received five complaints, the majority of these related to concerns regarding nursing care. Complaints were managed in accordance with the trust's policy.
- During the course of our announced inspection, we escalated our concerns to the director of nursing about the environment and also the care patients were experiencing. We found our concerns were taken seriously and we were provided with an action plan which gave assurance that actions would be taken.
- During our unannounced inspection we were assured that actions had been implemented to improve the discharge process on the unit. This included the implementation of acceptance criteria for the unit which ensured that the right patients were on the unit at the right time.

Are medical care services well-led?

Inadequate



We have rated well-led as inadequate.

There was a lack of clarity around the purpose and leadership of Holdforth Unit and there were concerns about the staffing levels, nursing standards and quality of care on the unit. Holdforth Unit was transferred from the In-Hospital Care directorate to the Out-of-Hospital Care directorate in February 2015. However there was confusion amongst leads where the unit sat in the hospital structure. The overarching plan for the unit was to become a nurse led community rehabilitation ward, however, there was no evidence of progress towards this

Medical care (including older people's care)

goal and the plans were not documented in the form of a strategy. There was also a lack of assurance on the effective management of the Out of Hospital care directorate risk register.

The trust responded immediately to the concerns raised during inspection and developed an action plan to manage the identified risks. We went back to the unit unannounced to check that improvements had been made. We found there had been a change in ward leadership and measures were in place to improve the quality of care. For example beds had closed and staffing levels had improved.

Staff on endoscopy and the medical rehabilitation day unit had a clear vision for their services and how they functioned in the local health economy. Staff we spoke with were aware of the corporate vision of the trust. We found the culture of care delivered by staff across all the medical services was open, dedicated, and compassionate and was strongly supported at divisional and ward level.

Vision and strategy for this service

- Staff on endoscopy and the medical rehabilitation day unit had a clear vision for their services and how they functioned in the local health economy. Staff we spoke with were aware of the corporate vision of the trust.
- Individual staff spoke with pride and compassion about what they thought good care looked like and how they demonstrated this on a daily basis.

Holdforth Unit

- Holdforth Unit had been transferred from the In-Hospital Care directorate to the Out-of-Hospital Care directorate in May 2014. However there was confusion amongst leads where the unit sat in the hospital structure. The medical staff were accountable to the In-Hospital Care directorate; however the nursing and therapy staff were accountable to the Out-of-Hospital Care directorate. The beds on Holdforth Unit were counted as part of the In-Hospital Care bed base and were used to support bed pressures during periods of increased activity in the acute medical wards at University Hospital North Tees.
- The overarching plan for the unit was for it to become a nurse led community rehabilitation ward; however there

was no evidence of progress towards this goal. Senior staff we spoke with were familiar with that vision for Holdforth Unit, but the plans were not documented in the form of a strategy.

- During our unannounced inspection we were provided with assurance that the vision and values of the unit were being discussed with staff. However, we were not assured that there was progression towards a documented strategy for the unit. Additionally, we were concerned that Holdforth would continue to be used as additional capacity for the UHNT site during winter pressures. We were not confident that concerns would be escalated appropriately as part of the escalation plan.

Governance, risk management and quality measurement

- Performance was recorded electronically for general medicine and shared throughout the directorate. We reviewed medicine executive meeting minutes. There was no standard meeting agenda or evidence that governance, quality measurement and risk were discussed at all meetings. There was no record of discussion of the directorate risk register in these minutes. The process for reporting incidents was embedded across the In-Hospital Care directorate front line staff, and we saw evidence of staff receiving feedback on individual incidents they had raised.

Holdforth Unit

- Governance arrangements and their purpose were unclear. There was no process in place to review key items such as the strategy, values, objectives, plans or the governance framework.
- There was no effective system for identifying, capturing and managing issues and risks at team, directorate and organisation level. Significant issues that threatened the delivery of safe and effective care were not identified and adequate action to manage these risks was not always sustained.
- We were concerned regarding the lack of clarity between the roles and responsibilities of the ward matron and senior matron and the assurance of clinical practices in the Holdforth unit.
- The bed base increased to 30 in January 2015 but managers were unable to tell us if a risk assessment had been completed to assess the risks and identify what control measures were needed. Managers were also

Medical care (including older people's care)

unable to tell us what monitoring had been undertaken after the bed base had increased to ensure the concerns identified in 2014 regarding leadership and patient care were not repeated.

- During our unannounced inspection we were provided with assurance that the bed numbers had reduced to 26 to ensure safe staffing levels.
- Staff we spoke with stated they were confident in reporting incidents and stated that they were actively encouraged to do so. We reviewed the Out of Hospital care directorate risk register which had 378 risks documented. We were informed that risks were identified as a result of incidents and then monitored by the risk handler. However, this was not apparent from the documentation we reviewed.

Leadership of service

Holdforth Unit

- We spoke with senior managers from both the In-Hospital Care directorate and the Out-of-Hospital Care directorate about the unit. Managers told us that from the summer of 2014, they had undertaken significant work with the unit to improve leadership and patient care on the unit and had reduced the bed base to 24 patients during this time.
- The trust had concerns about the leadership on the unit dating back to summer 2014. Reactive support was provided to the unit on a number of occasions; however, attainment of quality was not maintained.
- There was a lack of a robust assurance framework from ward to board despite the Staff and Patient Experience and Quality Standards framework, as we found flaws in the care that were not observed by the trust.
- We spoke with senior managers during the inspection about our concerns relating to nurse staffing, nursing documentation and care plans, mental capacity assessments, deprivation of liberty safeguards and medicines management. The trust responded immediately and developed an action plan to manage the identified risks.
- We went back to the unit unannounced to check that improvements had been made. We found there had been a change in ward leadership and measures were in place to ensure patients were getting the care they required. For example beds had closed and staffing had improved. which identified their individual needs,

Culture within the service

- Staff spoke enthusiastically about their work. They described how they loved their work, and how proud they were to work at the trust. We found the culture of care delivered by staff across all medical services was dedicated, compassionate and strongly supported at divisional and ward level.

Public engagement

- The percentage of patients who completed the NHS Friends and Family test across all medical services in June 2015 was 50% this was better than the England average for that month, at 27%. This test measured patients who were likely or extremely likely to recommend the trust. The results showed between April 2015 and June 2015 the average score was 96%.

Holdforth Unit

- We reviewed information from April 2015 NHS Friends and Family test and saw that 91% of respondents stated they would recommend the unit to their friends or family.
- We saw information which showed in November 2014 the healthcare user group (HUG) report and group members had spoken to five patients on the unit to gain feedback about their care and experiences.

Staff engagement

- The trust, including the In-Hospital Care directorate scored 3.6 out of 5 for staff engagement used within the NHS staff survey in 2014, this remained unchanged from the previous survey in 2013 and was below the England average of 3.7, although the score is improved from 2013. There was no information specifically for the directorate.

Holdforth Unit

- Staff patient experience quality team questionnaires/ audits were being undertaken within teams. This involved looking at hygiene, the environment, speaking with patients and reviewing their records.

Innovation, improvement and sustainability

Holdforth Unit

- There was little innovation or service development. There was minimal evidence of learning and reflective practice. The impact of service changes on the quality of care was not understood.

Medical care (including older people's care)

- The unit was looking at developing new roles to make the workforce more flexible. For example the unit was looking at developing a role for health care assistant staff to work across therapies and on the unit. They were also looking at rotating community staff through the unit to attract new staff and build resilience for the unit; however, these plans were not formalised as part of a strategy.

Surgery

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

Information about the service

The University Hospital of Hartlepool provides a range of surgical services for the population of the North East of England including County Durham and the immediate surrounding area.

The Surgery Directorate comprises the directorate of Trauma and Orthopaedics and the Directorate of Surgery, Urology and Outpatients (Elective Care Directorate). The Elective Care Directorate provides urology, colorectal, breast, upper gastrointestinal and bariatric surgery. Each directorate has a clinical director and management structures were shared across the two directorates.

On the University Hospital of Hartlepool site, there is a 20 bed elective care unit (Ward 4) to support the elective inpatient activity for surgery and orthopaedics. During this inspection we visited Ward 4 as well as all theatres and recovery areas on site.

We spoke with 12 patients and relatives and 14 members of staff. We observed care being given and surgical procedures being undertaken and looked at care records for eight people.

Summary of findings

We rated safe, effective, caring, responsive and well-led as good and the service overall as good.

We observed patients being treated with compassion, dignity and respect throughout our inspection at this hospital. Patients commented positively on the dedication and professionalism of staff and the quality of care and treatment received. Staff were familiar with the process for reporting incidents using systems and staff confirmed themes from incidents were discussed to promote shared learning.

Care pathways were in use including enhanced recovery pathways and we saw all wards completed appropriate risk assessments. Risk assessments, care plans and test results were completed at appropriate times during a patient's care and treatment. All wards used an early warning scoring system for the management of deteriorating patients. We looked at clinical records and observed that all patients had been consented appropriately. The development of advanced nurse practitioners had enabled patients to be consented in a timely manner.

We found that staffing levels were compliant with the required establishment and skill mix. Difficulties in the recruitment of junior doctors had been covered through the use of locum medical staffing and the development of advanced surgical care nurse practitioners and advanced trauma and emergency surgery nurse practitioners. Therapists worked closely with the nursing

Surgery

teams on the ward and daily handovers were carried out with members of the multidisciplinary team. The trauma and orthopaedics and surgery and urology directorates delivered consultant led seven day services.

The service was responsive to the needs of patients living with dementia and learning disabilities. A dedicated 'Homeward' team had been developed to ensure the arrangements for the discharge of patients was co-ordinated between all agencies and families. 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.

Senior managers had a clear vision and strategy for the division and staff were able to repeat this vision and discuss its meaning with us during individual interviews. Staff spoke positively about the service they provided for patients and emphasised quality and patient experience. We saw staff worked well together and there was respect between specialities and across disciplines. We saw examples of good team working on the wards between staff of different disciplines and grades

Are surgery services safe?

Good



Staff were familiar with the process for reporting incidents using systems and staff confirmed themes from incidents were discussed to promote shared learning. The NHS Safety Thermometer results were clearly displayed on the ward and in the theatre areas we visited. Monthly cleanliness audits were undertaken and infection control audits were completed every month.

Care pathways were in use including enhanced recovery pathways. Appropriate risk assessments were completed. There was a comprehensive pre-operative health screening questionnaire and assessment pathway. The ward used an early warning scoring system for the management of deteriorating patients. We looked at clinical records and observed that all patients had been consented appropriately.

Consent, Mental Capacity Act (MCA) and Deprivation of Liberty Safeguards (DoLS) training was delivered as part of staff induction. The development of Advanced Nurse Practitioners has enabled patients to be consented in a timely manner.

Performance reports within the group showed staff were up to date with their mandatory training. Staffing levels were calculated using a recognised tool and trust 'template'. We found that staffing levels were compliant with the required establishment and skill mix. Difficulties in the recruitment of junior doctors were covered with the use of locum medical staffing and the development of advanced surgical care nurse practitioners.

Incidents

- Staff were familiar with the process for reporting incidents, near misses and accidents using the trust procedures and systems. Staff said they were encouraged to report incidents and were aware how to complete appropriate incident recording forms.
- Feedback was given to ward managers on reported incidents and their outcomes; staff confirmed themes from incidents were discussed at staff meetings and displayed in staff rooms. We saw incidents were discussed at ward and clinic manager meetings from across the trust to promote shared learning.

Surgery

- No never events and two serious incidents within breast surgery (one) and colorectal surgery (one) had been reported at this hospital between January 2015 and July 2015. Risks identified as a result of incidents were added to the risk register, monitored by the 'risk handler' and discussed at the senior management team meetings.
- Mortality and morbidity meetings were held monthly in all relevant specialities and relevant staff participated in mortality case note reviews and reflective practice.

Duty of Candour

- We saw that information about duty of candour was displayed on the staff intranet.
- Staff we spoke with were aware of their responsibilities under the duty of candour requirements and the actions to be taken.

Safety thermometer

- The NHS Safety Thermometer is an improvement tool for measuring, monitoring and analysing patient harms and 'harm free' care. Information was clearly displayed on boards on the ward and theatre areas visited.
- Safety thermometer information included information about all new harms, falls with harm, and new pressure ulcers and was displayed on boards on the ward and theatre areas visited. There were no pressure ulcers, falls, or urinary tract infections during 2014/15 reported via the safety thermometer for Surgery.
- Care records showed that risk assessments for these were being appropriately completed on admission.

Cleanliness, infection control and hygiene

- Infection control information was visible in all ward and patient areas and the ward and theatres were visibly clean. We saw staff wash their hands and use hand gel between patients; bare below the elbow policies were complied with.
- All elective patients undergoing surgery were screened for Methicillin resistant Staphylococcus aureus (MRSA) and procedures were in place to isolate patients when appropriate in accordance with infection control policies. There had been no incidences of MRSA reported between April 2014 and March 2015.
- We saw evidence that monthly cleanliness audits were undertaken through announced and unannounced visits from domestic managers. These included the patients and visitors views and results were discussed

with staff and actions taken immediately to rectify any problems. Patient Led Assessments of the Care Environment (PLACE) visits examined the general cleanliness of each ward, area and equipment.

- Clinical waste bins were covered with foot opening controls and the appropriate signage was used for the disposal of clinical waste. Separate hand washing basins, hand wash and sanitizer was available on the ward, theatre and patient areas.
- Infection control audits were completed every month and monitored compliance with key trust policies such as hand hygiene. Recent audits (May 2015) showed 100% compliance with hand hygiene protocols on Ward 4. The results of audits were provided immediately to staff and displayed through the Nursing Dashboard.
- Nursing staff had received training in aseptic non-touch techniques. This training covered the necessary control measures to prevent infections being introduced to susceptible surgical wounds during clinical practice.
- The division participated in the ongoing surgical site infection (SSI) audits run by Public Health England. Each case of SSI was identified, discussed at formal meetings and actions identified to avoid a repetition.
- Cleanliness in theatres and recovery areas was observed to be exceptional.
- Ward rounds with one of the trust's microbiologist had been introduced to focus on infection and antibiotic issues.

Environment and equipment

- We observed checks for emergency equipment, including equipment used for resuscitation. Resuscitation equipment in all areas had been checked daily.
- Records showed equipment was serviced by the trust's maintenance team under a planned preventive maintenance schedule.
- All freestanding equipment in theatres was covered and had been dated when cleaned. Equipment was appropriately checked and cleaned regularly. There was adequate equipment on the ward to ensure safe care.

Medicines

- Medicines were stored securely in locked cupboards and fridges within the ward. Audits of controlled drugs were undertaken by two registered nurses at each shift change and quarterly by pharmacy staff.

Surgery

- Fridge temperatures were monitored on a daily basis with the temperature recorded.
- Ward based pharmacists had been introduced to review medication charts and discharge prescriptions to reduce the possibility of errors during the prescribing process.
- We observed the preparation and administration of controlled drugs was subject to a second independent check. After administration, the stock balance of an individual preparation was confirmed to be correct and the balance recorded.

Records

- Care pathways were in use including enhanced recovery pathways.
- Completed risk assessments included those for falls, pressure ulcers and malnutrition. All records (eight) we looked at were completed accurately.
- Audits showed 88% overall compliance (April 2015) with identified areas for improvement including the recording of GMC numbers and any deletions being countersigned, dated and timed.
- There was 100% compliance in completing early warning score documentation and undertaking appropriate actions.
- There was a comprehensive pre-operative health screening questionnaire and assessment pathway.
- Clinical notes were stored securely in line with Data Protection Act principles to ensure patient confidentiality was maintained. All records reviewed were completed in a consistent and comprehensive manner.
- Nursing documentation was kept at the end of the bed and centrally within the ward and the eight records we reviewed were completed appropriately.

Safeguarding

- Staff were aware of the safeguarding policies and procedures and had received training in this area. They were also aware of the trusts' whistleblowing procedures and how to contact the relevant safeguarding team for advice and support.
- Information provided by the trust showed 100% of staff requiring safeguarding adults (Levels 1 and 2) and safeguarding children (Level 1) within the division had completed the training. All consultants had carried out Level 3 safeguarding children.

- All staff we spoke with were able to describe action they would take if they had safeguarding concerns and examples were given where safeguarding concerns had been raised from the directorate.

Mandatory training

- Performance reports within the care group showed staff were up to date with their mandatory training.
- For example, 95% of staff had received consent training, 90% had received record keeping training, 95% had received infection control training and 90% had attended medicines management training.
- Staff we spoke with confirmed they were up to date with mandatory training and this included attending annual cardiac and pulmonary resuscitation training.

Assessing and responding to patient risk

- The ward used an early warning scoring system for the management of deteriorating patients. There were clear directions for escalation printed on the observation charts and staff spoken with were aware of the appropriate action to be taken if patients scored higher than expected. We looked at completed assessments within care records (eight) and saw that staff had escalated correctly where appropriate, and repeat observations were taken within the necessary time frames.
- We observed that theatre staff practiced the 'Five Steps to Safer Surgery, World Health Organisation (WHO)' and audits across all specialities showed variable compliance results. Compared to a baseline audit (July, 2015) there had been improvements in compliance with the completion of patient details (22% improvement) and sign out (25% improvement). Improvements were not identified in 'sign-in' and 'time out' aspects of the checklist. As a result the WHO checklist had been reformulated to improve compliance.
- A number of other appropriate risk assessments were also used e.g. for the prevention of venous thromboembolism (VTE), malnutrition (MUST) and falls and for the promotion of skin integrity and bone health.
- Pre-assessment of patients was in accordance with British Association of Day-care Surgery (BADs) guidelines to identify risks before treatment and develop individual care plans.
- Theatre lists were updated in 'real time' to reflect changing priorities and timescales.

Surgery

Nursing staffing

- Staffing levels for the ward were calculated using a recognised tool and trust 'template' reviewed every six months to determine the effectiveness and safety of staffing, pressures on the ward and highlight required changes to staffing.
- Daily staffing meetings were held across the trust to decide on staff shortfalls, moving staff between wards and across sites, agency usage and staff requests to the medical directorate. The Senior Clinical Matron 'Out of Hours' contributed to this process when appropriate.
- We reviewed the nurse staffing levels on the ward and within theatres and found that levels were compliant with the required establishment and skill mix.
- There was a safe staffing and escalation protocol to follow should staffing levels per shift fall below the agreed roster and acuity needs of patients. Staffing numbers on the ward had been adjusted flexibly between registered and unregistered staff to meet the needs of patients and in line with the protocol.
- Bank or agency staff were not routinely used and staff told us they were asked to cover staff shortages. Latest information (May 2015) confirmed the use of agency or bank staff was 1.2%.

Surgical medical staffing

- Surgical consultants from all specialities were on call for a 24-hour period and arrangements were in place for effective handovers. The general surgical on call team comprised of the general consultant and a consultant vascular surgeon provided through a Tees wide service.
- Patients that required unscheduled inpatient surgical care were placed under the direct daily supervision of a consultant and the hospital published a rota for the provision of general surgical emergency provision.
- Difficulties in the recruitment of junior doctors had been covered through the use of locum medical staffing and the development of advanced surgical care nurse practitioners. The use of locums within surgery was 19% (February 2015).
- Consultants were available on-call out of hours and would attend when required to see patients at weekends. Medical staffing within the division was made up of 37% at consultant level (England average 40%), 22% registrar level (England average 37%), middle career 21% (England average 11%) and 20% junior doctors (England average 13%).

Major incident awareness and training

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

Are surgery services effective?

Good



Patients were treated based on national guidance and enhanced recovery pathways were in place. We saw pre-planned pain relief was administered for patients on recovery pathways. Risk assessments, care plans and test results were completed at appropriate times during a patient's care and treatment.

Monthly staff meetings were taking place supported by informal one to one meetings. Training for surgical trainees had been developed and 'protected time' identified for completion. Systems were in place for revalidation and appraisal of medical staff. Therapists worked closely with the nursing teams on the ward and daily handovers were carried out with members of the multidisciplinary team. The ward worked with local authority services as part of discharge planning. The trauma and orthopaedics and surgery and urology directorates delivered consultant led seven day services.

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.
- Agreed pathways for surgical cancer patients were in place and monitored through peer review. Each cancer speciality had a designated medical and nursing lead to support the cancer pathways.

Surgery

- Local policies were written in line with national guidelines and updated every two years or if national guidance changed. For example, there were local guidelines for pre-operative assessments and these were in line with best practice.
- The surgery division took part in all the national clinical audits that they were eligible. The division had a formal clinical audit programme where national guidance was audited and local priorities for audit were identified.
- Local audits relating to infection control, checking of controlled drugs and use of personal protective clothing in theatres and recovery showed full compliance.

Pain relief

- Pre-planned pain relief was administered for patients on recovery pathways.
- There was a pain assessment scale within the National Early Warning Score (NEWS) chart used throughout the trust. NEWS audits were in place and supported through feedback from the Friends and Family Test and directly from patients. The ward had an identified a pain link nurse.
- Patients were regularly asked about their pain levels, particularly immediately after surgery, and this was recorded on a pain scoring tool that was used to assess patients' pain levels.
- All patients we spoke with reported their pain management needs had been met. The trust had undertaken an audit of post-operative pain relief with patients.
- Patients with complex analgesia needs were referred to the pain service for additional assessment.

Nutrition and hydration

- Patient-led Assessments of the Care Environment (PLACE) scored the trust above the England average for privacy, dignity and wellbeing (88, England average 87) in 2014.
- All patients were screened using the Malnutrition Universal Screening Tool (MUST). Where necessary patients at risk of malnutrition were referred to the dietician.
- The trust had a Fluid and Nutrition Group (FANG) in place to oversee the management of nutrition and hydration including the compliance with fluid balance treatment and recording. Fluid balance charts and nutrition assessments were completed where required in the eight patient records we reviewed.

- Nurses completed food charts for patients who were vulnerable or require nutritional supplements and support was provided by the Dietetic department.
- Records showed patients were advised as to what time they would need to fast from. Fasting times varied depending on when the surgery was planned.

Patient outcomes

- The hospital had better than the standardised relative readmission rates England average (100) for elective surgical patients for general surgery (65), urology (79) and trauma and orthopaedics (72).
- The National Bowel Cancer Audit (2014) showed better than England average results for clinical nurse specialist involvement (93%, England average 88%), discussion at MDT (100%, England average 99%) and scans undertaken (99%, England average 89%). 66% of patients stayed in the hospital for an average of more than five days (better than the England average of 69%).
- Lung cancer audit results showed the percentage of patients receiving surgery was lower than the England average (15%) at 13%. The audit showed results better than the England average for multi-disciplinary team discussion (98%, England average 96%) and slightly worse results for scans undertaken before bronchoscopy (89%, England average 91%).
- The hospital was worse than the national average for pre-operative assessment by a geriatrician (36%, national average 52%), and the mean length of total trust stay (20 days, national average 19 days).
- The division had introduced initiatives to improve adherence with national targets. Business cases and focus on additional weekend working and the introduction of additional theatre sessions been designed to reduce backlogs.
- Swab, pack surgical instrument and sharp count audits were completed within theatre and these were discussed at divisional meetings and actions identified if required.

Competent staff

- Staff told us that appraisals were undertaken annually and records for 2014 showed that staff across all wards in surgery and theatres had received an appraisal or had an appraisal planned. We saw that 100% of nursing staff and 90% of consultants within surgery had an appraisal between April 2014 and March 2015.

Surgery

- Monthly staff meetings were taking place and minutes were available to staff. These were supported by informal one to one meetings did take place.
- Junior doctors we spoke with told us they attended teaching sessions and participated in clinical audits. They told us they had received ward-based teaching and were supported by the ward team and could approach their seniors if they had concerns.
- Training for surgical trainees had been developed and 'protected time' identified for completion. All trainees had clinical supervisors and the directorate had a dedicated Medical Education Committee to ensure training and supervision issues were discussed.
- Systems were in place for revalidation and appraisal of medical staffing. There was a consultant identified who takes the lead for revalidation on behalf of the Clinical Director.

Multidisciplinary working

- Therapists worked closely with the nursing team on the ward where appropriate. Ward staff told us they had good access to physiotherapists, occupational therapists and speech and language therapists when needed.
- Daily handovers were carried out with members of the multidisciplinary team.
- There was pharmacy input on the ward during weekdays and dedicated pharmacy provision was planned.
- Staff explained the ward worked with local authority services as part of discharge planning.
- The surgical cancer pathway had established multidisciplinary working, monitored through the Cancer Strategy Group and peer review. Emergency patient care plans were reviewed at daily surgical meetings and a weekly bariatric multidisciplinary meeting was held as part of bariatric consortium arrangements.

Seven-day services

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

- The surgery and urology directorate delivered a consultant led seven day emergency surgical service. Elective activity was not carried out when consultants were covering emergency surgery.

Access to information

- Risk assessments, care plans and test results were completed at appropriate times during a patient's care and treatment and we saw these were available to staff enabling effective care and treatment.
- We reviewed discharge arrangements and these were started as soon as possible for patients. We saw discharge letters were completed appropriately and shared relevant information with a patient's general practitioner.
- There were appropriate and effective systems in place to ensure patient information was co-ordinated between systems and accessible to staff.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- We looked at eight clinical records and observed that all patients had been consented appropriately and this was in line with the Trust policy and Department of Health Guidelines.
- Staff told us mental capacity assessments were undertaken by the consultant responsible for the patients care and Deprivation of Liberty Safeguards were referred to the trust's safeguarding team.
- These were appropriately recorded in patient notes when appropriate.
- Consent, Mental Capacity Act (MCA) and Deprivation of Liberty Safeguards (DoLS) training was delivered as part of staff induction. The development of Advanced Nurse Practitioners has enabled patients to be consented in a timely manner and MCA and DoLS assessments were included in risk assessments.

Are surgery services caring?

Good



We observed patients being treated with compassion, dignity and respect throughout our inspection at this hospital. Patients commented positively on the dedication

Surgery

and professionalism of staff and the quality of care and treatment received. Patients told us staff the staff kept them well informed and did their best to keep patients informed.

The Friends and Family Test response rate was the same as the England average of 32%, between December 2013 and November 2014 and scored similar across all areas with the England averages. The Care Quality Commission in-patient survey (2014) showed an increase in patients' belief that they were involved as much as they wanted to be in decisions about their care and treatment over the previous year. There was information within care plans to highlight whether people had emotional or mental health problems and what support they required. Patients were able to access counselling services and the mental health team.

Compassionate care

- We observed patients being treated with compassion, dignity and respect throughout our inspection at this hospital. We saw that patients were spoken and listened to promptly.
- Patients commented positively on the dedication and professionalism of staff and the quality of care and treatment received. Patients were complimentary about the staff in the service, and felt informed and involved in their care and treatment. We observed patients being kept informed throughout their time within the anaesthetic room and theatres.
- Patients told us staff the staff kept them well informed, explained why tests and scans were being carried out and did their best to keep patients informed. Patients said they felt safe and confident in the nurses, doctors and support staff. Patients and relatives were positive about the care and treatment received.
- We saw staff were attentive to the comfort needs of patients. Doctors introduced themselves appropriately and curtains were drawn to maintain patient dignity.
- The Friends and Family Test response rate was the same as the England average of 32%, between December 2013 and November 2014 and scored similar across all areas with the England averages during that period. We reviewed patient comments and saw these were complimentary towards staff and facilities. We were told a number of awards had been received highlighting the positive care given within the ward.

- Patient-led Assessments of the Care Environment (PLACE) scored the trust above the England average for privacy, dignity and wellbeing (88, England average 87) in 2014.
- Numbers of written complaints to the trust have been consistently between 300 and 400 but fell in 2013/2014 compared to the previous year.

Patient understanding and involvement

- All patients said they were made fully aware of the surgery that they were going to have and this had been explained to them.
- Patients and relatives said they felt involved in their care and they had been given the opportunity to speak with the consultant looking after them.
- We saw ward managers and matrons were available on the ward so that relatives and patients could speak with them.
- Ward information boards identified who was in charge of the ward for any given shift and who to contact if there were any problems.
- The Care Quality Commission in-patient survey (2014) showed an increase (7.2 from 7.1) in patients' belief that they were involved as much as they wanted to be in decisions about their care and treatment over the previous year.
- There was also an increase in patients responding positively (8.3 from 8.1) to say they received answers they could understand when asking important questions to a nurse.

Emotional support

- Patients said they felt able to talk to ward staff about any concerns they had either about their care, or in general. Patients did not raise any concerns during our inspection.
- There was information within care plans to highlight whether people had emotional or mental health problems and what support they required for this.
- Patients were able to access counselling services and the mental health team.
- Assessments for anxiety and depression were completed at the pre-assessment stage and extra emotional support was provided by nursing staff for patients both pre and post operatively.

Are surgery services responsive?

Surgery

Good



The service was responsive to the needs of patients living with dementia and learning disabilities. The ward had an identified dementia champion as well as a learning disability liaison nurse who could provide advice and support. There was access to an independent mental capacity advocate (IMCA) for when best interest decision meetings were required. The bariatric service had been developed as part of a consortium arrangement with neighbouring NHS trusts to ensure the local population had access to this service.

The trust was not meeting the overall referral to treatment targets (RTTs) of 90% of patients admitted for treatment from a waiting list within 18 weeks of referral. The reasons for this had been identified and additional recruitment to consultant posts undertaken and locum cover arranged to reduce backlogs

Capacity bed meetings were held to monitor bed availability in the hospital. A dedicated 'Homeward' team had been developed to ensure the arrangements for the discharge of patients was co-ordinated between all agencies and families.

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. We saw information leaflets and posters available for patients explaining their procedure and after care arrangements. 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; all complaints received within the division had been handled in line with the trust policy.

Service planning and delivery to meet the needs of local people

- The hospital had an escalation and surge policy and procedure to deal with busy times.
- Capacity bed meetings were held to monitor bed availability in the hospital; managers responsible for reviewing planned discharge data and assessing future bed availability had been appointed.

- A dedicated 'Homeward' team was developed to ensure the arrangements for the discharge of patients was co-ordinated between all agencies, including social services, and families. All patients who had contact with this team made positive comments.
- During high patient capacity and demand elective patients were reviewed in order of priority for cancellation to prevent urgent and cancer patients being cancelled.
- The bariatric service was developed as part of a consortium arrangement with neighbouring NHS trusts to ensure the local population had access to this service.
- A business case for the expansion of orthopaedic services was agreed and is taking place which includes a reconfiguration of existing resources to provide foot and ankle services as a sub speciality service, increase the upper limb capacity and to develop a hand trauma service.

Access and flow

- A pre-assessment meeting was held with the patient before the surgery date and any issues concerning discharge planning or other patient needs were discussed at this stage. Patients requiring assistance from social services upon discharge were identified at pre-assessment and plans were continuously reviewed during the discharge planning process.
- The trust was not meeting the overall referral to treatment targets (RTTs) of 90% of patients admitted for treatment from a waiting list within 18 weeks of referral (November 2014). The RTT was not met within general surgery (88%). The reasons for this had been identified and additional recruitment to consultant posts undertaken and locum cover arranged to reduce backlogs
- RTTs were met for trauma and orthopaedics (91%) and urology (90.7%) during the same period.
- The directorate sent discharge summaries to GPs for 97% orthopaedic patients and 93% of surgery and urology patients. A specific discharge coordinator was appointed to support discharge.
- The average length of stay for elective and non-elective patients was comparable or better than the England average across the trust. However, there were variations between sites and specialties.

Surgery

- The average length of stay for elective patients was worse than the England average for trauma and orthopaedics (4.2 days, England average 3.5 days) and better than the England average for general surgery (1.4 days, England average 3.5 days).
- No patients had their operation cancelled and were not treated within 28 days between April 2011 and September 2014.

Meeting people's individual needs

- The service was responsive to the needs of patients living with dementia and learning disabilities. The ward had identified dementia champions as well as a learning disability liaison nurse who could provide advice and support with caring for people with these needs.
- 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.
- We saw that the care of patients following surgery was particularly effective through the provision of ongoing physiotherapy services.
- The ward had access to interpreters as required, requests for interpreter services were identified at the pre-assessment meeting.
- The trust had in place policies covering the 'Mental Capacity Act (2005) and Deprivation of Liberty Safeguards'. There was access to an independent mental capacity advocate (IMCA) for when best interest decision meetings were required. Training on these had been planned throughout 2014 and 2015 and 100% of staff had completed the training.

Learning from complaints and concerns

- Patients or relatives making an informal complaint were able to speak to individual members of staff or the ward manager.
- Staff were able to describe complaint escalation procedures, the role of the Patient Advice and Liaison Service (PALS) and the mechanisms for making a formal complaint. We saw leaflets available throughout the hospital informing patients and relatives about this process.
- We saw all complaints received within the division had been handled in line with the trust policy. Information

was given to patients about how to make a comment, compliment or complaint. There were processes in place for dealing with complaints at ward level and through the trust's Patient Advice and Liaison Service.

- Complaints and concerns were discussed at monthly staff meetings where training needs and learning was identified as appropriate.
- An example of learning from complaints included a further review of the number of upper limb service clinics available, resulting in an increase in the number of review appointments to ensure a more local service was maintained.
- If patients or their relatives needed help or assistance with making a complaint the Independent Complaints Advocacy Services (ICAS) contact details were visible on the ward and throughout the hospital.

Are surgery services well-led?

Good



Senior managers had a clear vision and strategy for the division and staff were able to repeat this vision and discuss its meaning with us during individual interviews. Joint clinical governance and directorate meetings were held each month. The directorate risk register was updated following these meetings and when needed. We saw action plans were monitored across the division.

Staff said speciality managers were available, visible within the division and approachable; leadership of the service was good, there was good staff morale and they felt supported at ward level. Staff spoke positively about the service they provided for patients and emphasised quality and patient experience.

NHS staff survey data (2014) showed the trust scored as expected in 20 out of 30 areas and better than expected in three areas. We saw staff worked well together and there was respect between specialities and across disciplines. We saw examples of good team working on the ward between staff of different disciplines and grades.

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.

Surgery

- The vision and strategy had been amended to account for a delay in redeveloping the provision of services within the trust and staff were able to repeat this vision and discuss its meaning with us during individual interviews.
- The trust vision and strategy was well embedded with staff, who were able to articulate to us the trust's values and objectives and they were clearly displayed on the ward and throughout the hospital.
- 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.
- Within the surgical directorate there were five sub specialities and within orthopaedics there were four sub specialities. Monthly speciality meetings were held and discussed financial and clinical performance, patient safety and operational issues.
- Nursing staff stated that they were well supported by their managers although we were told one-to-one meetings were informal.
- Medical staff stated that they were supported by their consultants and confirmed they received feedback from governance and action planning meetings.

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 involvement, infection control issues, alert notices, good practice, national service frameworks, clinical audits and research projects were discussed and action taken where required.
- The directorate 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.
- 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 identified risks and progress addressing them.

Leadership of service

- Staff said speciality managers were available, visible within the division and approachable; leadership of the service was good, there was good staff morale and they felt supported at ward level. Clinical director management meetings were held weekly and involved speciality managers.

Culture within the service

- At ward and theatre level we saw staff worked well together and there was respect between specialities and across disciplines. We saw examples of good team working on the ward between staff of different disciplines and grades.
- Staff were well engaged with the rest of the hospital and reported an open and transparent culture on the ward and felt they were able to raise concerns.
- Staff spoke positively about the service they provided for patients and emphasised quality and patient experience were a priority and everyone's responsibility.
- The directorate had recently taken part in a research programme to measure culture on one of the surgical wards in conjunction with a local university; the results were not available.

Public and staff engagement

- The Friends and Family Test response rate was the same as the England average of 32%, between December 2013 and November 2014 and scored similar across all areas with the England averages during that period. Staff told us that they had regular staff meetings and the Friends and Family Test (FFT) survey results were shared with them. Friends and Family Test (FFT) survey results were highlighted and displayed throughout the hospital.
- We saw patient user groups and patient panels were in place, meeting on a monthly basis and attended by senior management and clinical staff from the trust.
- NHS staff survey data (2014) showed the trust scored as expected in 20 out of 30 areas. It scored better than expected in three areas: percentage of staff working extra hours; percentage of staff witnessing harmful errors, near misses or incidents in the last month, and the percentage of staff experiencing harassment, bullying or abuse from staff in the last twelve months.

Surgery

Innovation, improvement and sustainability

- The development of advanced nurse practitioners has enabled the hospital to respond to patients' needs appropriately and mitigated difficulties recruiting junior doctors.
- The bariatric service was developed as part of a consortium arrangement with neighbouring NHS trusts to ensure the local population had access to this service.

Maternity and gynaecology

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

Information about the service

University Hospital of Hartlepool has a birthing team who provide care for women and families in the Hartlepool area. The service is for low risk women and entirely midwife-led, with no medical cover. The maternity service at University Hospital of Hartlepool delivered 109 babies between April 2014 and March 2015.

There is an antenatal day assessment unit and a birthing centre with four delivery rooms, a pregnancy advisory service and an early pregnancy service. Post-natal care is also provided at children's centres throughout Hartlepool. The birthing centre was opened for our inspection as there were no mothers on the unit that day. We also visited the day assessment unit, the pregnancy advisory centre and the early pregnancy assessment clinic.

We spoke with five staff, including specialist nurses and midwives; there were no women in the unit for us to speak with on the day of our inspection. We observed the environment and reviewed the service performance data.

Summary of findings

Overall we rated the maternity services as requires improvement at the University Hospital of Hartlepool. This was due to concerns in the areas of effective and well led. We rated safe and responsive as good and we were unable to rate services for caring as no patients were present at the time of our inspection.

We rated effective as requires improvement as there was no competency framework in place to support the development of band five midwives to enable progression and succession planning. Managers told us a competency based framework was under development and it was hoped this would be completed by September 2015. The recommended midwife to supervisor of midwives ratio was not being met. The recommendation is a ratio of 1:15 and at the time of inspection the ratio was 1:18. 27% of the trust midwifery staff had not received an annual review.

Guidelines that were out of date when we conducted the comprehensive inspection were updated by the time of the unannounced inspection; however, we were not assured that systems were in place to monitor and maintain this position. Referral times for termination of pregnancy and the full completion of the required documentation was an area for improvement. Plans had been put in place and required further audit to monitor and evidence progress.

We rated well-led as requires improvement as the maternity services risk register contained many generic risks and identifying risks specific to the services at

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Hartlepool was difficult. The lack of a rating system to measure performance on the maternity dashboard was also a concern. There were concerns about maternity leadership capacity as the senior operational role had a wide remit and was seen to be challenging. The midwifery management structure was flat with no additional support between the Head of Midwifery and the band seven midwives.

We found incident reporting was embedded within the service and noted examples of shared learning from incidents. Mandatory training participation rates were good and staff could articulate how they would manage safeguarding concerns.

There was good local leadership and staff were engaged and committed to the service. Staff were not based in the birthing unit, but they were available when the unit needed to open and individual needs of patients were a focus. The environment was welcoming and efforts had been made to make it less clinical. Although we were unable to rate caring, the staff we spoke with were clearly dedicated and passionate about the care and services they provided.

Are maternity and gynaecology services safe?

Good



We rated safe as good.

There were a number of ways of learning from incidents or sharing a change in practice. This included patient safety team meetings, publication of a monthly newsletter 'Risky Business', face to face feedback of action plans and emails. We observed a patient safety board at Hartlepool which included details and evidence of learning from incidents, for example recognition of sepsis. Staff demonstrated a good level of understanding of safeguarding and all staff had attended training on this. We had assurance that equipment was being maintained and checked on a daily basis. We found an expired oxygen cylinder but this was replaced once staff were alerted to this. The unit was clean and tidy and efforts had been made to make it feel welcoming. Midwives were available to open the birthing unit when needed, although they may be located at University Hospital North Tees. Support was provided by the midwives in the day assessment unit or community midwives if delays in staff arriving was anticipated.

Incidents

- There were no reported never events or serious untoward incidents (SUI) reported for Hartlepool maternity services for 2014/2015. Never Events are a particular type of serious incident that are wholly preventable.
- Trust policies for reporting incidents, near misses and adverse events were embedded in maternity. Incidents were reported on the trust electronic reporting system. The staff we spoke to could describe what types of incident they would report and the process for this.
- Incident reporting was encouraged, and there were a number of ways of learning from incidents or sharing a change in practice. This included patient safety team meetings, publication of a monthly newsletter 'Risky Business', face to face feedback of action plans and emails. We observed a patient safety board at Hartlepool which included details and evidence of learning from incidents, for example recognition of sepsis. Clinical incidents also fed in to mandatory training and were used as case scenarios.

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- Between December 2014 and April 2015 there were ten reported incidents from University Hospital of Hartlepool all of which were categorised no harm. Seven of these related to staffing issues.
- As midwifery staff rotated between University Hospitals North Tees and Hartlepool, staff were aware of SUI's that occurred at University Hospital North Tees and could describe learning and changes in practice from these, such as procedures following a neonatal death.
- Staff could explain the process if a mother's or baby's condition deteriorated and they required transfer to University Hospital North Tees for further management. We reviewed the hospital transfer policies for mother and neonates which supported what staff told us.
- Mortality and morbidity meetings took place monthly at University Hospital North Tees. We reviewed minutes of several meetings which confirmed a review of cases along with clinical details. Suggestions for improved practice/management were evidenced. It was noted that some minutes were brief.

Duty of Candour

- Staff could explain the Duty of Candour and the importance of being open and honest and described how following an incident, a meeting would be offered to those involved and an apology letter would be sent. There was a policy in place for this.

Safety thermometer

- The NHS safety thermometer is a local improvement tool for measuring, monitoring and analysing patient harms and harm-free care. The NHS safety thermometer allowed the proportion of patients who were kept 'harm-free' from venous thromboembolisms (VTE's), pressure ulcers, falls and urine infections to be measured on a monthly basis.
- This data was not collected for maternity services at University Hospital of Hartlepool.

Cleanliness, infection control and hygiene

- From April 2014 to March 2015 there were no recorded cases of Methicillin-Resistant Staphylococcus Aureus (MRSA) or Clostridium Difficile within the maternity department.
- The areas we visited were very clean and tidy. They felt welcoming and efforts had been made to make it feel less clinical, for example motivational quotes were on

the walls in the birthing pool room. Alcohol gel for hand hygiene and personal protective equipment were available in each area. We observed stickers indicating equipment had been cleaned.

- On the day of our visit the birthing pool was not in use due to the isolation of pseudomonas from the tap. The appropriate action had been taken. We were told daily checks of the birthing pool room incorporated running of the taps and the taps were swabbed on a monthly basis.

Environment and equipment

- Access to the birthing centre was via a voice only intercom system. The reception desk was located next to the entrance enabling compliance with Health Building Notice 09-02 – Maternity care facilities 2013.
- We observed the four delivery rooms had a range of birthing aids to facilitate normal birth. The unit environment was decorated to a high standard, particularly the birthing pool room.
- Best practice is for resuscitation trolleys to be checked daily (Royal Collage of Anaesthetics – Resuscitation – Raising the Standard). We reviewed records from April 2015 to the day of our visit and found daily checks had been completed.
- We found that the oxygen cylinder on the resuscitaire was out of date despite having been checked that day. We informed a member of staff and the cylinder was replaced.
- We checked equipment for evidence of portable appliance testing (PAT); this is the term used to describe the examination of electrical appliances and equipment to ensure they are safe to use, and should be done on an annual basis. We looked at all equipment in the areas we visited and all had in date PAT.

Medicines

- Medicines were stored in locked cupboards and we reviewed records which showed daily fridge temperatures had been recorded. We did find some stock drugs which were out of date, staff were informed of this. We reviewed medicines audit data but there was none specific to University Hospital Hartlepool.
- Controlled drugs were not stored within the birthing unit due to it being closed for periods of time when not in use. Controlled drugs could easily be accessed from another area within the hospital when required.

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Records

- The maternity service had developed its own maternity note template. Women carried their antenatal notes throughout pregnancy in line with National Institute for Health and Care Excellence (NICE) Quality Standard (QS) statement 3. No records were available for review at the time of our visit.

Safeguarding

- We reviewed training figures which showed all staff had attended level one adult safeguarding training and level three safeguarding children training.
- The Head of Midwifery (HOM) based at University Hospital North Tees was the safeguarding lead with the support of another midwife in an interim post.
- There was an up-to-date safeguarding policy and all staff we spoke with could describe what the process was if they had safeguarding concerns and how to contact the safeguarding teams for different areas. The staff also described good working relations with community midwives over safeguarding concerns.
- There was a policy and flow chart for the management of abduction of an infant. There was no evidence that a simulation of this had taken place and staff were not aware of this happening. There was a draft flow chart for the care pathway of teenage mothers. The trust did not have a specialist midwife for teenage pregnancies.
- We saw the Female Genital Mutilation (FGM) guideline which had a multi-agency approach and clearly demonstrated the arrangements to safeguard women with or at risk of FGM. The guideline included automatic safeguarding referral for female infants at risk of FGM as detailed in the Department of Health (DoH) guidelines.

Mandatory training

- Attendance rates for mandatory training for midwifery staff was between 80% and 100%. Mandatory training was a four day programme for midwives. The programme included, safeguarding training, resuscitation, information governance, blood transfusion and moving and handling. We were told clinical incidents and SUI's were often used as scenarios during training. Midwives had skills drills training at University Hospital of North Tees, which included participating in a scenario based on an emergency situation which could occur, for example obstetric haemorrhage.

- Staff told us about additional training being undertaken, for example presentation scanning training to enable interpretation of ultrasound scans and twin pregnancy study days.

Assessing and responding to patient risk

- A risk assessment at antenatal booking was done for all women using trust guidance to determine whether individuals were high or low risk. The trust had an antenatal screening specialist midwife and we were told there were fail safe systems across all screening programmes. A failsafe is a back-up mechanism in addition to usual care. This ensures if something goes wrong in the screening pathway, processes are in place to identify what has gone wrong and the actions needed to achieve a safe outcome.
- The unit used risk criteria to assess women in the antenatal day assessment unit. Women were also risk-assessed by telephone and if felt to be above the set criteria, they were referred to University Hospital North Tees. Only women who were low risk could use the birthing unit at Hartlepool.
- If concerns were identified over a cardiotocography (CTG) reading of the fetal heart rate, then the obstetric doctor on duty on the delivery suite at University Hospital North Tees would be contacted by telephone for medical support.

Midwifery staffing

- The birthing team was established in January 2015 and comprised of 6.0 whole time equivalent midwives (WTE). The caseload of the team was 120 women.
- A Birthrate Plus staffing review had commenced but not completed, the draft report was reviewed which indicated the required WTE number of midwives for a caseload of 120 women was being achieved.
- The birthing unit only opened when a woman was in labour and planned to deliver there. Staff were relocated to University Hospital North Tees and travelled to Hartlepool if the unit needed to open. Midwives were also on call at home. The antenatal day unit always had two midwives on duty who would cover the birth unit if a woman was admitted in labour before the birthing team arrived. Staff told us the demands placed upon the team to cover shortfalls and gaps within other parts of the maternity service were a challenge.
- We were told staffing shortages at University Hospital North Tees impacted on the birthing team being

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available to support community colleagues; this was supported by incident reports. There was no use of bank or agency staff. Staff were aware of the escalation policy and procedure for staffing shortages.

- The pregnancy advisory and early pregnancy services were delivered by two specialist nurses.

Medical Staffing

- This unit was midwifery-led and medical support if required was obtained by contacting the Delivery Suite at University Hospital North Tees in the first instance.

Major incident awareness and training

- Business continuity plans were in place for maternity and gynaecology services which included risks specific to each clinical area.
- Midwives attended skills and drills training at least twice a year which were scenarios based on maternal or neonatal emergencies. This also included evacuation from the birthing pool and all staff were well rehearsed in use of evacuation equipment.
- The trust had a major incident plan which outlined the roles and responsibilities of staff in each area.

Are maternity and gynaecology services effective?

Requires improvement



We rated effective as requires improvement. This was based on the lack of a competency framework to support the development and progression of band five and six midwives; out of date maternity guidelines and the requirement for all midwives to receive an annual review not being met. Managers told us a competency based framework was under development and it was hoped this would be completed by September 2015.

The recommended ratio of midwives to supervisor of midwives (SOM) is 1:15. At the time of inspection this ratio was 1:18, meaning the recommended ratio was not being met. The Local Supervising Authority Audit Report 2014/15 highlighted the completion of annual reviews for midwives as an area of improvement. 72% of annual reviews were completed. Guidelines that were out of date when we

conducted the comprehensive inspection were updated by the time of the unannounced inspection; however, we were not assured that systems were in place to monitor and maintain this position.

Women undergoing a termination of pregnancy (TOP) were not always seen within the recommend 14 days from referral. Actions had been taken to address this and reminders had also been sent to GPs to ensure full completion of the appropriate forms for TOP as a trust audit in July had highlighted some omissions.

Evidence-based care and treatment

- The care and treatment provided was based on guidance from professional bodies and experts such as NICE and The Royal College of Obstetrics and Gynaecology (RCOG) Guidelines were accessed on the trust intranet.
- We reviewed the birth unit guidelines and found they were due for review in October 2014. Staff were aware of this but unsure as to whose responsibility it was to ensure that guidelines were up to date. The Standard Operating Policy (SOP) for the birthing unit team stated “The team is supported by the Maternity Guidelines for North Tees and Hartlepool Family Health. These guidelines are regularly updated and audited within the framework for clinical governance and in line with CNST”. This was raised with the HOM on our unannounced inspection and we were assured that these had been updated. Quarterly guideline meetings had been arranged to monitor progress and maintain the currency of guidelines. These had not yet taken place and dates were to be confirmed.
- The function of the Local Supervising Authority (LSA) is to ensure midwifery care is safe and of high quality. This is done by annual auditing to ensure statutory supervision of midwives is in place. One of the criteria of the LSA audit is the involvement of the SOM in development or sharing of new guidelines. The audit on the 25th November 2014 found no evidence of this being done and supports our inspection findings that guidelines were not being regularly updated...
- The service had full United Nations Children’s Fund (UNICEF) Baby Friendly Initiative (BFI) accreditation; however at the time of inspection reassessment was pending.

Pain relief

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- There were several methods of pain relief available to women in labour including the use of a birthing pool, entonox gas and opiates; information on these was provided during pregnancy.
- During our inspection there were no women in the birthing unit so we could not confirm how effective pain management was.

Nutrition and hydration

- Staff told us food was offered to women and their partners and we saw there were facilities in the birthing unit for women to access hot and cold drinks.
- Breastfeeding rates at six to eight weeks from February 2014 to February 2015 were 20.2% for the birthing unit at Hartlepool. Breastfeeding support was provided, and there was a specialist midwife for infant feeding.

Patient outcomes

- 22 babies had been delivered at the birthing unit between January and June 2015. Two of these women required transfer to University Hospital North Tees.
- A trust learning event in March 2015 identified not all women (33%) were having carbon monoxide readings done at their 28 week appointments. The regional average of women who smoked whilst pregnant (18.9%) was more than the national average (12%). Following this event, staff were re-trained to raise awareness of the need to conduct carbon monoxide readings.
- An audit in July 2015 of 50 case notes (20 from Hartlepool) showed that the trust was not meeting the RCOG standard for seeing all women who have been referred for a termination of pregnancy within 14 days. An action plan was developed to address this with work expected to be completed by December 2015.

Competent staff

- The unit had a preceptorship programme for newly registered midwives; however this followed the Trust format for all new registrants and was not specific to midwifery. We reviewed some specific competency sheets however the programme did not include a comprehensive competency skills framework to demonstrate that midwives were assessed to a consistent standard. We were told a competency based framework was under development.
- We were told all staff had completed training on CTG interpretation as a result of a clinical incident.

- All staff we spoke with had a supervisor of midwives (SOM). This is a statutory role which provides guidance and support for all practicing midwives. The national recommendation is a ratio of 1:15. During the LSA inspection in November the ratio had been 1:13, however at the time of our inspection the ratio was 1:18. There were plans in place to address this; however the recommended ratio was not expected to be achieved until late summer 2015.
- The LSA report identified 73% of annual reviews had been completed and recorded on their database for 2014/2015, with a recommendation for SOMs to ensure all are completed.
- The trust had specialist midwives for antenatal screening, infant feeding and addictive behaviour based at University Hospital of North Tees. Other areas such as female genital mutilation, diabetes and twin pregnancies were supported by midwives with an interest in this area.

Multidisciplinary working

- Staff reported good communication and information sharing between departments. Cross site working had improved communication and teamwork.
- Staff from the pregnancy advisory service and early pregnancy unit worked closely with the service at North Tees, providing cover for annual leave and absences.
- There were close links with community staff with regards to safeguarding concerns.
- There were clinics available for women who were pregnant and may require additional help or support, for example mental health and physiotherapy.

Seven-day services

- Seven day services were not provided by the antenatal clinic, pregnancy advisory centre or the early pregnancy advisory clinic. These areas were identified as an area of focus in the trusts business plan for 2015/2016, however did not specifically refer to Hartlepool.
- The birthing unit opened as and when required, with systems in place to ensure staff were available. Medical support and advice was available via telephone and staff said there were no issues accessing this.

Access to information

- Information leaflets were available on a variety of subjects such as contraception, perineal tears and post-natal care.

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- Women who were pregnant carried their antenatal record with them in a file and information relating to discharge was sent to the patient's GP electronically.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- All staff completed training in the Mental Capacity Act and Deprivation of Liberty Safeguards as part of their mandatory training.
- Termination of pregnancy (TOP) must be performed within the legal requirements of the 1967 Abortion Act including the completion of the relevant certificates and consent forms. Women who were referred to the pregnancy advisory clinic for a TOP brought the necessary consent form with them. This form required the signatures of two professionals. We were told that nurses would not proceed with termination if there was no second signatory. We were told most women opted for expectant management, as the second part of medical management requires them to transfer to University Hospital North Tees.
- An audit of 50 forms completed by the trust in July 2015 found that the necessary signatures were present in all cases, however there were omissions in fully completing the forms. This included the names and qualifications of the persons completing the form. The trust sent a letter to GPs who used the service to remind them to fully complete the forms.

Are maternity and gynaecology services caring?

As there were no women in the unit at the time of our visit we were unable to rate caring. However, the staff we spoke with were clearly passionate about providing a good service and were patient focused.

Compassionate care

- There were no women in the unit when we visited so there was no observation of care. However, the staff we spoke with were clearly patient focused and talked about compassionate care.
- The recent Staff and Patient Experience Survey and Quality Standards had given the birthing unit 100% with regards to impression, experience and involvement.
- There was no Family and Friends test data available for the birthing unit due to the low number of admissions.

- From April 2013 to August 2014 there were four comments about the birthing unit on NHS choices; they all gave a five star rating (five being best).

Understanding and involvement of patients and those close to them

- The areas we visited had information boards and leaflets providing mums with information to enable them to make choices about their pregnancy, for example the customer care charter 'what do we think our customers want?'
- Women were involved in decisions about their preferred place of delivery and options during labour. Care plans were developed with their community midwives.

Emotional support

- There was a midwife who had a specialist interest in bereavement and there were policies and guidelines in place to support mothers and their family in the event of a stillbirth or neonatal death. There was also access to two British Association for Counselling and Psychotherapy (BACP) accredited counsellors, who had a focus on pregnancy loss, termination and bereavement.
- Midwives and the chaplaincy service could also provide support in these situations.

Are maternity and gynaecology services responsive?

Good



We rated responsive as good.

Services were available to women and were focused to meet their individual needs. Interpreters and translation services could be accessed if needed. Staff used daily rounding as a tool to identify any concerns at an early stage. There has only been one formal complaint and there was a policy in place for dealing with complaints. Although the birthing unit had low numbers of babies being delivered it could be accessed when required and staffing arrangements supported this.

Service planning and delivery to meet the needs of local people

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- Women had the option to deliver at home, in the midwifery led unit at Hartlepool or at University Hospital of North Tees.
- The business plan for 2015/2016 outlined the need to increase the use of the midwifery led unit at Hartlepool using a revised model of care.
- Maternity services worked with local commissioners of services, the local authority, other providers, GP and patient groups to co-ordinate care pathways. The Maternity Services Liaison Committee (MSLC) had an active role in delivering maternity services.
- In 2014 the pregnancy advisory service and early pregnancy assessment clinic were moved to the women's and children's directorate. This was seen as a positive change to support the development of care pathways.

Access and flow

- Staff told us there were times that the birthing unit could not be opened due to staff not being released from other areas. We found evidence of this occurring once between January and June 2015; this was identified in a complaint and in information provided by the trust.
- If women contacted their community midwife or the birthing unit to say she was in labour, there were communication systems in place to contact the staff allocated to the birthing unit so they could attend.
- The number of water births was not captured on the maternity dashboard data as individual data; water births were included in the figures for the number of normal deliveries.
- Staff in the antenatal day assessment unit told us they delivered 210 – 250 episodes of care per month. The unit offered a five day service. The schedule for antenatal appointments was in line with NICE Clinical Guideline 62.
- The early pregnancy assessment clinic had planned appointments with provision of six ultrasound scan slots per day and provided a five day service. We were not provided with information regarding what happened if additional scans were required. Appointments and referrals were made by community midwives, GP's or the emergency department. The unit did not take self-referrals. If women undergoing termination of pregnancy did not pass products of conception before

the unit closed they would be transferred to University Hospital North Tees. Data was not collected regarding the number of occasions this occurred. Foetal remains were tracked to the mortuary and collected weekly.

Meeting people's individual needs

- Women carried their own paper records with them and had contact numbers for their midwives, this included outside of normal working hours. Parent education classes were available in the community setting and information relating to labour and birth was provided at antenatal appointments.
- Staff told us how they would support individuals by using the expertise of midwives with specialist training or interests, for example substance misuse.
- Women who attended for termination of pregnancy were cared for in dedicated areas by nurses with specialist training.
- Staff could access interpreter services if required for women whose first language was not English.
- The environment was welcoming and there was a range of birthing equipment available to support low risk normal birth.

Learning from complaints and concerns

- There was a complaints policy and procedure of which staff were aware. They could describe the process and how to access the patient experience team. Daily rounding was used at the maternity unit. This was a process where staff asked women about aspects of their care. Staff said this was one way of identifying any concerns.

Are maternity and gynaecology services well-led?

Requires improvement



We rated well-led as requires improvement.

Staff we spoke with were uncertain about the future for the birthing unit. They said it was underutilised and they did not seem sure of how this was being addressed. This suggested a lack of communication with the senior management team, as we were told the birthing unit was supported by the commissioners. The risk register did not clearly identify risks specific to University Hospital of

Maternity and gynaecology

Hartlepool and the lack of a rating system and targets on the maternity dashboard was a concern as it provided no evidence of benchmarking. There was a lack of evidence of engagement with the Local Supervising Authority (LSA) and actions remained outstanding from the 2014 LSA annual audit action plan. 27% of midwives had not received their annual review and clinical guidelines were out of date at the time of the comprehensive inspection. Most staff we spoke with had a clear vision of providing midwife led holistic care for women who used the services.

Vision and strategy for this service

- Discussions with the management team informed us that the birthing unit was supported by commissioners. However, staff we spoke with were uncertain about the future for the birthing unit. They said it was underutilised and they did not seem sure of how this was being addressed.
- Staff who worked in the unit had a clear vision of providing midwife led holistic care for women who used the services. The trusts draft ten year strategy gave no clear indication as to the future plans for this service.

Governance, risk management and quality measurement

- We reviewed the maternity service dashboard; it did not have a rating system to indicate if there were any areas of concern. It did not separate data between University Hospital Hartlepool and University Hospital North Tees. There were no trust targets to indicate if figures provided were within agreed acceptable limits.
- The risk register for obstetrics identified 45 risks, but many of these were generic and several had not been addressed for over 12 months. Risk management meeting minutes from January 2015 identified 52 outstanding actions. Risks specific to University Hospital Hartlepool could not be clearly distinguished on the risk register. On our return inspection we were told of plans to review the risk register, but no specific details of this were provided.
- Patient safety meetings took place twice weekly and risk management meetings occurred monthly at University Hospital of North Tees. SOMs were present at these meetings and there was representation from University Hospital of Hartlepool maternity staff. We reviewed several meeting minutes; evidence of learning from incidents was variable, as some minutes were very brief

and had minimal records of learning. Other minutes were more detailed and included recommended actions / learning. There were no target dates noted for the recommended actions.

- There was a lack of evidence of engagement with the Local Supervising Authority (LSA) and actions remained outstanding from the 2014 LSA annual audit action plan. 27% of midwives had not received their annual review and clinical guidelines were out of date at the time of the comprehensive inspection.
- The risk management strategy had recently been updated. The Local Supervising Authority (LSA) stated that the risk management strategy should “clearly identify the role of the LSA and of Supervisor of Midwives being integral to trust governance. Additionally the Risk Management Strategy must describe the reporting arrangements for Supervisors of Midwives following investigations, audits or reviews”. These requirements were not evident from reviewing the strategy. There were no specific details on the role of SOM’s in relation to risk management.

Leadership of service

- The structure of the service was led by a clinical director, head of midwifery and children’s services, a general manager and a divisional finance manager based at University Hospital of North Tees. There were no band eight senior midwives to support the head of midwifery and the next level of management included band seven clinical leads and the patient safety lead. Staff said that senior management was not as visible at Hartlepool as at North Tees, and some staff felt disconnected and not involved in decisions about the service.
- The structure meant that the head of midwifery was responsible for a wide range of services. Discussions with staff suggested this limited maternity leadership as local leaders could feel isolated and relied on peer support with little involvement from more senior management.
- The areas we visited showed good local leadership evidenced through staff awareness of risk and incidents. The staff we spoke with felt well supported by their line manager and peers.

Culture within the service

- Discussions with the management team demonstrated a committed, patient focused team. Staff we spoke with were enthusiastic and passionate about the services

Maternity and gynaecology

they provided. They demonstrated strong commitment to developing the birthing unit and spoke about the challenges in engaging all midwives in the holistic approach that the birth team were endeavouring to establish.

- Staff often rotated to the maternity services at University Hospital of North Tees and felt this was a good way of keeping up to date and building cross site working relationships.

Staff and Public engagement

- The trust had a Maternity Services Liaison Committee which had good representation at board level and was

committed to bringing together service users and providers. The LSA report 2014 did not have assurance of good attendance of supervisors of midwives at these meetings. We were told various topics were covered at the meetings including maternity performance, staffing and engagement.

- There was no directorate specific information in the 2014 NHS staff survey results for staff engagement. The national survey showed on a scale of 1-5, with 5 being highly engaged and 1 being poorly engaged, the trust scored 3.63. This score placed the trust in the lowest (worst) 20% when compared with similar trusts.

Services for children and young people

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

Information about the service

The women and children's services directorate at the North Tees and Hartlepool NHS Foundation Trust was responsible for providing neonatal and paediatric services for children and young people. The Hartlepool satellite site provided a nurse-led paediatric day unit, day-case facilities and a children's outpatient department. Staff worked at both hospital sites and there was a hospital shuttle available for staff to travel between the Stockton and Hartlepool hospital sites.

The paediatric day unit had six beds in one bay and two individual cubicles/side rooms. The children's outpatient department was immediately adjacent to the paediatric day unit and patients and staff had to walk through the outpatient waiting area to access the paediatric day unit.

The paediatric day unit was open for day case surgery (for children aged 2 to 16) on Thursdays and Fridays from 8am – 4pm. Orthopaedic surgery was carried out on Thursdays and urology and general surgery on Fridays. The day case surgery service for children's and young people only carried out low risk procedures. Children's and young people's services provided at the Hartlepool site did not deal with any trauma cases.

There were 82 children's admissions at the Hartlepool site between July 2013 and June 2014. Of these 90% were day cases, 9% were emergencies and 1% were elective. There were 3856 outpatient attendances at the Hartlepool site between April 2014 and March 2015.

We inspected this service on a Friday morning and visited all of the clinical areas where children and young people

were admitted or which they attended on an outpatient basis. This comprised of the eight-bedded paediatric day unit, the children's outpatient department and the theatres. We spoke with seven staff, two of which were community staff involved in diabetes outpatient clinics, and two relatives. The three children for elective day surgery on the day of the visit were two years old, so we were unable to obtain any verbal feedback from children and young people about their experiences of using the service.

We reviewed three sets of medical/nursing records and four appraisal documents on site, in addition to management and quality documents related to the service. Children's and young people's services at the Hartlepool site and the Stockton site used the same documentation and were managed by the same management team.

Services for children and young people

Summary of findings

Overall, we rated well led as required improvement and safe, effective, caring and responsive as good. The overall rating for the service was good.

We found all clinical areas were visibly clean, child-friendly and well maintained. Medicines and patient records were handled safely and there were sufficient numbers of suitably qualified staff to meet the needs of the children and young people using the service. Staff received appropriate training, which included training in safeguarding and manual handling. Processes and documentation relating to pain relief for children and young people required improvement; evidence showed systems and processes for pain management within the service were not well embedded.

Staff were competent to carry out their roles and received appropriate professional development, including an annual appraisal. However, the documentation and format of the appraisal process for non-medical staff required further development. There was good evidence of multidisciplinary working within and between teams and children and families using the service were provided with appropriate information. Consent procedures were in place and followed.

Relatives we spoke with told us they were very happy with the care received. They said the staff were supportive and communication and involvement was good. The children's service was responsive to the individual needs of the children and young people who used it and there were effective systems and processes in place for dealing with complaints from people using the service.

Are services for children and young people safe?

Good



Services for children and young people at the Hartlepool site were safe.

Staff knew how to report incidents and these were followed up appropriately. Clinical areas were visibly clean and there were effective systems and processes in place to reduce the risk and spread of infection. The environment was child-friendly and well maintained. Equipment, including resuscitation equipment, used by the service was fit for purpose. Medicines were handled safely and administered correctly and medical records were stored securely and handled appropriately.

There were sufficient numbers of suitably qualified staff to meet the needs of the children and young people using the service. Staff working for the service rotated between the two hospital sites. Staff confirmed they received appropriate mandatory training to enable them to carry out their roles effectively and safely, training included awareness of safeguarding procedures.

Incidents

- Incidents within the service were reported using the trust's electronic system (Datix); staff we spoke with were familiar with the process for reporting incidents.
- Incidents that occurred in children's and young people's services were reported and collated jointly for the Stockton and Hartlepool hospital sites. The bimonthly risk management meeting included feedback about incidents; medical staff and senior nursing staff attended these meetings. When we reviewed minutes of these meetings, we saw they included the review of incidents and discussions around practice, lessons learnt and action plans to improve clinical practice.
- We reviewed the incident records for the four-month period December 2014 to March 2015 and saw there had been four incidents reported at the Hartlepool site. Two involved 'verbal abuse or disruption,' from relatives one was a fall, and one was a safeguarding issue.
- There had been no never events or serious incidents recorded in children and young people's services at the Hartlepool site.

Services for children and young people

Cleanliness, infection control and hygiene

- There were effective systems in place to reduce the risk and spread of infection. There had been no cases of MRSA or C.difficile in the children's service at the Hartlepool site.
- All of the areas we visited were visibly clean, including communal areas, toilets and bathrooms. We saw appropriate infection control notices were in place in bathrooms and toilets.
- We saw personal protective equipment (PPE) was readily available for staff to use and we observed staff using the PPE appropriately. However, the sharps bin in treatment room was full and a refuse bin was full in a second treatment room. Staff addressed both these issues immediately when they were pointed out to them.
- When we followed a patient to theatre, we observed everyone in the anaesthetic room wore appropriate PPE, including gowns and overshoes.

Environment and equipment

- During our visit to the Hartlepool site we visited all of the clinical areas where children and young people were admitted or which they attended on an outpatient basis, including the eight-bedded paediatric day unit, the children's outpatient department and the theatres.
- We observed the environment was roomy, well-lit and well maintained. There was a staff room and a playroom on the paediatric day unit.
- Resuscitation equipment was all in date and secure, including oxygen cylinders. There was a children's resuscitation trolley, which was stored in the treatment room, on the paediatric day unit immediately adjacent to nurses station and ward area. Records reviewed confirmed nursing staff had checked this daily.
- There was also an adult resuscitation trolley in one of the offices in the outpatient's area; this was for use in the children's outpatients areas. This trolley was secure and we found the equipment was all in date. Staff told us the office where the adult resuscitation trolley was located was open during the day, so the trolley was easily accessible at all times when the clinic was open.

Medicines

- Appropriate arrangements were in place in relation to obtaining, recording, storing and handling of medicines. Medicines were prescribed and given to children and

young people appropriately. Procedures were observed to be safe and medication documentation was good. For example, the drug charts we reviewed were populated correctly.

- Medications were stored appropriately; we saw the fridge for storing medication was located in the treatment room on the paediatric day unit and was locked. Staff told us the key for this fridge was left with security staff when the unit was unoccupied.
- The temperatures of the medication fridge were recorded daily, apart from at weekends when the unit was closed. Medications stored in this fridge were all checked and found to be in date.

Records

- Children's and young people's medical records were accurate, fit for purpose and stored securely. We did not see any unattended notes during our inspection and the notes trolley was secure.
- Documents in the three care records we reviewed, such as observation charts, were all correctly completed. Care records also contained appropriate risk assessments.
- However, we observed one consent form, which had been scanned. The handwriting was very faint and not legible. When we asked staff about this, they said the original document was usually present. They said clerical staff scanned the notes too early, and that this had been raised as an issue several times previously.
- The WHO surgical safety checklist was used for all patients undergoing surgery; records reviewed showed these had been completed correctly.

Safeguarding

- All staff had been trained in child protection level 3. Staff knew how to escalate concerns and told us they would always do so. Staff told us safeguarding training included case studies and scenarios.
- We saw information on display about safeguarding children in the PDU.

Mandatory training

- Staff we spoke with all told us their mandatory training was up to date; senior nursing staff we spoke with and records we reviewed confirmed this. Matrons received a RAG (red-amber-green) report of their staff's mandatory training from the trust once a month.

Services for children and young people

- Staff we spoke with told us their mandatory training consisted of a full study day including information governance, fire, child protection, infant feeding, basic life support and safeguarding. They said moving and handling was a half-day's training and was carried out separately.

Assessing and responding to patient risk

- In the three patient care records we reviewed, we saw completed paediatric early warning score (PEWS) documents.
- We observed three correctly completed WHO checklists in these patient's care records. The surgery inspection team found that 'Five Steps to Safer Surgery, World Health Organisation (WHO)' audits across all specialities in the trust showed variable compliance results.

Nursing staffing

- There were enough qualified, skilled and experienced staff to meet the needs of the children and young people using the service. The recommended minimum staffing levels for children's wards were being met, as advised by the Royal College of Nursing (RCN) staffing guidance – Defining staffing levels for children and young people's services (2013).
- On the paediatric day unit, the planned staff for the day of inspection was one nurse practitioner, one staff nurse, one health care assistant (HCA) and one play specialist; there was also a ward clerk in the afternoon. We confirmed that this was the actual number of staff on duty during our visit. We also reviewed staff rotas for the previous two weeks; these showed the Hartlepool site had been staffed as planned during that time.
- A nurse practitioner was available on site in the paediatric day unit for telephone referrals and advice from 10am-1pm on Mondays and Tuesday and 9am-1pm on Wednesdays.
- In the children's outpatient department on the morning of our inspection, one staff nurse was on duty; they told us they were on a phased return and did not usually work at that service/site. They told us the department was staffed by one registered nurse (RN) and one HCA.

Medical staffing

- The paediatric day unit was nurse-led. Staff told us a consultant surgeon and consultant anaesthetist were involved in the care pathways of children and young people undergoing surgical procedures at the Hartlepool site.
- When paediatric clinics were running at the site, paediatric consultants were available on site.

Are services for children and young people effective?

Good



Services for children and young people at the Hartlepool site were effective.

Staff, teams and services at the Hartlepool satellite site worked together well to deliver effective care and treatment for the children and young people using the service. The children's service participated in national audits relating to patient outcomes and no problems were identified. Staff, teams and services worked together well to deliver effective care and treatment for children and young people using the service. Staff were competent to carry out their roles and received appropriate professional development, including an annual appraisal. There was good evidence of multidisciplinary working within and between teams and children and families using the service were provided with appropriate information. Consent procedures were in place and followed.

However, we found the processes and documentation for ensuring children and young people were provided with appropriate pain relief required improvement. The two relatives spoken with did not identify any issues with pain relief on the day of the inspection. Staff's descriptions of pain management in the service showed that these systems and processes were not well embedded.

Evidence-based care and treatment

- The service was providing evidence-based care and treatment. Staff on the paediatric day unit knew that the unit used evidence-based practices, such as the paediatric early warning scoring system, the screening tool for the assessment of malnutrition in paediatrics and a standard operating procedure for surgical cases.

Services for children and young people

- Children's and young people's service at the Hartlepool site used the same documentation, policies and procedures as the Stockton site.
- We saw that pre-theatre checks had been completed correctly, according to the local standard operating procedures.
- Staff told us they audited ten sets of notes every two months; mattress audits and environmental audits were also carried out.
- There were no ward level medication audits; we found audits of medication focussed on prescribing procedures and practices.

Pain relief

- Staff on the paediatric day unit told us pain management was, "mainly done in theatres." They said a patient's pain management depended on the anaesthetist. Nursing staff on the ward told us they worked closely with the theatre staff and anaesthetists. They said the anaesthetist gave pain relief while the patient was in the theatre's recovery area. Staff told us they carried out pain assessments on patients, in co-operation with their parents (if appropriate).
- When we asked staff how they assessed pain, one told us they used, "Visual and behavioural cues" to assess pain in their post-operative patients. We found one of the three sets of care records we reviewed did not have any pain scores or PEWS recorded.
- We also found the surgical notes in one patient's care record did not have a record of pain relief administered by the anaesthetist. The family confirmed that the anaesthetist had discussed pain relief with them, however this was not documented.
- Children and young people undergoing surgery in the paediatric day unit were given a discharge prescription of medication to use at home.

Nutrition and hydration

- The paediatric day unit had snacks and drinks available within the unit, these included cereals and toast. Staff told us there were always 'snack boxes' available within the paediatric day unit for children and young people.

Patient outcomes

- We spoke with two staff involved in delivery of diabetes services for children and young people, which included clinics in children's outpatient department at Hartlepool. They told us, "The HbA1c levels for the

children and young people cared for by this service are good." The latest available paediatric diabetes audit from 2012/2013 showed results similar to the England and Wales average. For example, the median HbA1c (average blood sugar) at the University Hospital North Tees and University Hospital Hartlepool was 66 mmol/l; slightly lower (better) than the England average of 69 mmol/l.

- Information about emergency readmission rates were reported for together for the two hospital sites at the North Tees and Hartlepool NHS Foundation Trust. We did not see any readmission information that was specific for the Hartlepool site.

Competent staff

- Staff were competent to carry out their roles and received appropriate professional development, including an annual appraisal.
- Staff told us the service supported their development of skills and knowledge and they received the training they needed to carry out their role safely and competently. Staff told us cannulas were inserted in the anaesthetic room, if these were required.
- Staff feedback about opportunities to develop was positive. For example, staff told us the trust provided a leadership course, which was available to all levels of staff.
- We spoke with a research nurse for paediatric research programmes; they told us they were trained in good clinical practice (GCP). GCP is an international quality standard that defines standards for clinical trials involving human subjects.
- Staff told us that, since nurse led clinics had started at the site, GPs had learnt which patients to refer. Staff told us they had liaised with GPs and shown them the evidence base for the care of certain conditions.
- Staff we spoke with all told us they received an annual appraisal and appraisals were all up to date. We reviewed the individual performance development plans for four staff while we were on site. The managers did not keep records of appraisals they had carried out. This meant managers did not have a record of the objectives set, action plan or time scales.

Multidisciplinary working

Services for children and young people

- Staff, teams and services worked together well to deliver effective care and treatment for children and young people using the service. Staff told us they had regular contact with GPs, midwives, health visitors and community nurses.
- The two staff we spoke with from the diabetes service told us there were multidisciplinary team meetings every other week. They said the diabetes service was part of a regional network and they attended regional meetings along with other nurses. They said the diabetes service liaised with local schools and gave structured education. However, they said liaison between the diabetes service and child and adolescent mental health services (CAMHS) and social care was not always easy.
- In diabetes services, the trust held four adolescent clinics for young people aged 16 to 19 and young people were introduced to their adult diabetes nurse. At the time of the inspection, there was a vacant post for a diabetologist to care for adolescent patients.
- They said the paediatric service provided for children and young people at the Hartlepool site had “great joint working.”

Seven-day services

- Staff confirmed that children’s and young people’s services were not available at the weekends at the Hartlepool site. They told us other services on the site, such as pathology and pharmacy, were responsive and available when the service required them.

Access to information

- Staff we spoke with did not identify any issues with accessing clinical information relating to the patients using services at the Hartlepool site.

Consent

- The two parents we spoke with told us they were happy with the consent procedures. They told us consent had been fully explained to them. Staff told us children and young people were encouraged to be involved in decisions about their care and treatment.
- We saw the service had a policy for consent to examination or treatment. We reviewed this policy and saw it described obtaining consent from children and young adults deemed Gillick competent, and assessing

their understanding of the process to which they were giving consent. The policy also stated it was good practice to establish whether the parents agreed. Individual consent was age appropriate.

- The research nurse we spoke with told us all patients were consulted and consent obtained before they were included in clinical trials.

Are services for children and young people caring?

Good



Services for children and young people at the Hartlepool site were caring.

We spoke with two parents on the paediatric day unit during the morning of our visit. They both told us their experience of the service had been positive, especially the support, communication and involvement. Feedback from children and young people at the Hartlepool site in a 2014-2015 questionnaire was generally positive and the service had ‘You’re Welcome’ accreditation from the Department of Health. This showed the children’s service was meeting the needs of children and young people who used it.

Compassionate care

- We spoke with two parents on the paediatric day unit during the morning of our visit who both gave us positive feedback about the service. They told us staff on the unit were, “supportive.” One told us, “The support here is excellent,” they also said, “This is the best hospital for clear communication.”
- When we asked two parents on the surgical day unit how they would rate the service they had received, one said “9 out of 10” and the other “10 out of 10.”
- Staff on the paediatric day unit told us they handed out comment cards to patients and relatives on discharge. We also saw 14 thank you cards on display.
- We reviewed a ‘Young People’s Questionnaire 2014/15,’ which had been produced in June 2015. This report had responses from 11 patients from patients at the Hartlepool site. Comments included:
 - We found the staff extremely helpful, polite and caring.
 - Thanks for your support and kindness through my treatment.

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- They were helpful fitting me for a blood test without an appointment.
- We waited 4.5 hours until going to theatre. A staggered admission would be better. I was the oldest and everyone knew I would be last; it was a long wait and I was nervous.

Understanding and involvement of patients and those close to them

- Parents we spoke with told us they had been kept fully informed of their choices in clear language. We saw evidence of involvement in care planning in the care records we reviewed.
- We saw the service had 'You're Welcome' accreditation from the Department of Health. This showed the children's service was meeting the needs of children and young people who used it.

Emotional support

- Play specialists supported children and young people when they were taken to theatre. We observed the play specialist on duty on the day of the inspection provided appropriate distraction for a two-year-old patient, when we followed them and their parent to theatre.
- During our inspection visit, no specific evidence was identified which related to emotional support for children and young people using services at this site.

Are services for children and young people responsive?

Good



Services for children and young people at the Hartlepool site were responsive.

Access and flow were well established within the children's service at Hartlepool; there were no issues with delayed discharges from the service. The children's service was responsive to the individual needs of the children and young people who used it and there were effective systems and processes in place for dealing with complaints from people using the service.

Service planning and delivery to meet the needs of local people

- We found that the children's service had good links within the trust, and with commissioners, the local authority and other providers. These helped ensure services were planned and delivered to meet the needs of the local population.

Access and flow

- Children's services at the Hartlepool site only dealt with low-risk cases and did not deal with any trauma cases. GPs or midwives referred children and young people to the paediatric day unit at the Hartlepool site.
- Data submitted by the trust prior to the inspection showed here were 82 children's admissions to the paediatric day unit in the 12 months from July 2013 to June 2014. Of these 90% were day cases, 9% were emergencies and 1% were elective. There had been 3856 outpatient attendances in the 12 months between April 2014 and March 2015.
- The paediatric day unit was open for day case surgery (for children aged 2 to 16) on Thursdays and Fridays from 8am – 4pm. Orthopaedic surgery was carried out on Thursdays and urology and general surgery on Fridays. On the morning of our visit to the site, there were three children on the list, all two years old. Staff told us there should have been five children for surgery that morning, they explained one patient had cancelled and one had failed to attend.
- Staff told us there were no inpatient admissions to the paediatric day unit on Mondays, Tuesdays and Wednesdays. However, a nurse practitioner was available on site for telephone referrals and advice from 10am-1pm on Monday and Tuesday and 9am – 1pm on Wednesdays; there was also an allergy clinic on Wednesdays. The nurse practitioner told us they triaged telephone referrals in order to decide where the child or young person referred should be cared for.
- Staff told us patients could attend the paediatric day unit when it was open to have blood samples taken and the nurse practitioner working on the paediatric day unit explained how they reviewed low-risk cases referred to the unit. The paediatric day unit also looked after children and young people who needed a review, planned surgery, investigations or other procedures.
- Staff told us they felt the surgical day unit at the Stockton site had the capacity to carry out the elective day surgery cases currently performed at the Hartlepool site. Staff explained that children's day case surgery was

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carried out at the Hartlepool site because there was less pressure on theatre availability there, compared with the Stockton site. Staff told us there were, “No problems with delayed discharges here.”

Meeting people’s individual needs

- The children’s service at the Hartlepool site was responsive to the individual needs of children, young people and their families.
- Staff told us play specialists accompanied children to theatre before and after their surgery and provided appropriate distraction therapy. We followed a child to theatre during our visit and observed this to be the case.
- Staff on the paediatric day unit ran a phlebotomy service for children and young people. This meant children and young people did not have to attend the adult phlebotomy clinic to have their blood samples taken.
- Parents we spoke with told us all the information they required had been provided to them. Staff told us the Hartlepool site used all of the same information leaflets as the Stockton site. We saw these were stored in a file on the paediatric day unit nurse’s station.
- Staff told us that if a mattress audit identified a new mattress was required on the paediatric day unit then they could get one within an hour.
- The children’s outpatient department offered a range of clinics for children and young people from birth to 18 years old; these included diabetes and epilepsy. Staff told us there were visiting consultants from other NHS trusts who provided specialist clinics for conditions such as cystic fibrosis, muscular dystrophy and neurology.
- We spoke with two staff involved in the delivery of diabetes services for children and young people, which included clinics in the children’s outpatient department at Hartlepool. They told us the service was running a ‘camp’ for young patients aged 16 to 25; they said this would encourage networking between patients and there would be fun activities in addition to educational sessions about their condition.
- We observed paediatric day unit staff pushing patients returning from theatre on trolleys past children, young people and families in the children’s outpatient department waiting area. We judged this practice might cause distress to people in the waiting area and/or the patients returning from theatre.

Learning from complaints and concerns

- The service had a complaints policy and the feedback following complaints was timely. For example, 100% of complaints received met the initial trust timescale of a response within seven days.
- There had been five complaints recorded over the previous 12 months at the Hartlepool site, two in the outpatients departments and three in the day unit. We saw verbal complaints were recorded and acted upon. This showed there were effective systems and processes in place for dealing with complaints from people using the service.

Are services for children and young people well-led?

Requires improvement



We rated the well-led domain as requires improvement.

Systems and processes for risk management within the service were not effective and timely. Risks on the risk register for children and young people’s services were not identified by hospital site and it was therefore difficult to assess which were relevant to the Hartlepool location. The paediatric service across Stockton and Hartlepool sites had a joint incident log and risk register and we saw a number of high-level risks had been on the risk register for up to nine years. We found this risk register did not evidence that it was regularly reviewed and that risks were actively managed. The need to improve risk register management was known by the trust board and a plan was in place but not yet fully implemented.

The management team were committed to the vision and strategy for the children’s service and feedback from staff about the culture within the service, teamwork, staff support and morale was positive. There were systems and processes in place to regularly assess and monitor the quality of service that children and young people received. Evidence that demonstrated the service acted on feedback to improve children and young people’s experience of using the service.

Vision and strategy for this service

- The management team told us children’s service on the two hospital sites, Stockton and Hartlepool, had merged in 2008. They said the services were working together well, but it had taken some time to bring the two

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cultures together. The head of midwifery and children's services told us they had adopted a 'best of both' approach during the transition from two services, which had worked effectively.

- Staff working in paediatrics were formally 'in consultation' at the time of the inspection about changes to working practices, shift patterns and opening hours at the Stockton site. The children's outpatient department matron told us the service was planning a similar consultation and those working in children's outpatient clinics at the Hartlepool site would be included.

Governance, risk management and quality measurement

- An effective framework was in place for governance and quality monitoring. There was a patient safety team for women and children's services and meetings were held in a regular basis. For example, patient safety and risk management meetings, morbidity and mortality meetings and ward meetings.
- Staff we spoke with felt governance within the service was good. Staff we spoke with were knowledgeable about patient safety, complaints and incidents.
- However, we found systems and processes related to risk management in the service were not robust. The need to improve risk register management was known by the trust board and a plan was in place but not yet fully implemented. The paediatric service across Stockton and Hartlepool sites had a joint incident log and risk register and we saw a number of high-level risks had been on the risk register for up to nine years. We found this risk register did not evidence that it was regularly reviewed and that risks were actively managed.

Leadership of service

- Staff we spoke with gave positive feedback about the management team. They said they were confident in the managers of the unit. Staff told us the managers were, "supportive," and "approachable." However, some staff said they felt the trust board were not visible and staff on the 'shop floor' would not recognise them.

Culture within the service

- Staff told us the Hartlepool hospital site provided a good environment to work in and the team and managers in children's and young people's services were supportive. One said, "There is a friendly atmosphere here amongst all the departments."
- Staff told us they would recommend the trust as a good place to work; they also told us they would recommend the trust as a good place for children and young people to be treated.
- One of the staff from the diabetes team told us, "The paediatric team is the best team I have ever worked with; there is great joint working."

Public engagement

- Local and national feedback surveys had been carried out by the service; however, the majority of these surveys reported results for both hospital sites together.
- In the paediatric day unit, we saw information on display that showed children's and young people's service at the Hartlepool site had scored 100% in the trust's, 'Staff patient experience and quality standards' on the 20 May 2015.

Staff engagement

- Senior nursing staff in the paediatric day unit told us no staff meetings were held at the Hartlepool site; staff meetings were only held at the Stockton site. All of the staff working in the paediatric outpatients department worked at both hospital sites whereas the paediatric day unit staff tended to be more site-based.
- Staff told us they could use the hospital shuttle to travel between the Stockton and Hartlepool sites.

Innovation, improvement and sustainability

- The paediatric and neonatal departments in the trust participated in a number of national and local research studies and were involved in a large number of clinical trials.
- Medical staff at the Stockton site told us research within the service helped improve clinical practice and patient health outcomes. Medical and nursing staff at all levels were involved in research within children's services.
- The management team told us the trust was supportive of the research carried out within the service; research was discussed and encouraged and was on the trust's agenda.

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

Information about the service

The University Hospital of Hartlepool outpatients department and diagnostic imaging department are situated on the main hospital site in Hartlepool. There was a shuttle bus to provide patient transport between the hospitals at Stockton and Hartlepool. The elective care directorate manages the outpatient department as a support function and there are specific specialties that manage their own outpatient department. Clinics were held in the following medical specialties: respiratory, diabetes, rheumatology, gastrointestinal, haematology, cardiology, chemical pathology and nephrology. Surgical clinics included orthopaedics, urology, colorectal, upper gastrointestinal, thyroid, vascular, bariatric and pain services. Visiting consultants from neighbouring trusts provided clinics for oncology, ophthalmology, ENT, dermatology and oral surgery. There was a separate women's outpatients department for gynaecology clinics. Breast clinics were held in the main outpatients department. Clinics were led by nurses, allied health professionals and doctors.

The diagnostic imaging department offered a range of diagnostic imaging and interventional procedures, as well as substantial plain film reporting and an ultrasound service. A clinical lead radiologist managed the diagnostic imaging services and was also the head of service and based at University Hospital of North Tees. A mobile breast screening service was provided on weekdays and one Saturday per month. A medical physics service was hosted but staffed and managed by another local trust.

There were 92,780 outpatient attendances April 2014 to March 2015 at University Hospital of Hartlepool. There was a total of 48,994 attendances for diagnostic imaging procedures April 2014 to March 2015. The DNA rate (percentage of patients who did not attend an outpatient appointment at Hartlepool was 8% which is slightly higher (worse) than average when compared to other Trusts in England.

During the inspection we spoke with seven patients and one relative, five nurses, and three doctors. We observed the diagnostic imaging and outpatient environments, checked equipment and looked at patient information.

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Summary of findings

Overall we rated the care and treatment received by patients in the University Hospital of Hartlepool outpatient and diagnostic imaging departments as good for safe, caring and responsive. We rated well-led as requires improvement.

Patients were very 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 for their conditions. Patients were protected from the risk of harm because there were policies in place to make sure that any additional support needs were met. Staff were aware of these policies and how to follow them. However no nursing and midwifery registered staff or additional clinical services staff in women's outpatients at University Hospital of Hartlepool had attended Level 2 or Level 3 safeguarding children training.

However there were some areas that needed improvement in the outpatients department, such as the systems in place for utilising clinic rooms effectively and communicating a clear departmental strategy for the future. The diagnostic imaging departments were well led, proactive and staff worked as a team across all sites towards continuous improvement for good patient care. The departments learned from complaints and incidents and put systems in place to avoid recurrences.

Are outpatient and diagnostic imaging services safe?

Good



The level of care and treatment delivered by the outpatient and diagnostic imaging services was good. Staffing levels were based on the knowledge and expertise of department managers and were flexible to meet the different demands of clinics and patients. There were sufficient staff to make sure that care was delivered to meet patient needs.

Incidents were reported using the hospital's electronic reporting system. Incidents were investigated and lessons learned were shared with all of the staff. The cleanliness and hygiene in the departments was within acceptable standards. Personal protective equipment (PPE) was readily available for staff and was disposed of appropriately after use. Guidelines around the use of PPE by staff drawing blood required updating in line with WHO (World Health Organisation) best practice.

Staff were aware of the various policies designed to protect vulnerable adults or those with additional support needs. Patients were asked for their consent before care and treatment was given. Patients were protected from receiving unsafe care because diagnostic imaging equipment and staff working practices were safe and well managed. Medical records were available for outpatient clinics, with a few exceptions and electronic records were available to supplement these if necessary. Staff in all departments were aware of the actions they should take in the case of a major incident.

Incidents

- There were no reported never events reported for Hartlepool outpatient services for 2014/2015. Never Events are a particular type of serious incident that are wholly preventable.
- The departments had robust systems to report and learn from incidents and to reduce the risk of harm to patients.
- The trust used an electronic system to record incidents and near misses. Staff we spoke with had a good working knowledge of the system and said they could

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access the system and knew how to report incidents. Staff were able to give examples of incidents that had occurred and investigations that had resulted in positive changes in practice.

- There had been a total of 55 incidents, including one serious incident, reported within outpatients in the 12 month period from June 2014 to May 2015.
- The serious incident was caused by a pressure ulcer due to a poorly fitting plaster cast. Staff across the trust had discussed the possible causes and reasons for the problems, the lessons learned were distributed to relevant staff and the team produced new guidelines for the plaster technicians and published and distributed information leaflets to patients about signs to look for and a direct telephone number to call for advice or guidance. The plaster request form was amended to include the Braden assessment tool, which prompted staff to consider all variables, such as diabetes, skin integrity, neuropathies, VTE (venous thrombo-embolism) status, as well as type of plaster to be applied.
- There were two occasions when no doctors attended planned and booked clinics at University Hospital of Hartlepool and one occasion when a patient had to be offered a new appointment because the clinic letter had not been typed in time. It was noted in the incident report that clinical staff did not write in patients' notes and relied on secretaries typing letters as the only means of communicating the outcomes of previous appointments.
- There had been six radiological incidents reported under ionising radiation medical exposure IR(ME)R across all sites at the trust in the previous year. All of these were low level and included two incidents of imaging the incorrect body part, two incidents of incorrect patient demographics, one incident of previous history checks not being carried out and one incident of a previous scan not being documented so the procedure was repeated unnecessarily. Trusts are required to report any unnecessary exposure of radiation to patients. There was evidence that these had each been investigated, clear actions had been taken and appropriate action plans implemented as a result of learning. A standard operating procedure (SOP) was being developed for staff to follow and all staff who requested x-rays had been given the opportunity to shadow radiographers to understand radiology requirements as part of their training.

- Radiology discrepancy incidents were discussed by case review with radiologists and referring clinicians. Medical staff took the opportunity to learn, work as a multidisciplinary team and exercise the primary stage of duty of candour when agreeing that a patient should be informed of a reporting error.
- Staff were aware of their responsibilities in terms 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 regarding incidents and complaints.

Cleanliness, infection control and hygiene

- Nursing staff in outpatients departments undertook a daily rounding system to check cleanliness of the environment, hand hygiene and compliance with checklists and signatures.
- The infection control nurse team for the trust carried out regular hand-washing audits. Compliance varied between 88% and 100% across all departments. Results were fed back to staff at staff meetings and collated for Infection Control. The results were displayed on the department notice boards. Unannounced Infection and prevention and control audits had been carried out in the previous 12 months and reports had been drawn up with actions to be taken but we found no records to show if points had been actioned.
- Personal protective equipment (PPE) such as gloves and aprons was used appropriately and available for use throughout the departments and, once used, was disposed of safely and correctly. We observed PPE being worn when treating patients and during cleaning or decontamination procedures. All areas had stocks of hand gel and paper towels.
- We saw, and patients reported, that staff washed their hands regularly before attending to each patient. Hand gel was available for patients, visitors and the public to use and dispensers were clean and well stocked.
- Patient waiting and private changing areas were clean and tidy. Single sex and disabled toilet facilities were available and these areas were also clean.
- PLACE (patient led assessment of the care environment) audit had been completed in February 2015. Scores for main outpatients were 99% for cleanliness, 93% for privacy, dignity and wellbeing and 98% for condition, appearance and maintenance. There were a number of actions identified within the outpatients and diagnostic

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imaging departments. During our inspection we saw that these actions had been carried out but no actions had been completed on the action logs. The diagnostic imaging department, outpatient areas and clinic rooms were clean, tidy and uncluttered, and we saw staff maintaining the hygiene of the areas by cleaning equipment in between patient use, reducing the risk of cross-infection or contamination.

- We saw that treatment rooms and equipment in outpatients were cleaned regularly. Diagnostic imaging equipment was cleaned and checked regularly. Rooms used for diagnostic imaging were decontaminated and cleaned after use. Processes were in place to ensure that equipment and clinical areas were cleaned and checked regularly. The trust conducted unannounced cleaning audits to ensure that all areas had been checked and signed off clean. Decontamination audits had been carried out in all outpatients departments in 2014 and recommendations had been made to improve safety and cleanliness.

Environment and equipment

- We saw, and staff confirmed that, there was sufficient equipment to meet the needs of patients within the outpatients and diagnostic imaging departments.
- Equipment throughout the departments was calibrated, maintained and the medical engineering department managed maintenance contracts.
- Resuscitation trolleys for adults and children, and equipment including suction and oxygen lines were all checked and cleaned daily and checklists were signed and found to be up to date. Trolleys were locked and tagged and staff made regular checks of contents and their expiry dates.
- Most areas we inspected were clean, spacious and bright. Consulting, treatment and testing rooms were well stocked and equipment labelled as clean was clean.
- There was sufficient seating in reception areas and most clinical areas we saw had very few patients waiting for consultations. Seating was in good condition.
- Water fountains were provided for patients' use and there was a shop and hospital café at the University Hospital at Hartlepool where people could purchase drinks and snacks. The trust told us that patients at the hospital had complained that they were not able to get a drink in the department. The catering managers were planning to provide a drinks machine in the area with a separate seating area.

- The outpatients and orthopaedic outpatients departments had some toys for small children attending with adults or those attending fracture clinics. The children's outpatient department was located separately on the main hospital site.
- A report on the diagnostic imaging equipment across all trust diagnostic imaging departments carried out by the Radiation Protection Advisor for 2014 had identified that some pieces of equipment required replacement and a programme had been put in place to manage this. There were no other concerns about the diagnostic imaging departments across the trust.
- During our observations we saw that there was clear and appropriate signage regarding radiological hazards in the diagnostic imaging departments.
- Staff wore dosimeters and lead aprons were available for use in diagnostic imaging areas. This was to ensure that they were not exposed to high levels of radiation and dosimeter audits were used to collate and check results. Results were lower than the previous year, but not significantly different, and within the acceptable range.
- In diagnostic imaging, quality assurance (QA) checks were in place for equipment. These were mandatory checks based on the ionising regulations 1999 and the ionising radiation (medical exposure) regulations (IR(ME)R) 2000. These protected patients against unnecessary exposure to harmful radiation.
- The design of the diagnostic imaging environment kept people safe. Waiting and clinical areas were clean. There were radiation warning signs outside any areas that were used for diagnostic imaging. Illuminated diagnostic imaging treatment room no entry signs were clearly visible and in use throughout the departments at the time of our inspection.
- Specialised personal protective equipment was available for use by staff within radiation areas.

Medicines

- We checked the storage and management of medicines and found effective systems in place. No controlled drugs were stored in the outpatients departments. Small supplies of regularly prescribed medicines were stored in locked cupboards and, where appropriate, locked fridges. We saw the record charts for the fridges

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which showed that the temperature checks were carried out daily and that temperatures were maintained within the acceptable range. All medicines we checked were in date.

- There had been a medicines management audit carried out in some departments with results disseminated to staff and an action plan had been drawn up. However, we were told that no formal drugs audits or stock checks were carried out in outpatients by staff or the pharmacist and the trust told us they were planning to put these in place.
- Medicines management training figures were 100% for registered nurses across the outpatients and diagnostic imaging departments.
- PGDs (patient group directions) for drugs used in the outpatients and diagnostic imaging departments were in place and had been reviewed appropriately.

Records

- Records in the outpatient departments were a mixture of paper based and electronic. Within the diagnostic imaging departments, records were digitised and available to be viewed across the trust.
- Records contained patient-specific information relating to the patient's previous medical history, presenting condition, demographic information and medical, nursing and allied healthcare professional interventions.
- Records management and preparation for clinics in outpatients was complicated due to the use of several different processes. Some records contained only information relevant to the actual appointment with electronic information available via a computer terminal in each consulting room and some were totally paper based. Notes for patients who did not attend (DNA) were returned to medical records promptly.
- The trust reported that at the University Hospital of Hartlepool 99.4% of patients were seen in outpatients with their full medical record being available.
- There was a system in place for appointments that were conducted by doctors from another trust. Files were sent over from the relevant trust a day or two before each clinic. The reception staff kept the files so that they could contact the patients if the clinic was cancelled at short notice.
- Staff reported an incident if all of the records for an entire clinic were missing, but would not report an incident if a single set of records was missing from a clinic.

- We reviewed two patient records at University Hospital of Hartlepool and four radiology patient records which were completed with no obvious omissions. Nursing assessments of blood pressure, weight, height and pulse were routinely completed when patients attended the outpatient departments and radiology risk assessments were carried out and recorded electronically. We observed these checks being undertaken during our inspection.
- Diagnostic imaging and reports were stored electronically and available to clinicians via PACS (Picture Archiving and Communications System).
- Risk assessments were carried out with ongoing safety indicators for all radiological equipment, processes and procedures. These were easily accessible to all diagnostic imaging staff.
- The diagnostic imaging departments kept an electronic list of approved referrers and practitioners. This ensured that all staff, both internal and external, could be vetted against the protocol for the type of requests they were authorised to make.
- Staff in diagnostic imaging were able to demonstrate safety mechanisms to ensure patient doses for radiation were recorded.

Safeguarding

- All staff we spoke to were aware of safeguarding policies and procedures and knew how to report a concern. They knew that support was available if they needed it or they had a query.
- According to information provided by the trust, 100% of applicable staff had undergone safeguarding adults Level 1 (alserter) and 100% had completed safeguarding children Level 2 training. However, the department training records showed that none of the nursing and midwifery registered staff or additional clinical services staff in the women's outpatients had completed Level 2 safeguarding children training where required.
- Patient details for patients who did not attend appointments were checked by staff for any issues of concern. Patients were followed up after failing to attend and referrers were informed. The Child DNA process had been reviewed with the development of operational guidelines in the form of a SOP following a recent incident in orthopaedic outpatients.

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- The vulnerable adult DNA process has been reviewed within the department and managers were developing operational guidelines in the form of a SOP which would be rolled out in orthopaedics and main outpatient departments.

Mandatory training

- The outpatient and diagnostic imaging departments had systems and processes provided by the trust to ensure staff training was monitored although the inspection team found this information difficult to interpret. Trust standards for mandatory training were identified and compliance against those was recorded.
- The trust considered reducing the level of life support training to basic life support (BLS), but following a cardiac arrest outside the outpatient department, a team brief was held and staff were given the opportunity to reflect on their involvement: what went well, what could have been done differently and identified training requirements. As a result of this, intermediate life support (ILS) training for all staff continued.
- The trust told us that staff were allowed sufficient time to attend face to face training and to work through workbooks.
- Mandatory training compliance for outpatients across all sites varied slightly between staff groups and the target rates were noted to be mostly achieved.
- Mandatory training compliance for diagnostic imaging varied between staff groups and the rates were collated across the whole Trust because staff were managed centrally and many rotated across sites. The target rates were also mostly achieved.

Assessing and responding to patient risk

- There were emergency assistance call bells in all patient areas, including consultation rooms, treatment rooms and diagnostic imaging areas. Staff confirmed that, when emergency call bells were activated, they were answered immediately.
- Staff were aware of actions to take if a patient's condition deteriorated while in each department and explained how they could call for help, access the paediatric and adult cardiac arrest teams and the process for transferring a patient to the accident and emergency department at the University Hospital of North Tees. There were also a number of resuscitation trolleys and defibrillators across outpatients and diagnostic imaging departments which were available.

- Staff at the University Hospital of Hartlepool told us that since the accident and emergency department had closed they had seen a number of patients who attended outpatient appointments with conditions that required urgent transfers to accident and emergency.
- There were policies and procedures in the diagnostic imaging departments to ensure that the risks to patients from exposure to harmful substances were managed and minimised.
- The Radiation Protection Adviser report from March 2014 highlighted that all new equipment had been risk-assessed to ensure the safety of staff and patients.
- Diagnostic imaging policies and procedures were written in line with the Ionising Radiation (Medical Exposure) 2000 regulations. IR(ME)R. Staff were able to contribute and inform working practices. An example of this was that the CT policies had recently been updated by the senior radiographer and were awaiting authorisation by the trust protocols panel before being published on the intranet.
- There were named certified Radiation Protection Supervisors to give advice when needed and to ensure patient safety at all times. The trust had radiation protection supervisors (RPS) at each site who liaised with the Radiation Protection Advisor (RPA).
- Two senior radiologists; one for the main diagnostic imaging departments across the trust and another for breast services, were Administration of Radioactive Substances Advisory Committee (ARSAC) certificate holders for diagnostic imaging. Their role was to be available and contactable for consultation and to provide advice on aspects relating to radiation protection concerning medical exposures in radiological procedures. They led on the development, implementation, monitoring and review of the policy and procedures to comply with Ionising Radiation (Medical Exposure) 2000 regulations. IR(ME)R.
- Arrangements were in place for radiation risks and incidents defined within the comprehensive local rules. Local rules are the way diagnostics and imaging work to national guidance and vary depending on the setting. Policies and processes were in place to identify and deal with risks. This was in accordance with (IR(ME)R 2000).
- Staff asked patients if they were or may be pregnant in the privacy of the x-ray room therefore preserving the privacy and dignity of the patient. This was in accordance with the radiation protection requirements

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and identified risks to an unborn foetus. We saw different procedures were in place for patients who were pregnant and those who were not. For example patients who were pregnant underwent extra checks.

- We observed diagnostic imaging staff checking patients' height and weight as part of a Radiology Dose Audit in accordance with IR(Me)R 2000 and Institute of Physics and Engineering in Medicine (IPEM) (1988) regulations.
- Outpatients' staff used early warning scores to monitor and manage patient risk. Patients were assessed and given scores which directed how the patient was then managed and treated.
- The outpatients and diagnostic imaging departments utilised risk assessments for patient management including the WHO checklist for invasive procedures (staff were trialling an adaptation of the WHO checklist in an outpatient setting and had previously used a local format within the department), administration of medication in an outpatient setting for eye drops and injections, risk assessment for plaster cast application and management, VTE assessment in orthopaedic outpatients as part of plaster cast management, MUST assessments in main outpatients, Falls risk assessment within the fracture clinic and pregnancy testing prior to radiology and dermatology medications.

Nursing and allied health professional staffing

- We looked at the staffing levels in each of the outpatients and diagnostic imaging departments. There were very few vacancies and managers told us that staff retention was high. All department managers told us that staff were flexible to be able to ensure cover was available. Staff told us there were sufficient staff to meet service and patient needs and that they had time to give to patients. Rotas were compiled based upon activity within the departments.
- Managers told us they were able to adjust the number of staff covering main outpatients and orthopaedics outpatient clinics across all sites to accommodate those that were busy or where patients had greater needs.
- Within the diagnostic imaging departments, there were sufficient radiography and nursing staff to ensure that patients were treated safely. There were current vacancies; however, recruitment was ongoing.
- Planned and actual numbers of staff on shift were displayed and matched demand.
- Managers told us that staff sickness was monitored and that rates were consistently very low. Trust figures

provided to us showed that the staff sickness rate was 4% across the trust. Sickness rates had been provided for the period between April 2014 and March 2015 and rates ranged between 0% and 20% with the highest levels occurring in January 2015. The average sickness rate for the period between October 2014 and March 2015 was 5% for outpatients and radiology.

Medical staffing

- Medical staffing was provided to the outpatient departments by the various specialties which ran clinics. Medical staff undertaking clinics were of all grades; however we saw that there were consultants available to support lower grade staff when clinics were running.
- There was a national shortage of radiologists and the trust had had three vacancies in the previous 12 months, two of which had recently been recruited to and leaving just one to be filled. At the time of our inspection there were sufficient staff to provide a safe and effective service across all sites. There were 10 consultant radiologists, one breast specialist radiologist (plus one vacancy as above); one long term locum and 2 consultants who had recently retired from the trust provided additional support. There were 2.5 whole time equivalent specialist radiology registrars who rotated through trusts in the north east and were supernumerary.
- Some diagnostic imaging reporting was outsourced at times of need such as summer holidays and the Christmas period. There was a service level agreement and contract in place for this. At other times, medical staff undertook additional reporting and on-call work with locally agreed trust overtime arrangements.

Major incident awareness and training

- There was a major incident policy and staff were aware of their roles in the case of an incident. Staff contact lists were checked every 6 months to ensure up to date details were available.
- There were business continuity plans to make sure that specific departments were able to continue to provide the best and safest service in the case of a major incident. Staff were aware of these and able to explain how they put them into practice.

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Are outpatient and diagnostic imaging services effective?

Room utilisation for clinics in main outpatients lacked robust management. Staff were unable to plan resources effectively as information about which clinics would run on behalf of other trust specialties was regularly missing. Recording of actions completed following audits and checks within the outpatients department lacked rigour. Staff understood about consent although no staff had received Mental Capacity Act training. There were no established models of regular nursing clinical supervision in outpatients and staff received different types and frequency of informal supervision depending on their area of work.

Referral to treatment times met national targets.

Outpatient clinics ran every weekday with some breast services extending over weekends; care and treatment was evidence-based and targets were met consistently. There was evidence of multidisciplinary working across teams and local networks in some specialties.

Diagnostic imaging services for inpatients were available seven days a week and service availability was increasing and continuously improving. Diagnostic imaging staff undertook regular departmental and clinical audits to check practice against national standards and action plans were put in place and monitored to make improvements when necessary.

Evidence-based care and treatment

- We saw reviews against IR(ME)R regulations and learning disseminated to staff through team meetings and training.
- The trust had a radiation safety policy in accordance 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.
- The trust had radiation protection supervisors for each modality to lead on the development, implementation, monitoring and review of the policy and procedures to comply with Ionising Radiation (Medical Exposure) 2000 regulations. IR(ME)R.

- National Institute for Health and Care Excellence (NICE) guidance was disseminated to departments. Staff we spoke with were aware of NICE and other specialist guidance that affected their practice. For instance the national breast screening programme for evidence based practice was followed in the breast clinic. Staff had developed standard operating procedures for new work within the departments, for example Prostate clinic (an injection used in prostate cancer treatment) in the outpatient setting.
- The departments were adhering to local policies and procedures. Staff we spoke with were aware of the impact they had on patient care.
- The diagnostic imaging departments carried out quality control checks on images to ensure that the service met expected standards.

Pain relief

- Simple pain relief medication was administered if required by staff in the outpatients department. Records were maintained to show medication given to each patient.
- Patients we spoke with had not needed pain relief during their attendance at the outpatient departments.
- Diagnostic imaging staff carried out pre-assessment checks on patients prior to carrying out interventional procedures. Pain relief for procedures such as biopsies was prescribed by radiologists and administered safely as required.

Facilities

- The main out patients department were under-utilised during our inspection. We noted empty rooms in departments we visited. Staff told us they had no control over what clinics were held and showed us evidence of numerous occasions when rooms were booked but not used. We were told that these were often booked by other trusts for visiting clinicians.

Patient outcomes

- The trust provided us with information about the previous 11 months appointments which showed that the trust outpatient departments saw 141,213 patients. Of these, 55,918 were new appointments and 85,295 were review appointments.
- According to information supplied by the trust, the percentage of appointments cancelled by the trust was consistently low with an average over the previous four

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months of 0.68% which was much better than the England average of 6%. The main reasons given for cancellations were annual leave, on-call changes and sickness.

- The Did Not Attend (DNA) rate for the University Hospital of Hartlepool was 8% which was worse than the England average of 7%. There were Trust policies in place for managing DNA's and reception staff talked us through the process but there had been no positive change to the rate at the time of our inspection.
- The trust's 'new to review' rate (the ratio of new appointments to follow-up) was 1:2.6. There was disparity between the two main hospital sites with University Hospital of North Tees performing at 1:2.2 (in line with the England average of 1:2.24) whilst University Hospital of Hartlepool was consistently higher (worse) than the England average at 1:3.2.
- The data for percentage of patients waiting over 30 minutes to see a clinician was not regularly collected by the Trust but a snapshot taken in March 2015 revealed that delays affected 5.5% generally and 2.5% of orthopaedic outpatients. Staff did inform patients about delays and the reasons for them.
- After receiving care and treatment, patients were either given another appointment or provided with information about the follow-up appointment process (for example six monthly or yearly reviews) when they would be sent an appointment letter.
- All diagnostic images were quality checked by radiographers before the patient left the department. National audits and quality standards were followed in relation to radiology activity and compliance levels were consistently high.
- Audits carried out in diagnostic imaging included thermo luminescent dosimeter audits for every room, screening checks of lead aprons, weekly checks of unreported images, imaging plate artefacts, radiographers' sensitivity and specificity and referrer errors.

Competent staff

- There were systems within departments to make sure that staff received an annual appraisal and in diagnostic imaging and outpatients 100% of all staff had taken part in appraisals. In all departments staff were encouraged to discuss development needs at appraisal and as opportunities arose.

- Advanced practitioner and leadership strategy courses had been undertaken and more staff had been identified to attend for the year ahead.
- Radiographers completed local induction and preceptorship competencies as well as medical devices training, all of which was well documented. They undertook clinical peer support and one to one supervision meetings. Staff were supported to carry out continuous professional development activities, complete mandatory training, appraisal and specific modality training. One to one meetings were also used to sign off competencies, maintain Healthcare Professions Council (HCPC) continuous professional development portfolio, carry out reflective practice and complete new medical devices training. Therapists took part in peer reviews.
- Radiologists working in interventional roles were trained in specialist areas by the clinical leads, for example in breast clinics.
- Nominated key staff were identified to attend and feedback information on medical devices, infection control, tissue viability, safeguarding, dementia, vulnerable adults, sensory loss and health promotion.
- Students were welcomed in all departments. Radiography students came for 12-month placements and a radiographer student was interviewed as part of the inspection at Peterlee Community Hospital. They told us that they felt supported and enjoyed working within the department
- There were formal arrangements for induction of new staff. All staff completed full local induction and training before commencing in their role. We saw induction training records for staff within the diagnostic imaging department.
- Medical revalidation was carried out by the trust. There was a process to ensure that all consultants were up to date with the revalidation process.
- There were no established models of regular nursing clinical supervision in outpatients and staff received different types and frequency of informal supervision depending on their area of work. Clinical supervisions allow staff to reflect on and review their practice in a safe environment.
- Outpatient department staff were encouraged to question practice if they had any concerns. Local protocols and competencies had been agreed for ophthalmology, dermatology, ENT, diagnostic imaging and electronic requests. Competency packs for staff

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were held within the departments and staff were encouraged to attend courses to update their skills and knowledge where appropriate; Orthopaedic out-patients had departmental competencies for registered nurses, health care assistants, plaster technicians and reception staff. All new staff were allocated a mentor within the departments who would support staff to achieve competencies.

- Recruitment and selection procedures were followed to ensure staff were appropriately skilled and had relevant knowledge. All staff received a local and trust Induction. All staff were supervised during learning. Additional support could be given in the form of an agreed action plan. Staff would not work unsupervised in an area that they were not deemed competent.
- Monthly RAG (red/amber/green) reports on mandatory training were produced and distributed by Training and Development. Departmental managers monitor compliance regularly and ensured that all staff were up to date with reviews. Time out was provided for staff to work through workbooks and attend face to face training as required.

Multidisciplinary working

- The outpatients department at University Hospital of Hartlepool hosted outpatient clinics run by other trusts. Staff told us that they were able to raise issues directly with the other trusts. However, managers told us that a general lack of communication between teams often prevented information being passed on and therefore staff and patients were sometimes not informed that clinics were cancelled. Information about which clinics would run on behalf of other trust specialties was regularly missing and staff were unable to plan resources effectively. This included staff and facilities. Managers told us that clinics could be cancelled at very short notice and outpatient department staff would have to contact patients to let them know.
- There was evidence of multidisciplinary working in the outpatients and imaging departments. For example, nurses and medical staff ran joint clinics and staff communicated with other departments such as diagnostic imaging and community staff when this was in the interest of patients.
- We saw that the departments had links with other departments and organisations involved in patient journeys such as GPs, support services and therapies.

- A range of clinical and non-clinical staff worked within the outpatients departments. Staff were observed working in partnership with a range of staff from other teams and disciplines, including radiographers, physiotherapists, nurses, booking staff, and consultant surgeons.
- Staff were seen to be working towards common goals, asked questions and supported each other to provide the best care and experience for the patient.
- Managers or senior staff in all outpatient and diagnostic imaging departments held daily staff meetings. These had been introduced the week before our inspection and all members of the multidisciplinary team attended. Staff reported that they were a good method to communicate important information to the whole team.
- Specialty multidisciplinary team (MDT) meetings were attended by staff from the specialist clinical areas and outpatients department including nurses, physiologists, consultant leads and radiologists. These meetings were held weekly and the teams discussed management plans as well as case reviews and sharing of best practice.
- MDT work took place in specialist clinics; there were dressings clinics alongside consultant clinics for dermatology, physiotherapy clinics were provided alongside the trauma clinics to support patients coming out of plaster cast and group exercise sessions were offered to orthopaedic surgery patients at Peterlee Community Hospital; extended scope physiotherapists and ultrasonographers worked alongside some consultant clinics.
- Staff were able to refer to the intermediate care team who were based in accident and emergency and the plaster room service received referrals from podiatry and physiotherapy.

Seven-day services

- Outpatient services were open between from Monday to Friday every week. Diagnostic imaging services were available on weekdays with plain film imaging available to inpatients seven days per week.
- The imaging departments provided general radiography, CT and ultrasound scanning services for outpatients and inpatients every weekday. There was a rota to cover evenings and weekends for plain film radiography only so that inpatients could access diagnostic imaging services when they needed to. Staff

Outpatients and diagnostic imaging

told us that the University Hospital of Hartlepool inpatient admission criteria ensured that patients would not routinely require CT scanning services. This was available at the University Hospital of North Tees if a patient's condition deteriorated and CT was necessary.

Access to information

- Systems and processes were in place if patient records were not available at the time of appointments. Staff told us that some patients' medical records were unavailable for clinics and that this was reflected in their incident reporting if a whole clinic's notes did not turn up. At University Hospital of Hartlepool this was recorded as 0.66%. Some letters and discharge summaries were stored electronically through the electronic document portal. This provided back up when patients' notes were unavailable. Staff agreed that a patient would always be seen as long as there was some information about them available and temporary notes would be created for the episode and merged with main records when available.
- There were systems in place to flag up urgent unexpected findings to GPs and consultants. This was in accordance with the Royal College of Radiologist guidelines.
- Turnaround times for urgent radiology reports were 60 minutes for general scans and 30 minutes for suspected stroke patients.
- Diagnostic imaging departments used picture archive communication system (PACS) to store and share images, radiation dose information and patient reports. Staff were trained to use these systems and were able to access patient information quickly and easily. Systems were used to check outstanding reports and staff were able to prioritise reporting so that internal and regulator standards were met. There were no breaches of standards for reporting times.
- All staff had access to the trust intranet to gain information relating to policies, procedures, NICE guidance and e-learning.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- Staff told us that patient consent was confirmed before carrying out any personal care or interventional procedure. Mental Capacity Act (MCA) training and Deprivation of Liberty Safeguards (DoLS) training was incorporated in safeguarding adults and dementia

training and training levels were 100%. The trust told us that procedure specific formal consent protocols were being introduced into both the main outpatient and orthopaedic outpatients departments and that MCA and DoLS information was kept in each department. They told us that if any queries arose in the outpatient setting, staff would contact the named leads within the trust for advice.

- Nursing, diagnostic imaging, therapy and medical staff understood their roles and responsibility regarding consent and were aware of how to obtain consent from patients. They were able to describe to us the various ways they would do so. Staff told us that, in the outpatients department, consent was usually obtained verbally. This was the case for the majority of diagnostic imaging procedures, although consent for any interventional radiology was obtained in writing prior to attending the diagnostic imaging departments.
- Patients told us that staff were very good at explaining what was happening to them prior to asking for consent to carry out procedures or examinations.

Are outpatient and diagnostic imaging services caring?

Good



During the inspection, we saw and were told by patients, that the staff working in the outpatient and diagnostic imaging departments were kind, caring and compassionate at every stage of their journey and patients were given sufficient time for explanations about their care and were encouraged to ask questions.

People were treated respectfully and their privacy was maintained in person and through actions of staff to maintain confidentiality and dignity.

There were services to emotionally support patients and their families. Patients were kept up to date and involved in discussing and planning their treatment and were able to make informed decisions about the treatment they received.

Compassionate care

Outpatients and diagnostic imaging

- Staff in outpatients and diagnostic imaging were caring and compassionate to patients. We observed positive interactions with patients. Staff approached patients and introduced themselves, smiling and putting patients at ease.
- Staff respected patients' privacy and dignity. Staff could access private areas to hold confidential conversations with patients if necessary and receptionists informed staff quickly if patients had communication difficulties. Clinic names were not displayed in order to maintain privacy and confidentiality. Consultation and treatment rooms had solid doors and patients could get changed before seeing a clinician. Staff were observed to knock on doors before entering and doors were closed when patients were in treatment areas.
- We spoke with sixteen patients and two relatives and all said that staff were friendly with a caring attitude. There were no negative aspects highlighted to us.
- We observed staff behaving in a caring manner towards patients they were treating and communicating with and respecting patients' privacy and dignity throughout their visit to the department.
- The Friends and Family Test (FFT) had been rolled out fully in outpatients and managers told us that feedback through FFT demonstrated that staff were caring. The most recent FFT data for June 2015 showed that the percentage of patients who would recommend services at University Hospital of Hartlepool main outpatients was 92% (equal to the England average of 92%), orthopaedic outpatients was 88% (worse than the England average).
- The trust told us that a recent friends and family test result demonstrated that communication had been an issue, which led to the reinforcement of Customer Care Charter to staff.
- Therapists carried out comprehensive patient feedback audits. We saw information collected and results had been published. Audits carried out in the previous 12 months showed 100% patient satisfaction with the care they had received.
- Staff within the main outpatient and orthopaedic departments developed their own outpatient charter based upon the 6c's (An NHS England initiative around Compassion in Practice; Care, Compassion, Competence, Communication, Courage, and Commitment, introduced after feedback from the

Francis Report, the Keogh Report, the Cavendish and Berwick Reviews) which was then rolled out to all staff within the department. Posters of the outpatient charter were displayed in all outpatient waiting areas.

Understanding and involvement of patients and those close to them

- Patients told us that they were involved in their treatment and care and relatives said that they were kept informed and involved by nursing and medical staff. All those we spoke with told us that they knew why they were attending an appointment and had been kept up to date with their care and plans for future treatment.
- Outpatients and diagnostic imaging staff involved patients in their treatment and care. We saw staff explaining treatment.
- Staff told us that families were invited into the consulting room as long as the patient was agreeable.
- Patients and families were given time to ask questions.

Emotional support

- Patients told us that they felt supported by the staff in the departments. They reported that, if they had any concerns, they were given the time to ask questions.
- Staff made sure that people understood any information given to them before they left the departments.
- Emotional support for patients was available. For example, specialist nurses and psychologists worked with the clinical teams in the breast services department and were present for extra support when patients received bad news.

Are outpatient and diagnostic imaging services responsive?

Good



We found that outpatient and diagnostic services were responsive to the needs of patients who used the services. Extra clinics and scanning sessions were added to meet demand. Waiting times were within acceptable timescales, with outpatient DNA (did not attend) rates worse than the average for Trusts in England. Patients were able to be seen quickly for urgent appointments if required.

Outpatients and diagnostic imaging

Clinics and related services were organised so that patients were only required to make one visit for investigations and their consultation. Some patients' conditions were monitored remotely which reduced the need for some very frequent or urgent appointments. New appointments were rarely cancelled but review appointments were often changed.

There were mechanisms to ensure that services were able to meet the individual needs, such as for people living with dementia, a learning disability or physical disability, or those whose first language was not English. There were also systems to record concerns and complaints raised within the department, review these and take action to improve patients' experience.

Service planning and delivery to meet the needs of local people

- The outpatients department organised 2200 clinics a year across the four trust sites. They flexed capacity and staffing to meet demand. Extra clinics were added to ensure provision met demand for example an increased referral pattern was noticed for general surgery so two extra clinics had been scheduled. Capacity issues were discussed with heads of departments at Patient Tracking Line meetings every two weeks for each specialty and with the clinicians.
- Clinics were organised to meet patients' needs. For instance: Breast clinics were organised so that all investigations and consultations happened on the same day.
- Management teams in outpatients and diagnostic imaging had noted a significant increase in demand for respiratory services. The teams anticipated a 7-10% overall increase in activity in the coming year. The diagnostic imaging managers recognised that any changes in clinical activity would increase the radiology workload across all modalities, but especially CT. Capacity was stretched at present but two new radiologists had recently been recruited.
- Staff meetings in the outpatients department at University Hospital of Hartlepool had been introduced in the week before our inspection. They were held first thing in the morning to plan for the day ahead. Staff told us they discussed each clinic taking place, previous

performance in terms of appointment utilisation and over runs and highlighted concerns such as patient numbers or cancellations. They discussed the previous day's activity such as late starts and overruns.

- The diagnostic imaging department had good processes in place and the capacity to deal with urgent referrals and additional scanning sessions were arranged to meet patient and service needs.
- Digital dictation had been introduced in diagnostic imaging to enable a swift turnaround for reports and letters. Diagnostic imaging reporting and record-keeping was electronic and paperless methods were used to reduce time and administration requirements.
- Managers told us that the trust were exploring moving more outpatient sessions from the hospital to community settings, including One Life at Hartlepool and Peterlee Community Hospital, to bring care closer to the patient's home. Staff were aware that this system used a considerable amount of trust resources in terms of finance and staffing but this had been a specific request from commissioners
- There had been a recent introduction of telephone assessment for fracture patients, which aimed to improve the service for patients as well as reduce the number of DNAs.
- Both main and orthopaedic outpatients departments were responsive to additional clinic requests from clinicians to accommodate 2 week rules and short notice additional clinics.
- The main outpatients department at University Hospital of Hartlepool hosted specialists from other trusts to enable local patients to access regional services. Patient records would arrive in the department a few days prior to the clinics so that staff had access to patient information should any problems arise.
- Diagnostic imaging departments hosted medical physics services from a local trust. There was a service level agreement (SLA) in place.

Access and flow

- The bookings team, based at University Hospital of North Tees received all outpatient referral letters by post and electronically. These were checked within 24 hours of receipt and forwarded to consultants for triage, to be returned within five days.

Outpatients and diagnostic imaging

- Referral to treatment times (RTT), diagnostic waiting times, cancer waiting or diagnosis times were all better than, or close to national targets. The percentage of people seen by a specialist within two weeks of an urgent GP referral was slightly worse than the England average (at 94% against the England average of 95%). However the percentage of people waiting less than 31 days from diagnosis to first definitive treatment for all cancers was consistently slightly better (87% against the England average of 84%).
- The percentage of non-admitted patients seen within 18 weeks of referral was consistently over 98% and higher (better) than the England operational standard of 95%. The percentage of patients with incomplete care pathways who started their consultant-led treatment ranged between 96 and 98%. The operational standard in England is 92%.
- Guidelines say that 95% patients should start consultant-led treatment within 18 weeks of referral. The rate for this trust was consistently more than 98% of patients seen within 18 weeks of referral, for patients not admitted. This was consistently better than the England average.
- The trust was performing above and better than the England average for patients with all cancers being seen urgently within two weeks.
- The trust was performing consistently similar to or slightly worse than the England average for the percentage of people waiting less than 62 days from urgent GP referral to first definitive treatment for all cancers. 82% of patients were seen within 62 days for Quarter 1 of 2014/15 but this rose rapidly to better than average at 87% in Quarter 2.
- There were no review appointment waiting lists and no backlog of non-RTT patients.
- The trust used the 'Choose and Book' system. Choose and Book is a national electronic referral service which gives patients a choice of place, date and time for their first outpatient appointment in a hospital or clinic. The majority of patients used this system to make appointments and the team estimated they received an average of 250 calls per day. For other patients, booking staff made appointments then telephoned the patient to check they were suitable.
- The rates of patient non-attendance for the outpatients department for the 12 months between July 2013 and June 2014 (DNA rate) for the Trust, across all sites, averaged out at 8%. This was worse than the national average of 7%. We saw there were policies in place for DNAs. Booking and reception staff were able to tell us the procedure for managing DNAs. Adults who had previously missed an appointment were telephoned the day before to remind them to attend.
- Diagnostic imaging waiting times for all departments and from all urgent and non-urgent referrals met national targets. The trust was better than the England average for diagnostic waiting times. This sharply increased to worse than the England average in October 2014 due to a medical staff vacancy within cardiology but following a pathway management programme had since consistently achieved the 99% standard since that period.
- It was trust policy not to cancel clinics within 6 weeks of when they were due to run. Some were cancelled within the six-week range but the percentage of all cancellations was 0.73% or less for every month from December 2014 to March 2015. In most cases clinics would be reduced rather than cancelled and patients told us that their review appointments were often changed and sometimes this happened more than once.
- Patients were informed if clinics were running late. Patients were informed of the reason for the delay and approximate time they would be seen. If the patient could not wait a new appointment would be made. We saw staff inform patients, apologise and explain why clinics were running late.
- In diagnostic imaging we were told that all waiting time targets for patients following their arrival at the departments were met and the most recent diagnostic imaging dashboard confirmed this. The arrival time of patients into the departments was recorded and any unexpected delays were explained to individuals.
- In the diagnostic imaging departments, reporting times for urgent and non-urgent procedures consistently met or were better than national and trust targets for all scans and x-rays.
- Patients who cancelled diagnostic imaging appointments were all re-booked to attend within the national target of 6 weeks of their original appointment date.

Meeting people's individual needs

- Breast and respiratory services offered a one-stop-shop approach to appointments where all investigations and consultations were carried out on the same day and

Outpatients and diagnostic imaging

patients left with a diagnosis and treatment plan. Patients we spoke with liked this approach. The service also offered interventional radiology treatments on the same day of a referral if required. This was corroborated by the consultant radiologists.

- The senior sister in the outpatients department had purposely chosen to use an office just off the patient waiting area. She told inspectors that she had chosen this so she could be available for patients and staff but also observe and assist any patients who may need extra support.
- Patients who were required to be at the hospital for long periods of time, for example those with multiple appointments or waiting for ambulances, were offered food or a snack and regular drinks by staff.
- Staff told us they were aware of individual needs and responded accordingly. They ensured that patients who may be vulnerable, distressed or anyone with special needs were managed appropriately, including private waiting, contacting general practitioners, CPN or social services and safeguarding referrals would be instigated if any concerns were raised.
- A daily rounding by a senior member of staff enabled patients and those close to them to express concerns and allowed staff opportunities to meet individual needs.
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- Departments were able to accommodate patients in wheelchairs or who needed specialist equipment. There was sufficient space to manoeuvre and position a person using a wheelchair in a safe and sociable manner.
- Patients had access to a wide range of information. Information was available on notice boards and leaflets. There was information that explained procedures such as x-rays. There was information about illnesses and conditions including where to go to find additional support.
- The bookings teams organised interpreter services for patients who did not speak or understand English. Staff

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Learning from complaints and concerns

- Staff in all departments told us complaints were few and that the main issues were waiting times and cancelled clinics. The patient safety coordinator discussed these with the core service lead. Patterns and themes were identified and the lessons learned were shared with the team and the referring service. There were three informal complaints raised and only one formal complaint documented regarding outpatient services at University Hospital of Hartlepool.
- Staff were aware of the local complaints procedure and were confident in dealing with concerns and complaints as they arose. Managers and staff told us that complaints, comments and concerns were discussed at local team meetings, actions agreed and any learning was shared.
- None of the patients we spoke with had ever wanted or needed to make a formal complaint. Some had raised concerns during their attendance. They told us that their concerns had been dealt with professionally and, where possible, action taken to address the concern. On the whole they were happy with the experience they received from the departments.
- Information was accessible on the Trust web site including the complaints policy.
- Complaints were managed effectively in diagnostic imaging and we were shown actions taken to address concerns and complaints and their outcomes.
- The trust told us that intentional rounding by senior staff in the out-patient setting enabled staff to provide local resolution to concerns or complaints as they were raised. They said that staff followed up with phone calls to patients to ensure satisfactory resolution. All concerns and complaints where applicable were recorded via the Datix system.

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Are outpatient and diagnostic imaging services well-led?

Outpatients and diagnostic imaging

Requires improvement



We rated well-led as requires improvement. Senior managers talked of the trust's vision for the future of the outpatients department and were aware of the risks and challenges. However staff told us they felt the service was fragmented and changes to meet current and future departmental needs could not be considered because there was no clear departmental strategy following a pause in plans for a new hospital at Stockton. It was not always possible to see from the risk register which risks had been managed and which were still waiting to be actioned. The expected implementation of an electronic booking system that was due in September 2015 was not identified as a risk at the time of inspection and was not included in the departmental or trust risk registers.

Local managers were active, available and approachable to staff. Business continuity plans had been developed to manage incidents, accidents and risks and these were simple to implement and effective but written action plans were not revisited to check that actions had been taken. Regular daily meetings took place where service was planned and anticipated problems were discussed. There was an open and supportive culture where incidents and complaints were discussed, lessons learned and practice changed. Staff felt proud to work for the trust and felt they provided a good service to patients.

The diagnostic imaging departments had good leadership and management and staff told us they were kept informed and involved in strategic working and plans for the future. The department was supportive of staff who wanted to work more efficiently and were able to develop to improve their practice, be innovative and try new services and treatments.

Vision and strategy for this service

- Senior managers told us that the trust vision and strategy were well embedded and discussed at staff meetings. Staff told us that senior managers were approachable to ask questions or discuss their concerns but that the outpatients service was “procedures driven” and that there was no senior management or estates investment into the departments at the University Hospital of Hartlepool.

- Managers told us that they were working with the transformation programme, looking at clinic allocations, clinic efficiency, room allocations and care closer to home and that they had a clear outpatient transformation project plan which was corporately led. However, this did not appear to be understood by staff at ground level. Staff told us that there was no overall strategy for outpatients; that discussions were taking place but they did not know what they were about; the service was fragmented and had not progressed.
- Staff told us that because of a lack of communication between specialties and directorates they could not make decisions on how to use resources. They felt that they provided a fragmented service and that this was often caused by lack of communication between specialties and directorates.
- The diagnostic imaging department had good leadership and management and staff told us they were kept informed and involved in strategic working and plans for the future
- The trust had a strategy for the introduction and continued use of more efficient and effective working using information technology such as electronic, records and digital dictation systems.
- A new electronic patient booking system was due to be implemented two months following our inspection which all staff were anticipating. However, it was not clear how much planning had been done and at what stage the team were at.

Governance, risk management and quality measurement

- Risk registers were held and controlled by Heads of Departments and staff were able to influence what risks were included. Risks were discussed by the patient safety team and learning was shared across the organisation via newsletters, regular dissemination meetings, team brief and staff communication emails.
- Actions taken by teams following root cause analysis were not well recorded and it was not always possible to see from the risk register which risks had been managed and which were still waiting to be actioned. Staff told us that it had taken 10 years for a window to be replaced in main outpatients.
- The outpatient patient safety coordinator reported on risk, incidents and complaints. They told us that these issues informed each other. The departmental risk register was reviewed at weekly team meetings where

Outpatients and diagnostic imaging

the team worked through risks and actions. The expected implementation of an electronic booking system that was due in September 2015 was not identified as a risk and was not included in the departmental or trust risk registers.

- Senior staff told us that a new risk manager had recently been appointed and that they intended to review the risk management processes and the risk register including current risks.
- Serious incidents were discussed at patient safety and quality meetings, led by the deputy director of patient safety. Clinical directors attended and if trends were identified such as patient falls then the training and development staff would attend to deliver training on “hot spots”.
- Following serious incidents regarding grade three pressure ulcers in orthopaedic patients with plaster casts, the risk assessment document was communicated through the orthopaedic clinical governance session in April 2015 and an SOP (standard operating procedure) was developed for full contact plaster casts with information cards for patients. The documents were approved at Health Records committee and were awaiting approval prior to printing.
- Department managers carried out investigations of incidents and reported back to teams. The patient safety team monitored Datix reports, carried out trends analysis and sent out a trust-wide bulletin on incidents, trends and learning was shared from directorate to directorate. The trust-wide serious untoward incident (SUI) panel met on a weekly basis. The trust told us the directorate risk register was updated frequently and amber coded risks were assigned to specific staff who updated any actions and revised the risk assessment as required. However, the risk register we were presented with showed very few revisions or actions. Risks were reviewed at directorate meetings and where appropriate the outpatient staff would liaise with directorates.
- Diagnostic imaging had a separate risk management group consisting of modality (specialist diagnostic imaging services for example CT and MRI) leads, radiology risk assessors and radiology protection specialists.
- We saw minutes of the radiology protection working group where radiation protection supervisors (RPS)

from specialties within the department and across all sites, raised, discussed and actioned risks identified within the department and agreed higher level risks to be forwarded to the patient safety manager.

- The organisation had systems to appraise NICE guidance and ensure that any relevant guidance was implemented in practice.

Leadership of service

- Staff found the managers of the service to be approachable and supportive. All the staff we spoke with told us they were content in their role and many staff we spoke with told us that they had worked at the hospital for many years. Staff felt that they could approach managers with concerns but did not always feel listened to, or confident that action would be taken when possible. We observed good, positive and friendly interactions between staff and managers.
- Staff felt that managers communicated well with them and kept them informed about the day to day running of the departments but outpatient department managers could not consider changes to meet current and future departmental needs because there was no clear departmental strategy.
- Diagnostic imaging department leadership was positive and proactive. Staff told us that they knew what was expected of staff and the department and that positive changes were planned and some had already taken place.
- There were no established models of regular nursing clinical supervision in outpatients and staff received different types and frequency of informal supervision depending on their area of work.
- Staff told us that they had annual appraisals and were encouraged to manage their own personal development. Staff were able to access training and development provided by the trust and external courses were funded by the trust.
- Outpatient matrons for main outpatients and orthopaedic outpatients carried out peer review on each department. They attended the monthly senior matron meetings for surgery and orthopaedics to maintain links and awareness. Monthly tripartite meetings had been set up to support staff and plan for the inspection process. Both departmental matrons had completed Leadership Development Programmes which had been rolled out to other staff.

Outpatients and diagnostic imaging

Culture within the service

- Staff were proud to work at the hospitals. They were passionate about their patients and felt that they did a good job. They were encouraged to report incidents and complaints and felt that these would be investigated fairly
- Diagnostic imaging staff told us that they felt there was a culture of staff development and support for each other. Staff were open to ideas, willing to change and were able to question practice within their individual modalities and suggest changes.
- We were told by outpatients and diagnostic imaging staff that there was a good working relationship between all levels of staff and across all sites. In diagnostic imaging we saw that there was a positive, friendly but professional working relationship between consultants, nurses, radiographers and support staff.

Public engagement

- The friends and family test had been rolled out fully in outpatients and positive feedback had been received by the departments and staff were able to give us working examples of changes that had been made following patient comments.
- Therapy services carried out patient surveys and results were consistently 100% positive. The team distributed patient comments in monthly bulletins.
- We were told that intentional rounding allowed senior staff to speak to patients on a daily basis, solve any potential problems or issues at the time.
- The hospital user group (HUG) visited the departments and carried out surveys which were fed back to departments regarding patient experience and measures that could be taken to improve it. The most recent PLACE scores for University Hospital of Hartlepool were better than the England average.

Staff engagement

- Orthopaedic outpatients' staff had recently instigated a weekly team brief which was held to ascertain what has gone well, and what could have been improved in the previous week. This meeting was documented.

- Staff told us they participated in team meetings and were confident to talk about ideas and sharing of good news as well as issues occurring the previous day or anticipated problems for the day ahead.
- Staff survey results for the whole Trust showed that 78% of staff felt satisfied with the quality of work and patient care they were able to deliver. Outpatients and diagnostic imaging staff told us that they enjoyed working for the trust and we interviewed several people who had been employed for 20 years or more. Staff were proud of the service they provided and felt they worked in highly skilled teams. Staff told us that they would be proud if members of their family were cared for by staff in the department.
- The trust told us that nursing, allied professional and therapy staff were keen to work with consultants to develop new practices, including the introduction of new drugs and procedures.
- Departmental staff liaised with visiting specialists to keep updated with new practices and developments to ensure that services offered were in line with current practice and effective.
- Staff shared their achievements with the rest of the trust in the trust magazine Anthem which was published and available via the intranet.
- The trust was proud to inform us that the main outpatient department staff at University Hospital of Hartlepool had been nominated for the Hartlepool Mail Health Team of the year award.

Innovation, improvement and sustainability

- Staff had produced posters and delivered presentations at the Society of Orthopaedic and Trauma Nursing international conference on the development of virtual fracture clinics and on the roles of speciality nurses.
- The trust told us that a number of staff within the departments had completed modules on service improvement and that one current project was working to improve the staff engagement and sustainability in clinical supervision.
- An outpatient department sister was in the process of scoping the introduction of trauma condition specific information leaflets.

Outstanding practice and areas for improvement

Outstanding practice

- The development of advanced nurse practitioners had enabled the hospital to respond to patients' needs appropriately and mitigated difficulties in recruiting junior doctors.
- The bariatric service had been developed as part of a consortium arrangement with neighbouring NHS trusts to ensure the local population had access to this service.
- Staff had produced posters and delivered presentations at the Society of Orthopaedic and Trauma Nursing international conference on the development of virtual fracture clinics and on the roles of speciality nurses.
- The trust told us that a number of staff within the departments had completed modules on service improvement and that one current project was working to improve the staff engagement and sustainability in clinical supervision.
- A project in conjunction with Hartlepool Council was initiated to improve health care for people living with learning disabilities. When a patient with learning disabilities was admitted to the hospital, an alert was generated and they were admitted to a virtual ward managed by the learning disabilities lead nurse. This ensured that the trust was able to respond to their needs in an appropriate and timely manner.

Areas for improvement

Action the hospital **MUST** take to improve

- Ensure there are systems and processes in place to minimise the likelihood of risks by completing the 5 Steps to Safer Surgery checklist.
- Ensure staff follow trust policies and procedures for managing medicines, including controlled drugs.
- Ensure that risk assessments are documented along with personal care and support needs and evidence that a capacity assessment has been carried out where required.
- Ensure effective systems are in place which enable staff to assess, monitor and mitigate risks relating to the health, safety and welfare of people who use the service.
- Ensure that all policies and procedures in the In-Hospital Care directorate are reviewed and brought up to date.
- Ensure midwifery policies, guidelines and procedural documents are up to date and evidence based.
- Ensure there are always sufficient numbers of suitably qualified, skilled and experienced staff to deliver safe care in a timely manner.
- Ensure that all annual reviews for midwives take place on a timely basis.
- Ensure all staff attend the relevant resuscitation training.

Action the hospital **SHOULD** take to improve

- Ensure the processes and documentation used for appraisal of non-medical staff meets their personal development needs in children and young people services.
- Ensure that formal drugs audits and stock checks are carried out regularly in outpatients.
- Ensure that clinic planning, room utilisation and staffing is effectively managed and controlled for outpatient clinics including those hosted by the trust.
- Ensure that established models of regular nursing clinical supervision are implemented for all staff involved in patient care.
- Ensure that strategy and management plans regarding transforming the outpatients departments are communicated to all staff.
- Have a competency based framework in place for all grades of midwives.
- Have systems in place to achieve the nationally recommended ratio of 1:15 for supervision of midwives.
- Indicate benchmark data on the maternity performance dashboard to measure performance.
- Ensure the availability of a diabetes specialist midwife.
- Provide simulation training to prevent the abduction of an infant.

This section is primarily information for the provider

Requirement notices

Action we have told the provider to take

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

Regulated activity	Regulation
Treatment of disease, disorder or injury	Regulation 9 HSCA (RA) Regulations 2014 Person-centred care Regulation 9(3)(a) <ul style="list-style-type: none">• Ensure there are systems and processes in place to minimise the likelihood of risks by completing the 5 Steps to Safer Surgery checklist.
Treatment of disease, disorder or injury	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment Regulation 12(2)(c)(e)(g)(h) <ul style="list-style-type: none">• Ensure staff follow trust policies and procedures for managing medicines, including controlled drugs.• Ensure that risk assessments are documented along with personal care and support needs and evidence that a capacity assessment has been carried out where required.
Treatment of disease, disorder or injury	Regulation 17 HSCA (RA) Regulations 2014 Good governance Regulation 17(2)(a)(b)

This section is primarily information for the provider

Requirement notices

- Ensure effective systems are in place which enable staff to assess, monitor and mitigate risks relating to the health, safety and welfare of people who use the service.
- Ensure that all policies and procedures in the In-Hospital Care directorate are reviewed and brought up to date.
- Ensure midwifery policies, guidelines and procedural documents are up to date and evidence based.

Regulated activity

Regulation

Treatment of disease, disorder or injury

Regulation 18 HSCA (RA) Regulations 2014 Staffing

Regulation 18(1),18(2)(a)

- Ensure there are always sufficient numbers of suitably qualified, skilled and experienced staff to deliver safe care in a timely manner.
- Ensure that all annual reviews for midwives take place on a timely basis.
- Ensure all staff receive the relevant resuscitation training.