

# The Newcastle upon Tyne Hospitals NHS Foundation Trust

## Inspection report

Freeman Hospital  
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We plan our next inspections based on everything we know about services, including whether they appear to be getting better or worse. Each report explains the reason for the inspection.

This report describes our judgement of the quality of care provided by this trust. We based it on a combination of what we found when we inspected and other information available to us. It included information given to us from people who use the service, the public and other organisations.

This report is a summary of our inspection findings. You can find more detailed information about the service and what we found during our inspection in the related Evidence appendix.

## Ratings

### Overall rating for this trust

Outstanding 

Are services safe?

Good 

Are services effective?

Outstanding 

Are services caring?

Outstanding 

Are services responsive?

Outstanding 

Are services well-led?

Outstanding 

Are resources used productively?

Outstanding 

# Summary of findings

## Combined quality and resource rating

Outstanding 

We rated well-led (leadership) from our inspection of trust management, taking into account what we found about leadership in individual services. We rated other key questions by combining the service ratings and using our professional judgement.

## Background to the trust

The Newcastle upon Tyne Hospitals NHS Trust received NHS Foundation Trust status in June 2006. The trust provides a full range of acute and specialist hospital and community services. The main sites are the Royal Victoria Infirmary including the Great North Children's Hospital, Freeman Hospital including the Institute of Transplantation, Northern Centre for Cancer Care and Renal Services, Dental Hospital, Campus for Ageing and Vitality, International Centre for Life and Community Services.

The trust serves a population of over 3 million. 14% of the population of Newcastle upon Tyne are aged 65 and over, compared to 18% nationally. The Local Authority (LA) had a similar breakdown by ethnicity to the national average, with 13% of the population being BAME residents. Newcastle upon Tyne performed significantly below the England average for most of the indicators in the Local Health Profile, particularly on the mortality indicators.

The health of people in Newcastle upon Tyne is generally worse than the England average. Newcastle upon Tyne is one of the 20% most deprived districts/unitary authorities in England and about 25% (12,000) of children live in low income families.

Life expectancy is 12.9 years lower for men and 10.4 years lower for women in the most deprived areas of Newcastle upon Tyne than in the least deprived areas.

The trust has 1729 beds and employed 14,604 members of staff. During 2017/18, the trust saw 207,813 inpatient admissions, 1,260,900 outpatient attendances, 201,262 accident and emergency attendances and delivered 6,500 babies, carried out over 400 transplants and performed 588,000 scans and over 3 million lab tests. There were 1861 in-hospital deaths.

## Overall summary

Our rating of this trust stayed the same since our last inspection. We rated it as Outstanding   

## What this trust does

The Newcastle upon Tyne Hospitals NHS Foundation Trust (NuTH) achieved foundation status in 2006. The acute trust was established in 1998 following the merger of the Royal Victoria Infirmary and Associated Hospitals NHS Trust and the Freeman Group of Hospitals NHS Trust. It is one of the largest teaching hospitals in England providing academically led acute, specialist and community services for adults and children to a large and diverse population across the North East and Cumbria as well as nationally and internationally.

The trust operated from six registered locations.

- The Royal Victoria Infirmary (which includes the Great North Children's Hospital)
- The Freeman Hospital (which includes the Northern Cancer Centre and Institute of Transplantation)

# Summary of findings

- Campus for Ageing and Vitality
- The Dental Hospital
- The Centre for Life
- The Regional Drug and Therapeutics Centre.

The Trust continues to pride itself on the delivery of outstanding services and this is reflected in positive staff and patient experience feedback. The Trust operates across a number of locations including acute sites (Freeman Hospital and Royal Victoria Infirmary) along with the Campus for Ageing and Vitality (CAV) and Centre for Life and a number of community sites.

The trust currently provides over 1700 inpatient beds, 507 day-case beds and 3500 outpatient clinics per week. The trust employs approximately 14,500 staff. During 2017/18, there were 207,813 inpatient admissions and 1,260,900 outpatient attendances. During the same period there were 205,864 accident and emergency attendances and 1847 deaths. Between July 2017 and June 2018 6,244 deliveries at the trust.

Trust services are commissioned by Newcastle and Gateshead Clinical Commissioning Group (CCG), however also have contracting arrangements with 11 CCGs, three local authorities and NHS England. The Trust delivers comprehensive list service portfolios with a range of specialist services to other commissioners across the country via individual contract arrangements. The Trust currently has 81 Wards, 136 Critical Care beds, 62 operating theatres and has approximately 14,500 staff across a number of professions and staff groups. The Trust saw in excess of 1.9 million patients in 2017/18 which is comparable with the previous year.

The CQC has carried out a number of inspections of the trust; the last comprehensive inspection of the acute services was in January 2016. We rated effective, caring, responsive and well led as outstanding safe was rated as good. We rated the trust as outstanding overall.

## Key questions and ratings

We inspect and regulate healthcare service providers in England.

To get to the heart of patients' experiences of care and treatment, we ask the same five questions of all services: are they safe, effective, caring, responsive to people's needs, and well-led?

Where we have a legal duty to do so, we rate the quality of services against each key question as outstanding, good, requires improvement or inadequate.

Where necessary, we take action against service providers that break the regulations and help them to improve the quality of their services.

## What we inspected and why

We plan our inspections based on everything we know about services, including whether they appear to be getting better or worse.

Our comprehensive inspections of NHS trusts have shown a strong link between the quality of overall management of a trust and the quality of its services. For that reason, all trust inspections now include inspection of the well-led key question at the trust level. Our findings are in the section headed "is this organisation well-led?"

## What we found

### Overall trust

# Summary of findings

Our rating of the trust stayed the same. We rated it as outstanding because:

- We rated effective, caring, responsive and well-led as Outstanding and safe was rated as good. All five ratings stayed the same as our previous inspection in 2016.
- In rating the trust, we took in to account the current ratings of the services that we did not inspect during this inspection but that we had rated in our previous inspection.
- We rated well led for the trust overall as outstanding. This was not an aggregation of the core service ratings for well led.
- Our full inspection report summarising what we found and the supporting evidence appendix containing detailed evidence and data about the trust is available on our website.

## Are services safe?

Our rating of safe stayed the same. We rated it as good because:

- There were enough medical and nursing staff employed by the trust and staffing levels were acceptable. Staff followed safeguarding processes to protect vulnerable adults and children from abuse and referred suspected cases of abuse to the proper authority in a timely way.
- Staff understood their responsibilities in relation to patients giving consent to treatment and the principles of the Mental Capacity Act 2005 that applied where a patient's capacity to consent was in doubt.
- The end of life service had fully implemented the care of the dying patient document and addressed all the issues we previously identified at our last inspection. Additionally, patient care and outcomes had improved, and the team's thorough education offer to staff on wards had meant that at this inspection, we found that care of the dying really was everyone's business.
- Safety was a priority that the whole team were engaged with. Incidents were rare, and medicines appropriately managed. Information systems shared with local partners underpinned record keeping with paperless notes and clear audit trails.
- All areas we visited were visibly clean and we saw members of the team taking appropriate infection control measures. For example, the mortuary was clean and tidy, and trust cleanliness audits confirmed high standards of cleanliness in all areas.
- The trust had enough staff with the right qualifications, skills, training and experience to keep people safe from avoidable harm and to provide the right care and treatment.
- The trust-controlled infection risk well. Staff kept themselves, equipment and the premises clean. They used control measures to prevent the spread of infection.

However;

- Mandatory training levels were below the trust's 95% target for all staff, however, data provided showed the year to date which was April 2018 to December 2018. However, staff were meeting the trajectory to complete mandatory training by end of March 2019 and could easily access training as required.
- In diagnostics resuscitation trolley checks had not been consistently completed between 1 October 2018 and 16 January 2019.
- The service had challenges with paediatric radiologist staffing levels and were under resourced by three paediatric radiologists.

# Summary of findings

## Are services effective?

Our rating of effective stayed the same. We rated it as outstanding because:

- The trust had evidence-based policies and procedures relating to care, which were easily accessible to staff and were audited regularly to ensure that staff were following relevant clinical pathways.
- There was strong evidence of different disciplines of staff from across the trust working well together throughout the trust.
- The end of life team was stable, experienced and committed. The team's focus on continuous development meant that standards were constantly rising. Topic specific sub groups ensured that any areas in need of improvement remained 'on the radar' and progress was regularly checked. Staff were given sufficient time to develop new and innovative ways to improve.
- Staff were well supported to develop in their role, acquiring new skills and sharing best practice. New team members were given extended protected time to enable them to become fully embedded within the team and staff spoke very positively about how they felt 'invested in'. The team's extensive skills and knowledge were effectively cascaded to wider hospital staff through numerous training opportunities.
- All staff were actively involved in monitoring quality and outcomes for patients. The service took part in local and national benchmarking and was one of the pilot organisations developing the national palliative care dataset. Patients had positive and consistent outcomes as a result.
- Staff, teams and services were working collaboratively and were using innovative ways of delivering joined up care. People's discharge was discussed and planned at the earliest stage possible and patients received the same quality of care seven days a week.

## Are services caring?

Our rating of caring stayed the same. We rated it as outstanding because:

- Staff provided holistic care to patients. They maintained patients' privacy and dignity and dealt with people in a kind and compassionate way. Staff treated patients as individuals and the care they provided met people's physical and mental health needs. Families and carers were also offered support when staff identified this was needed.
- People were truly respected and valued as individuals and were empowered as partners in their care, practically and emotionally by an exceptional and distinctive service.
- Patients and those closest to them were active partners in their care. They knew what the plan was for their care, and where appropriate, had discussed their preferred place of death with staff.
- Staff 'went the extra mile' to support patients and we heard of multiple examples of additional support such as arranging emergency accommodation for vulnerable patients' pet dogs. They also voluntarily provided extra touches such as providing and arranging flowers for the mortuary viewing rooms.
- There was a chaperone policy and chaperones were available to patients as needed. In diagnostics staff were aware of patients who may be anxious of claustrophobic and supported patients as needed. Patients could visit the department before an appointment to reduce anxiety if required.

However:

- While privacy and dignity were maintained in the diagnostics department areas visited, there were occasions during the inspection where patients were waiting to be seen on beds in the corridors on the main x-ray department which did not support a patient's privacy and dignity whilst in the department.

# Summary of findings

- During the inspection there was limited evidence staff in diagnostics had access to communication aids to enhance communication with people with additional needs where required.

## Are services responsive?

Our rating of responsive stayed the same. We rated it as outstanding because:

- The emergency department was mostly meeting the target for patients to be admitted or treated and discharged within four hours, although this was a challenge.
- The emergency department was performing better than the England average for a number of other performance measures relating to the flow of patients thus indicating patients were receiving the most appropriate care in a timely manner.
- The views and opinions of patients were important, and the trust engaged with hard to reach patient groups to improve their patient journey experience.
- People's spiritual care was well catered for, and the chaplaincy team could accommodate the preferences and needs of people from all faiths, or no faith.
- Families of people nearing the end of their life in hospital were very well supported by the team's specialist healthcare assistants. They provided reduced fees for car parking, comfort packs, shared diaries and respite breaks for those at the bedside as well as hot drinks and a chance to talk.
- People knew how to give feedback about their experiences and could do so in a variety of ways. The end of life service received very few concerns and complaints, but treated these seriously, investigated them and learned lessons from the results.

However:

- The diagnostics service did not meet the reporting time targets. To assist in addressing challenges with reporting times, the trust had recently started to outsource some MRI and CT elective reporting work.
- The diagnostics service did not always meet the two-week urgent waiting time targets.

## Are services well-led?

Our rating of well-led stayed the same. We rated it as outstanding because:

- Leaders were experienced and had the right skills and abilities to provide high quality, sustainable care. Service managers were focussed on the quality issues, priorities and challenges for the team.
- There was an inclusive, learning and supportive culture in the trust for example by the approach the trust took to dealing with incidents and complaints.
- Staff felt appreciated by their colleagues and managers.
- The culture in the trust supported staff to deliver good patient care. Staff were encouraged and supported to be innovative and we saw examples of innovative ways of working.
- Staff felt there was strong supportive, forward thinking, innovative leadership within the trust.
- The End of Life team were passionate about continuous improvement and had been nominated for and won regional and national awards. Learning from practice, both positive and negative, was central and discussed at each team meeting. The team had made positive improvements since our last inspection and had addressed all the issues previously highlighted.

However:

# Summary of findings

- Leadership in the end of life service was shared by medical and nursing staff in different directorates. While this was working effectively, the lack of an operations manager had the potential to restrict future development of the service.

## Ratings tables

The ratings tables show the ratings overall and for each key question, for each service, hospital and service type, and for the whole trust. They also show the current ratings for services or parts of them not inspected this time. We took all ratings into account in deciding overall ratings. Our decisions on overall ratings also took into account factors including the relative size of services and we used our professional judgement to reach fair and balanced ratings.

## Outstanding practice

We found examples of outstanding practice across the trust in all core services we inspected. For more information, see the Outstanding practice section of this report.

## Areas for improvement

For more information, see the Areas for improvement section of this report.

## Action we have taken

For more information on action we have taken, see the sections on Areas for improvement and Regulatory action.

## What happens next

We will check that the trust takes the necessary action to improve its services. We will continue to monitor the safety and quality of services through our continuing relationship with the trust and our regular inspections.

## Outstanding practice

### Urgent and Emergency Care

- The department continued to deliver performance very close to national standards and was consistently better than the England average for all performance metrics.
- The culture around incidents was open, responsive, fair and proactive. All staff took incidents seriously and the feedback and investigation processes were positive and robust.
- The department produced a handbook for new staff detailing previous incidents as a way of improving safety and making sure new starters benefitted from previous lessons learned.
- Clinical audit and clinical effectiveness were given high priority within the department and electronic record systems were effectively used to reduce administrative burden on staff and deliver easily accessible information for analysis.
- Post discharge calls were made to frail, elderly and vulnerable patients to follow up and check whether they needed any extra support once home.
- Rapid Assessment and Treatment (RAT) for ambulance patients made sure patients did not wait in queues in corridors and were handed over quickly. This released ambulance crews quickly and made sure patients started treatment quickly.
- The process for receiving comprehensive handover for patients brought in as a major trauma was professional, well-rehearsed, focussed and slick. Every member of staff knew exactly their role.

# Summary of findings

- Staff looked at the patient and their family unit as a whole and as individuals, identified when relatives or carers needed support, signposted them to support services and gave them information to ensure their needs were supported.
- The department had a stock of clothes for patients to wear had they arrived in soiled clothing. This was to protect their dignity. Vulnerable patients such as the homeless were encouraged to take additional clothes if they needed them.
- The department had prepared information to give to children whose parent or sibling had passed away.
- The extended role of the patient flow coordinator reduced the administrative burden on clinical staff, improved the efficiency of staff once test results had been received and sped up the administrative process when patients were transferred to wards.
- Clinical educators organised or delivered training supported by specialties to improve nurses' medical knowledge of management of patients in the department.
- Clinical research took place in the department and was seen as an important way of improving care for patients.
- The department was highly rated by medical students and junior doctors as a good place to study and work.

## End of life

- The team were part of the pilot to develop a Public Health England dataset for palliative care in 2015. As early adopters, they have continued to use this dataset to inform their daily discussions of patient care.
- Nurse specialists entering the end of life team were supernumerary for the first six months in post. They did see patients but were also offered extensive shadowing and development opportunities and given the chance to develop their own interests.
- Mortuary and chaplaincy staff provided exceptional support to families of deceased patients, continuing the highest standards of privacy and dignity after death and ensuring that those closest to the patient were emotionally and spiritually supported. The viewing rooms in the mortuary provided bespoke environments to meet individual needs.
- The team worked with a local domestic gas company to provide emergency gas safety certificates for people whose discharge home could be delayed because they had a gas appliance in the room where their bed would need to be. The gas company provided this service the same day or early the following morning, free of charge.
- Links had been established with a local charity supporting homeless people and some workers had been trained to assess whether people they supported could be nearing the end of their life. A local hostel worked with the charity and team to provide end of life care in a safe environment. Chaplaincy services could refer people's dogs for emergency accommodation if needed.
- The team attended group supervisions with a clinical psychologist. This was an opportunity to discuss troubling or difficult cases in a safe environment. These sessions were protected time and ensured that the emotional wellbeing of staff was always a high priority.
- The team had led nationally on a piece of work overseeing the withdrawal of ventilation for end of life patients in a home setting. They have conducted more withdrawals than anywhere in the county and findings were presented internationally.

## Diagnostic Imaging

- The service was committed to improving services by learning from when things went well or wrong, promoting training, research and innovation. The service participated in research and developed its services and staff to provide care and treatment to patients.



# Summary of findings

- There was evidence in the departments of quality improvement and innovation to provide a better service to patients.

## Areas for improvement

### **Urgent and Emergency Care**

The provider should:

- Ensure staff continue the trajectory to meet the 95% mandatory training compliance rate for all subjects including safeguarding vulnerable adults and children.
- Ensure the new system for carrying out routine observations of patients is fully embedded within the department.
- Ensure staff within the paediatric department act when fridge temperatures exceed maximum levels to maintain the integrity of temperature sensitive medicines and evidence this action.
- Ensure staff fully complete FP10 information within logs as required and have a robust quality assurance system in place to provide evidence of completion.
- The department may wish to consider the environment of the relatives' room to make it more of a friendly and welcoming place.
- Continue work to address unplanned reattendances.
- Support security staff to access appropriate mental health training and provide them with the facility to debrief with other staff in the department after an incident.

### **End of Life**

The provider should:

- Consider whether an operations manager or other operational resource would strengthen the team's leadership and governance.

### **Diagnostics**

The provider must:

- Ensure resuscitation trolley checks are completed as required.
- Continue to address waiting times and reporting times and achieve their targets.

The provider should:

- Continue to address paediatric radiologist staffing level shortages.
- Ensure mandatory training targets including safeguarding training are achieved.
- Continue to implement the World Health Organisation (WHO) checklist and audit as required.
- Consider ways to improve privacy and dignity on patients attending the diagnostic imaging department.
- Consider communication aids to assist in communication with patients as required

# Summary of findings

## Is this organisation well-led?

Our comprehensive inspections of NHS trusts have shown a strong link between the quality of overall management of a trust and the quality of its services. For that reason, we look at the quality of leadership at every level. We also look at how well a trust manages the governance of its services – in other words, how well leaders continually improve the quality of services and safeguard high standards of care by creating an environment for excellence in clinical care to flourish.

This was our first review of well led at the trust under our next phase methodology. We rated well led as outstanding because:

- There was compassionate, inclusive and effective leadership at all levels. Leaders at all levels demonstrated high levels of experience, capacity and capability needed to deliver excellent and sustainable care.
- Leaders at all levels were highly visible and approachable, for example visiting clinical areas within the organisation and attending leadership conferences.
- There was an embedded system of leadership development and succession planning. There were plans in place to improve the diversity of the leaders at all levels within the organisation.
- The leadership was knowledgeable about issues and priorities for the quality and sustainability of services and understanding the challenges which will impact on the trust and acted to address them.
- There was a strategy which included supporting objectives, plans were stretching, challenging and innovative, while remaining achievable. There was a new strategy in the process of being developed all staff we spoke with informed us it was fully aligned with plans in the wider health economy, and there was a trust wide commitment to system-wide collaboration and leadership.
- There was a systematic and integrated approach to monitoring, reviewing and providing evidence of progress against the strategy. We found evidence where plans were consistently implemented and had a positive impact on quality and sustainability of service.
- Leaders had an inspiring shared purpose, which, encouraged compassionate, inclusive and supportive relationships among staff so that they felt respected, valued and supported. The corner stone initiative call flourish was used to support staff to promote health and wellbeing. Leaders at every level live the vision and embody shared values, prioritise high-quality, sustainable and compassionate care, and promote equality and diversity. They encouraged pride and positivity in the organisation and focused attention on the needs and experiences of people who used services. For example, all staff we spoke with told us and demonstrated the trust core value of *“Putting patients at the heart of everything we do”*.
- We found there was strong collaboration, team-working and support across all functions and multidisciplinary teams. There was a common focus on improving the quality and sustainability of care and people’s experiences.
- The board and other levels of governance within the organisation functioned effectively. We found they interacted with each other appropriately. Structures, processes and systems of accountability, including the governance and management of partnerships, joint working arrangements and shared services, were clearly set out, understood and effective.
- The trust had sought an independent review of the governance structures and were due to implement the new streamlined governance with the trust strategy in the new financial year.

# Summary of findings

- The organisation had processes in place to manage current and future performance. There was a robust process to identify, understand, monitor and address current and future risks. Performance issues were escalated to the appropriate committees and the board through established structures and processes.
- Clinical and internal audit processes worked well and had a positive impact on quality governance. Financial pressures were managed so that they did not compromise the quality of care. Service developments and efficiency changes were developed and led by all member of the team including clinicians. Improvement initiatives were supported by experts in the field through the research and innovation hub, this ensured the quality of care was well understood.
- The trust invested in innovative and best practice information systems and processes, in addition the trust was recognised as Global Digital Exemplar. The information used in reporting, performance management and delivering quality care was consistently found to be accurate, valid, reliable, timely and relevant.
- There was a demonstrated commitment at all levels to sharing data and information proactively to drive and support internal decision making as well as system-wide working and improvement. For example, the trust was leading on the great north care record which was a new way of sharing medical information across the North East and North Cumbria.
- There were consistently high levels of constructive engagement with staff and people who use services, including a wide range of equality groups. There was evidence of constructive challenge from people who use services, the public and stakeholders. The board welcomed and saw using the peoples voice as a vital way of holding services to account.
- Services were developed with the full participation of those who used them. We were told staff and external partners were seen as equal partners.
- The trust took a leadership role in the health system to identify and proactively address challenges to meet the needs of the populations of the North East and North Cumbria.
- There was an embedded, systematic approach to improvement, which made use of a recognised improvement methodology. Improvement was seen as a way to learn and enhanced performance.
- Improvement methods and skills were available through the research and innovation hub and were available and used across the organisation. All staff we spoke with informed us they were empowered to lead and deliver change. All innovation was celebrated. There was a clear, systematic and proactive approach to seeking out and embedding new and sustainable models of care. There was a strong record of sharing work locally, nationally and internationally.

## Use of resources

Please see the separate Use of Resources report for details of the assessment and the combined rating.

## Ratings tables

Key to tables					
Ratings	Not rated	Inadequate	Requires improvement	Good	Outstanding
Rating change since last inspection	Same	Up one rating	Up two ratings	Down one rating	Down two ratings
Symbol *	↔	↑	↑↑	↓	↓↓
Month Year = Date last rating published					

\* Where there is no symbol showing how a rating has changed, it means either that:

- we have not inspected this aspect of the service before or
- we have not inspected it this time or
- changes to how we inspect make comparisons with a previous inspection unreliable.

### Ratings for the whole trust

Safe	Effective	Caring	Responsive	Well-led	Overall
Good ↔ May 2019	Outstanding ↔ May 2019	Outstanding ↔ May 2019	Outstanding ↔ May 2019	Outstanding ↔ May 2019	Outstanding ↔ May 2019

The rating for well-led is based on our inspection at trust level, taking into account what we found in individual services. Ratings for other key questions are from combining ratings for services and using our professional judgement.

### Rating for acute services/acute trust

	Safe	Effective	Caring	Responsive	Well-led	Overall
Royal Victoria Infirmary	Good ↑ May 2019	Outstanding ↔ May 2019	Outstanding ↔ May 2019	Outstanding ↔ May 2019	Outstanding ↔ May 2019	Outstanding ↔ May 2019
Freeman Hospital	Good ↔ May 2019	Outstanding ↔ May 2019	Outstanding ↔ May 2019	Outstanding ↔ May 2019	Outstanding ↔ May 2019	Outstanding ↔ May 2019
Dental Hospital	Good Jun 2016	Outstanding Jun 2016	Good Jun 2016	Good Jun 2016	Outstanding Jun 2016	Outstanding Jun 2016
<b>Overall trust</b>	Good ↔ May 2019	Outstanding ↔ May 2019	Outstanding ↔ May 2019	Outstanding ↔ May 2019	Outstanding ↔ May 2019	Outstanding ↔ May 2019

Ratings for the trust are from combining ratings for hospitals. Our decisions on overall ratings take into account the relative size of services. We use our professional judgement to reach fair and balanced ratings.

### Ratings for Royal Victoria Infirmary

	Safe	Effective	Caring	Responsive	Well-led	Overall
Urgent and emergency services	Good ↑ May 2019	Outstanding ↑ May 2019	Outstanding ↑ May 2019	Outstanding ↑ May 2019	Outstanding ↑ May 2019	Outstanding ↑ May 2019
Medical care (including older people's care)	Good Jun 2016	Outstanding Jun 2016	Good Jun 2016	Good Jun 2016	Good Jun 2016	Good Jun 2016
Surgery	Good Jun 2016	Good Jun 2016	Outstanding Jun 2016	Outstanding Jun 2016	Outstanding Jun 2016	Outstanding Jun 2016
Critical care	Outstanding Jun 2016	Outstanding Jun 2016	Outstanding Jun 2016	Good Jun 2016	Outstanding Jun 2016	Outstanding Jun 2016
Services for children and young people	Requires improvement Jun 2016	Outstanding Jun 2016	Outstanding Jun 2016	Outstanding Jun 2016	Outstanding Jun 2016	Outstanding Jun 2016
End of life care	Good ↔ May 2019	Outstanding ↑ May 2019	Outstanding ↑ May 2019	Outstanding ↑ May 2019	Good ↑ May 2019	Outstanding ↑ May 2019
Diagnostic imaging	Good May 2019	Not rated	Good May 2019	Requires improvement May 2019	Good May 2019	Good May 2019
Outpatients and diagnostic imaging	Good Jun 2016	Not rated	Good Jun 2016	Good Jun 2016	Good Jun 2016	Good Jun 2016
Maternity and gynaecology	Good Jun 2016	Outstanding Jun 2016	Outstanding Jun 2016	Good Jun 2016	Outstanding Jun 2016	Outstanding Jun 2016
<b>Overall*</b>	Good ↑ May 2019	Outstanding ↔ May 2019	Outstanding ↔ May 2019	Outstanding ↔ May 2019	Outstanding ↔ May 2019	Outstanding ↔ May 2019

\*Overall ratings for this hospital are from combining ratings for services. Our decisions on overall ratings take into account the relative size of services. We use our professional judgement to reach fair and balanced ratings.

## Ratings for Freeman Hospital

	Safe	Effective	Caring	Responsive	Well-led	Overall
Medical care (including older people's care)	Good Jun 2016	Outstanding Jun 2016	Outstanding Jun 2016	Good Jun 2016	Good Jun 2016	Outstanding Jun 2016
Surgery	Good Jun 2016	Good Jun 2016	Outstanding Jun 2016	Outstanding Jun 2016	Outstanding Jun 2016	Outstanding Jun 2016
Critical care	Outstanding Jun 2016	Outstanding Jun 2016	Outstanding Jun 2016	Good Jun 2016	Outstanding Jun 2016	Outstanding Jun 2016
Services for children and young people	Good Jun 2016	Outstanding Jun 2016	Outstanding Jun 2016	Outstanding Jun 2016	Outstanding Jun 2016	Outstanding Jun 2016
End of life care	Good →← May 2019	Outstanding ↑ May 2019	Outstanding ↑ May 2019	Outstanding ↑ May 2019	Good ↑ May 2019	Outstanding ↑ May 2019
Diagnostic imaging	Good May 2019	Not rated	Good May 2019	Requires improvement May 2019	Good May 2019	Good May 2019
Outpatients and diagnostic imaging	Good Jun 2016	Not rated	Good Jun 2016	Good Jun 2016	Good Jun 2016	Good Jun 2016
<b>Overall*</b>	Good →← May 2019	Outstanding →← May 2019	Outstanding →← May 2019	Outstanding →← May 2019	Outstanding →← May 2019	Outstanding →← May 2019

\*Overall ratings for this hospital are from combining ratings for services. Our decisions on overall ratings take into account the relative size of services. We use our professional judgement to reach fair and balanced ratings.

## Ratings for Dental Hospital

	Safe	Effective	Caring	Responsive	Well-led	Overall
<b>Overall*</b>	Good Jun 2016	Outstanding Jun 2016	Good Jun 2016	Good Jun 2016	Outstanding Jun 2016	Outstanding Jun 2016

\*Overall ratings for this hospital are from combining ratings for services. Our decisions on overall ratings take into account the relative size of services. We use our professional judgement to reach fair and balanced ratings.

## Ratings for community health services

	Safe	Effective	Caring	Responsive	Well-led	Overall
Community health services for adults	Good Jun 2016	Good Jun 2016	Good Jun 2016	Good Jun 2016	Good Jun 2016	Good Jun 2016
Community health services for children and young people	Good Jun 2016	Good Jun 2016	Good Jun 2016	Good Jun 2016	Good Jun 2016	Good Jun 2016
Community end of life care	Good →← May 2019	Good →← May 2019	Outstanding ↑ May 2019	Outstanding ↑ May 2019	Good →← May 2019	Outstanding ↑ May 2019
Community dental services	Good Jun 2016	Good Jun 2016	Good Jun 2016	Good Jun 2016	Good Jun 2016	Good Jun 2016
<b>Overall*</b>	Good →← May 2019	Good →← May 2019	Good →← May 2019	Good →← May 2019	Good →← May 2019	Good →← May 2019

\*Overall ratings for community health services are from combining ratings for services. Our decisions on overall ratings take into account the relative size of services. We use our professional judgement to reach fair and balanced ratings.

# Freeman Hospital

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## Key facts and figures

Freeman Hospital is situated just outside of the city of Newcastle upon Tyne and has over 1000 beds. It opened in 1977, when services from several hospitals across the city and elsewhere in the North East were relocated into one centre.

Freeman Hospital provides a wide range of services including medicine, surgery, critical care, end of life care and outpatients and diagnostic imaging. There are highly specialised services at the hospital, including the UK's first Institute of Transplantation, which opened in 2011, and the Northern Centre for Cancer Care, which opened in 2009.

During this inspection we inspected the emergency department, end of life care and diagnostic imaging core services.

Our inspection was unannounced (staff did not know we were coming) to enable us to observe routine activity.

Before this inspection we reviewed information about the service and after the inspection we requested further information from the trust.

## Summary of services at Freeman Hospital

**Outstanding**   

Our rating of services stayed the same. We rated them as outstanding because:

- People were truly respected and valued as individuals and were empowered as partners in their care, practically and emotionally, by an exceptional and distinctive service. Staff went the extra mile to support their patients. Emotional and spiritual support for patients and their families was second to none. Patients told us the care they received exceeded all expectations.
- Services were tailored to meet the needs of individual people and were delivered in a way to ensure flexibility, choice and continuity of care. Care and treatment were holistically planned in collaboration with patients, making them active partners in their care at all levels.
- We saw evidence of strong, innovative multidisciplinary and multiorganisational working. There was a robust strategic plan in place which demonstrated how the hospital worked with other organisations to ensure care was planned and delivered to meet the needs of patients in a sustainable, future proof way.



# Summary of findings

- Specialist knowledge and expertise was readily accessible. Staff were proactively supported to acquire new skills and share best practice. Research and quality improvement were embedded in practice. All staff were actively engaged in monitoring and improving quality and outcomes for patients.
- The leadership, governance and culture were used to drive and improve the delivery of high-quality person-centred care. Leaders set stretching, innovative objectives and conducted in depth analysis and planning as to how they would be achieved.
- Staff were empowered to suggest and deliver changes and were encouraged to be innovative. Staff told us they felt strongly supported and invested in by leadership.

# End of life care

**Outstanding** ☆ ↑

## Key facts and figures

The trust provided end of life care at the Freeman Hospital. End of life care covered all care given to patients who are approaching the end of their life and following their death. It could be delivered on any ward or within any area of a trust. It included medical and nursing care, specialist palliative care, bereavement support, chaplaincy and mortuary services.

The trust had 1,800 deaths from July 2017 to June 2018.

*(Source: Hospital Episode Statistics)*

End of life care was last inspected as part of our comprehensive inspection programme in 2016. We rated safe, effective, caring and responsive as good, and well led as requires improvement.

At this hospital there was no dedicated inpatient end of life ward and patients received end of life care on general wards. General ward staff were supported by specialist end of life teams consisting of nurse specialists, consultants in palliative medicine, Macmillan end of life healthcare assistants and administrative/clerical support staff. Bereavement services, chaplaincy and mortuary teams completed the holistic service. Ward staff received education and training from these teams as well as accessing specialist support.

The end of life service was available 24 hours a day, including access to specialist medical and nursing care, and an on-call chaplaincy and mortuary service.

During this inspection, we visited Wards 2, 3, 7, 34 and 35. We also visited bereavement services, chapels and faith rooms, chapels of rest and the mortuary.

At this inspection we inspected all five domains.

Our inspection was unannounced (staff did not know we were coming) to enable us to observe routine activity.

Before this inspection, we reviewed information about the service and after the inspection we requested further information from the trust.

During our visit, the inspection team spoke with one patient and their relatives, and 13 members of staff including consultants, junior doctors, clinical support workers, nurses and therapists. We checked six sets of patient records and five 'Do Not Attempt CPR' forms.

## Summary of this service

Our rating of this service improved. We rated it as outstanding because:

- The service had fully implemented the care of the dying patient document and addressed all the issues we previously identified at our last inspection. Additionally, patient care and outcomes had improved and the team's education and training for staff on wards had meant that at this inspection, we found that care of the dying really was everyone's business.
- People were truly respected and valued as individuals. Staff went the extra mile to support their patients and people were positive about their care and treatment. Emotional and spiritual support for patients and their families was of a very high standard. second to none.

# End of life care

- The staff team were stable, experienced and committed. The team's focus on continuous development meant that standards were constantly rising. Topic specific sub groups ensured that any areas in need of improvement remained 'on the radar' and progress was regularly checked. Staff were given sufficient time to develop new and innovative ways to improve.
- There was a 'can-do' approach to end of life care when it came to people's individual needs and preferences. The team were proactive in seeking solutions to barriers to fulfilling these and were willing not afraid to try new things to ensure patients' care was right for them. People with protected characteristics under the Equality Act (2010) were offered care in a way that was tailored to suit them and empower them to make as many decisions about their care and their death as they wished.
- Safety was a priority that the whole team were engaged with. Incidents were rare, and medicines appropriately managed. Information systems shared with local partners underpinned record keeping with paperless notes and clear audit trails.
- Care and treatment were holistically planned in collaboration with patients and other local providers. Patients were identified earlier than at our last inspection, seen earlier by the specialist team, and discharged home earlier if this was their preference, leading to overall improvements in outcomes.
- Leadership was strong and compassionate. The team's vision and strategy were well articulated and progress against three-year plans was regularly checked. Ward staff had more awareness of the team's key documents than at our previous inspection. Staff contributed to research and the development of national guidance and conducted regular audits of their service.

However:

- The service was not meeting the trust's 90% target for staff receiving an annual appraisal. Medical staff appraisal rates were 62.5% and qualified nursing staff 77% at the time of our inspection.
- Leadership was shared by medical and nursing staff in different directorates. While this was working effectively, the lack of an operations manager had the potential to restrict future development of the service.

## Is the service safe?

Good   

Our rating of safe stayed the same. We rated it as good because:

- The service had enough staff with the right qualifications, skills, training and experience to keep people safe from avoidable harm and to provide the right care and treatment in line with national guidance. We saw evidence of an experienced, stable team who valued teaching and learning highly.
- Staff knew how to report an incident using the trust's electronic system and were aware of the importance of doing this. When things went wrong, staff apologised and gave patients honest information and suitable support. There were clear routes for feedback and learning from incidents to be shared and they were using these effectively.
- Staff understood how to protect patients from abuse and the service worked well with other agencies to do so. Staff had training on how to recognise and report abuse and they knew how to apply it.
- Staff kept detailed records of patients' care and treatment. Records were clear, up-to-date and easily available to all staff providing care. This extended to colleagues working in the community, hospices, ambulances and GP surgeries.

# End of life care

- All areas we visited were visibly clean and we saw members of the team taking appropriate infection control measures. The mortuary was clean and tidy, and trust cleanliness audits confirmed high standards of cleanliness in areas delivering end of life care.
- Specialist equipment was well maintained and accessible. Syringe drivers, used to give medicines to end of life patients, were looked after by staff with the correct competencies and were always available when needed.
- Medicines were appropriately prescribed and given. Patients received the right medication at the right dose at the right time. The service conducted regular audits to ensure that this remained the case and provided regular support to ward staff on this topic.
- Staff assessed risks to patients daily as part of a routine review of their care and ongoing evaluation, and a consultant was on call 24 hours a day to review patients as needed.

However:

- Mandatory training levels were below the trust's 95% target for nursing, mortuary, chaplaincy and bereavement services staff. At this inspection, information provided by the trust showed compliance for this site had deteriorated, with nursing staff meeting the 95% target in eight of 13 training courses. Staff were meeting the trajectory to complete mandatory training by end of March 2019 and could easily access training as required.

## Is the service effective?

**Outstanding**  

Our rating of effective improved. We rated it as outstanding because:

- End of life care services were well resourced, and we observed an entirely holistic approach to the assessment, planning and delivery of care and treatment to patients. Patients in need of end of life care were identified at an earlier stage in their care and the issues we found with syringe drivers at our previous inspection had been resolved. The trust had now fully implemented the care of the dying patient document which was being used as a guide to delivering high-quality end of life care.
- Staff were well supported to develop in their role, acquiring new skills and sharing best practice. New team members were given extended protected time to enable them to become fully embedded within the team and staff spoke very positively about how they felt 'invested in'. The team's extensive skills and knowledge were effectively cascaded to wider hospital staff through numerous training opportunities.
- The team attended group supervisions with a clinical psychologist. This was an opportunity to discuss troubling or difficult cases in a safe environment.
- All staff were actively involved in monitoring quality and outcomes for patients. The service took part in local and national benchmarking and was one of the pilot organisations developing the national palliative care dataset. Patients had positive and consistent outcomes as a result. The team were piloting an enhanced supportive care package which was undergoing evaluation to show the added benefit to patients suggested by initial feedback.
- The service provided care and treatment based on national guidance and evidence of its effectiveness. The trust had an implementation policy for National Institute of Health and Clinical Excellence guidelines and a sub-committee of the trust board was responsible for monitoring compliance. Non-compliance was escalated to the trust board.
- The team had led nationally on a piece of work overseeing the withdrawal of ventilation for end of life patients in a home setting. They had conducted more withdrawals than anywhere in the county and findings were presented internationally.

# End of life care

- Staff, teams and services were working collaboratively and were using innovative ways of delivering joined up care. People's discharge was discussed and planned at the earliest stage possible and patients received the same quality of care seven days a week.
- People's need for food and drink was assessed and revisited regularly. Staff used special techniques if people had difficulty eating or drinking. Personal preferences were discussed with patients and adjustments made as necessary.
- Staff assessed and monitored patients regularly to see if they were in pain. A suitable assessment tool was in use to support those unable to communicate verbally, and staff gave pain relief when needed.
- Consent to care and treatment was obtained in line with legislation, and staff understood how and when to assess whether someone had the capacity to make decisions about their care. Staff followed trust policies when a person could not give consent.

However:

- The service was not meeting the trust's 90% target for staff receiving an annual appraisal. Medical staff appraisal rates were 62.5% and qualified nursing staff 77% at the time of our inspection. Staff were meeting the trajectory to complete appraisals by end of March 2019.

## Is the service caring?

**Outstanding**  

Our rating of caring improved. We rated it as outstanding because:

- People were truly respected and valued as individuals and were empowered as partners in their care, practically and emotionally by an exceptional and distinctive service.
- Patients and those closest to them were active partners in their care. They knew what the plan was for their care, and where appropriate, had discussed their preferred place of death with staff.
- Staff 'went the extra mile' to support patients and we heard of multiple examples of additional support such as arranging emergency accommodation for vulnerable patients' pet dogs. They also voluntarily provided extra touches such as providing and arranging flowers for the mortuary viewing rooms.
- The mortuary and chaplaincy teams provided exceptional support to families of deceased patients, continuing the highest standards of privacy and dignity after death and ensuring that those closest to the patient were emotionally and spiritually supported.
- Feedback from people who used the service and those closest to them was extremely positive and regular surveys showed this was an improving picture. People's communication needs, and experiences were regularly audited and the team were constantly looking to improve practice and learn from this.
- Staff provided multiple examples of how their determination and creativity had overcome obstacles to delivering care. They spoke proudly and passionately about how they worked together with patients to achieve the best outcomes for them, and this respect and compassion continued after the patient's death.
- Staff were motivated to provide very high standards of care for patients which had been officially recognised by the trust's senior leaders. Ward staff spoke very positively about the team's input and the difference that this had made to patients.

# End of life care

## Is the service responsive?

**Outstanding**  

Our rating of responsive improved. We rated it as outstanding because:

- Services were tailored to meet the needs of individual people and were delivered in a way that ensured flexibility, choice and continuity of care. People's needs, and preferences were central to the planning and delivery of care. People's preferred place of death was recorded and audited regularly, and fulfilled preferences were in line with the national average. The team's recording of preferred place of death had risen from 39% to 99.5% in the last two years.
- The team were proactive in understanding the needs and preferences of different groups. Their innovative work with a charity supporting people who were homeless, and the LGBT community were just two of several examples where the team worked collaboratively and with purpose to improve patients' experience of care.
- The team's enhanced supportive care pilot project, supporting over 200 patients, had led to a reduction in the number of emergency admissions for patients with certain forms of cancer who were receiving better joined up care in their own homes.
- Staff were motivated to 'go the extra mile' in their care for patients and would find innovative ways of supporting patients' preferences. As a result, almost all people who wished to die at home were supported to do so.
- We heard examples of the team working with domestic gas companies to provide emergency gas safety certificates to prevent delayed discharges. The gas company provided this service promptly and free of charge.
- Care and treatment was available when needed and the team visited new referrals promptly. The specialist team saw 87% of people the same day, and 97% within 24 hours. Work was ongoing with external local and regional partners to ensure that people received seamless care, treatment and support.
- People's spiritual care was well catered for, and the chaplaincy team could accommodate the preferences and needs of people from all faiths, or no faith.
- Links had been established with a local charity supporting homeless people and some workers were trained to assess and support people nearing the end of their life.
- Families of people nearing the end of their life in hospital were very well supported by the team's specialist healthcare assistants. They provided reduced fees for car parking, comfort packs, shared diaries and respite breaks for those at the bedside as well as hot drinks and a chance to talk.
- People knew how to give feedback about their experiences and could do so in a variety of ways. The service received very few concerns and complaints, but treated these seriously, investigated them and learned lessons from the results.

## Is the service well-led?

**Good**  

Our rating of well-led improved. We rated it as good because:

- Leaders were experienced and had the right skills and abilities to provide high quality, sustainable care. Service managers were focussed on the quality issues, priorities and challenges for the team.

# End of life care

- There was a clear vision and three-year strategy that focused on the early identification of patients at the end of life, and the strategy communicated the goal of integrated services at the centre of patient care. This had been co-produced with the regional network and the needs of the local population were carefully considered. A quarterly strategy group meeting monitored progress.
- Managers promoted a positive culture and staff felt valued and supported. There was a clear sense of common purpose based on shared values. Staff at all levels valued their teammates and were collaborative and respectful. The team's ethos that caring for the dying was everyone's business was embedded across the hospital.
- The team had a comprehensive approach to continually improving the quality of its services, underpinned by a robust audit programme. High standards of care were secured by promoting an environment in which excellence in clinical care would flourish. Governance provided continuing assurance up to board level.
- The team had effective systems for identifying risks, planning to eliminate or reduce them, and coping with both the expected and unexpected. The team's risk register was part of a wider document but easily filtered, and staff knew their current risks, which all related to short term project funding.
- The service engaged well with patients, staff, the public and local organisations to plan and manage appropriate services and collaborated with partner organisations effectively.
- The team were passionate about continuous improvement and had been nominated for and won regional and national awards. Learning from practice, both positive and negative, was central and discussed at each team meeting. The team had made positive improvements since our last inspection and had addressed all the issues previously highlighted.

However:

- Leadership was shared by medical and nursing staff in different directorates. While this was working effectively, the lack of an operations manager had the potential to restrict future development of the service.

## Outstanding practice

- The team were part of the pilot to develop a Public Health England dataset for palliative care in 2015. As early adopters, they have continued to use this dataset to inform their daily discussions of patient care.
- The service took part in local and national benchmarking and was one of the pilot organisations developing the national palliative care dataset.
- Nurse specialists entering the end of life team were supernumerary for the first six months in post. They did see patients but were also offered extensive shadowing and development opportunities and given the chance to develop their own interests.
- The team worked with a local gas company to provide emergency gas safety certificates for people whose discharge home could be delayed because they had a gas appliance in the room where their bed would need to be. The gas company provided this service the same day or early the following morning, free of charge.
- Links had been established with a local charity supporting homeless people and some workers had been trained to assess whether people they supported could be nearing the end of their life. A local hostel worked with the charity and team to provide end of life care in a safe environment. Chaplaincy services could refer people's dogs for emergency accommodation if needed.
- The team attended group supervisions with a clinical psychologist. This was an opportunity to discuss troubling or difficult cases in a safe environment. These sessions were protected time and ensured that the emotional wellbeing of staff was always a high priority.

# End of life care

- The team had led nationally on a piece of work overseeing the withdrawal of ventilation for end of life patients in a home setting. They have conducted more withdrawals than anywhere in the county and findings were presented internationally.
- A member of the team was awarded the Dundas Medal (a national palliative care award) in 2018. They had worked with heart and lung transplant teams to provide care to this group of patients, who did not normally receive palliative care but did have an unmet need. Feedback had been overwhelmingly positive and led to improved support for this group of patients.

## Areas for improvement

We found areas for improvement in this service.

The provider should:

- Consider whether an operations manager or other operational resource would strengthen the team's leadership and governance.



# Diagnostic imaging

Good 

## Key facts and figures

The imaging specialties at the Freeman Hospital included computed tomography (CT), magnetic resonance imaging (MRI), Ultrasound, Plain Film X-ray, Fluoroscopy, Gamma cameras and single photon emission computed tomography (SPECT) CT.

Interventional Radiology was provided at the Freeman Hospital and there was a nuclear medicine department at the Freeman Hospital.

Diagnostic imaging provided services to adults and children at the Freeman Hospital.

There were around 499,985 examinations provided across the trust for diagnostic imaging between April 2017 and March 2018. This included approximately 66,780 CT examinations, approximately 81,970 diagnostic ultrasonography, approximately 28,370 fluoroscopy examinations, 52,375 MRI examinations, Approximately 260,000 plain film x-rays and approximately 575 SPECT CT examinations.

The nuclear medicine department carried out approximately 12,000 procedures across the trust each year.

*(Source: Acute provider information request – context)*

We previously inspected diagnostic imaging jointly with outpatients, so we cannot compare our new ratings directly with previous ratings.

The service had an ionising radiation medical exposure regulation (IR(ME)R) inspection from the Care Quality Commission (CQC) in July 2018. Following the IR(ME)R inspection an improvement notice was issued, and this was removed prior to this inspection following submission by the trust of a compliant action plan.

During the inspection we visited the main x-ray department, fluoroscopy, Cardiology diagnostics, ultrasound, Magnetic Resonance Imaging (MRI), Computed Tomography (CT) at the Freeman Hospital.

During the inspection we spoke with 20 staff, 13 patients and reviewed four records and safety forms.

Our inspection was unannounced (staff did not know we were coming) to enable us to observe routine activity.

## Summary of this service

We previously inspected diagnostic imaging jointly with outpatients, so we cannot compare our new ratings directly with previous ratings.

We rated this service as good because:

- Staff understood how to protect patients from abuse and the service worked well with other agencies to do so. Staff had training on how to recognise and report abuse, and they knew how to apply it.
- The service controlled infection risk well. Staff kept themselves, equipment and the premises clean. They used control measures to prevent the spread of infection.
- The service had suitable premises and equipment and looked after them well.
- The service had enough staff with the right qualifications, skills, training and experience to keep people safe from avoidable harm and to provide the right care and treatment.

# Diagnostic imaging

- Staff kept detailed records of patients' care and treatment. Records were clear, up-to-date and easily available to all staff providing care.
- The service followed best practice when prescribing, giving, recording and storing medicines. The service managed patient safety incidents well.
- The service provided care and treatment based on national guidance and evidence of its effectiveness. Managers monitored the effectiveness of care and treatment and used the findings to improve them. Staff of different kinds worked together as a team to benefit patients.
- Staff understood how and when to assess whether a patient had the capacity to make decisions about their care.
- Staff cared for patients with compassion. Feedback from patients confirmed that staff treated them well and with kindness. Staff provided emotional support to patients to minimise their distress. Staff involved patients and those close to them in decisions about their care and treatment.
- The service planned and provided services in a way that met the needs of local people. The service took account of patients' individual needs. People could access the service when they needed it.
- The service treated concerns and complaints seriously, investigated them and learned lessons from the results, and shared these with all staff.
- Managers at all levels in the service had the right skills and abilities to run a service providing high-quality sustainable care. The service had a vision for what it wanted to achieve and workable plans to turn it into action.
- Managers across the service promoted a positive culture that supported and valued staff, creating a sense of common purpose based on shared values.
- The service systematically improved service quality and safeguarded high standards of care by creating an environment for excellent clinical care to flourish.
- The service had good systems to identify risks, plan to eliminate or reduce them, and cope with both the expected and unexpected.
- The service collected, analysed, managed and used information well to support all its activities, using secure electronic systems with security safeguards.
- The service engaged well with patients, staff, the public and local organisations to plan and manage appropriate services and collaborated with partner organisations effectively.
- The service was committed to improving services by learning from when things went well or wrong, promoting training, research and innovation.

However:

- The service did not meet the diagnostic imaging reporting time targets. To assist in addressing challenges with reporting times, the trust had recently started to outsource some MRI and CT elective reporting work.
- The service did not always meet the two-week urgent waiting time targets.
- While mandatory training was provided to all staff and managers told us staff were being asked to complete it, mandatory training compliance rates were not achieving the 95% target the trust set. Mandatory safeguarding training compliance did not achieve the trust target. Mandatory training and safeguarding training compliance was between April 2018 and April 2019 and therefore was expected to improve as the year progressed.
- Resuscitation trolley checks had not been consistently between 1 October 2018 and 16 January 2019.

# Diagnostic imaging

- The service had challenges with paediatric radiologist staffing levels and were under resourced by around three paediatric radiologists.
- The interventional radiology department used the World Health Organisation (WHO) safety checklist. However, audit of the checklist had only recently commenced.
- While privacy and dignity was maintained in department areas visited. There were occasions during the inspection where patients were waiting to be seen on beds in the corridors on the main x-ray department which did not support a patient's privacy and dignity whilst in the department.
- During the inspection there was limited evidence staff had access to communication aids to enhance communication with people with additional needs where required.

## Is the service safe?

**Good** ●

We previously inspected diagnostic imaging jointly with outpatients, so we cannot compare our new ratings directly with previous ratings.

We rated safe as good because:

- Staff understood how to protect patients from abuse and the service worked well with other agencies to do so. Staff had training on how to recognise and report abuse, and they knew how to apply it.
- The service controlled infection risk well. Staff kept themselves, equipment and the premises clean. They used control measures to prevent the spread of infection.
- The service had suitable premises and equipment and looked after them well.
- The service had enough staff with the right qualifications, skills, training and experience to keep people safe from avoidable harm and to provide the right care and treatment.
- Staff kept detailed records of patients' care and treatment. Records were clear, up-to-date and easily available to all staff providing care.
- The service followed best practice when prescribing, giving, recording and storing medicines.
- The service managed patient safety incidents well.

However:

- While mandatory training was provided to all staff and managers told us staff were being asked to complete it, mandatory training compliance rates were not achieving the 95% target the trust set. Mandatory safeguarding training compliance did not achieve the trust target. Although, Staff were meeting the trajectory to complete mandatory training by end of March 2019 and could easily access training as required.
- Resuscitation trolley checks had not been consistently between 1 October 2018 and 16 January 2019.
- The service had challenges with paediatric radiologist staffing levels and were under resourced by around three paediatric radiologists.

## Is the service effective?

# Diagnostic imaging

We do not rate effective in diagnostic imaging, however we found:

- The service provided care and treatment based on national guidance and evidence of its effectiveness. Managers monitored the effectiveness of care and treatment and used the findings to improve them. Staff of different kinds worked together as a team to benefit patients.
- Audits were completed across the department including diagnostic reference level audits. Staff had access to radiation protection supervisors, a radiation protection advisor and a medical physics expert on site. The services completed annual radiation protection reports.
- Food and drinks were available to patients waiting in the departments for a period of time or where required and staff could provide food and drink as needed.
- Staff were supported to develop in their roles and were supported to complete further training to increase skills and knowledge.
- The service had 24 hours, 7 day a week opening in the radiology department and provided rapid access to CT scanning.
- Staff understood how and when to assess whether a patient had the capacity to make decisions about their care.

However:

- The interventional radiology department used the World Health Organisation (WHO) safety checklist. However, audit of the checklist had only recently commenced.

## Is the service caring?

**Good** 

We previously inspected diagnostic imaging jointly with outpatients, so we cannot compare our new ratings directly with previous ratings.

We rated caring as good because:

- Staff cared for patients with compassion. Feedback from patients confirmed that staff treated them well and with kindness.
- Staff provided emotional support to patients to minimise their distress. Staff involved patients and those close to them in decisions about their care and treatment.
- Feedback from patients was positive and told us they felt involved in the decision-making process where applicable and felt their privacy and dignity had been respected in diagnostic imaging.
- There was a chaperone policy and chaperones were available to patients as needed. Staff were aware of patients who may be anxious or claustrophobic and supported patients as needed. Patients could visit the department before an appointment to reduce anxiety if required.
- The service had access to a mental health first aider to provide additional support and care to patients and overall, patients we spoke with also felt they had been offered adequate psychological and emotional support where relevant in the department. Quiet rooms were available if required.
- The neuroradiology department had three play therapists and specialists who had assisted in training staff in disruption techniques for relevant patients attending the service.

# Diagnostic imaging

However:

- While privacy and dignity was maintained in department areas visited, there were occasions during the inspection where patients were waiting to be seen on beds in the corridors on the main x-ray department which did not support a patient's privacy and dignity whilst in the department.
- During the inspection there was limited evidence staff had access to communication aids to enhance communication with people with additional needs where required.

## Is the service responsive?

**Requires improvement** 

We previously inspected diagnostic imaging jointly with outpatients, so we cannot compare our new ratings directly with previous ratings.

We rated responsive as requires improvement because:

- The service did not meet the diagnostic imaging reporting time targets. To assist in addressing challenges with reporting times, the trust had recently started to outsource some MRI and CT elective reporting work.
- The service did not always meet the two-week urgent waiting time targets.

However:

- The service planned and provided services in a way that met the needs of local people. The service took account of patients' individual needs. People could access the service when they needed it. The service treated concerns and complaints seriously, investigated them and learned lessons from the results, and shared these with all staff.
- Between September 2017 and March 2018, the percentage of patients waiting more than six weeks to see a clinician was similar to the England average, but reduced and was generally better during 2018 whereas the England average has risen.

## Is the service well-led?

**Good** 

We previously inspected diagnostic imaging jointly with outpatients, so we cannot compare our new ratings directly with previous ratings.

We rated well-led as good because:

- Managers at all levels in the service had the right skills and abilities to run a service providing high-quality sustainable care. The service had a vision for what it wanted to achieve and workable plans to turn it into action.
- Managers across the service promoted a positive culture that supported and valued staff, creating a sense of common purpose based on shared values.
- The service systematically improved service quality and safeguarded high standards of care by creating an environment for excellent clinical care to flourish.
- The service had good systems to identify risks, plan to eliminate or reduce them, and cope with both the expected and unexpected.

# Diagnostic imaging

- The service collected, analysed, managed and used information well to support all its activities, using secure electronic systems with security safeguards.
- The service engaged well with patients, staff, the public and local organisations to plan and manage appropriate services and collaborated with partner organisations effectively.
- The service was committed to improving services by learning from when things went well or wrong, promoting training, research and innovation.

## Outstanding practice

We found examples of outstanding practice in this service.

- The service was committed to improving services by learning from when things went well or wrong, promoting training, research and innovation. The service participated in research and developed its services and staff to provide care and treatment to patients.
- There was evidence in the departments of quality improvement and innovation to provide a better service to patients.

## Areas for improvement

We found areas for improvement in this service.

The provider must:

- Ensure resuscitation trolley checks are completed as required.
- Continue to address waiting times and reporting times and achieve their targets.

The provider should:

- Continue to address staffing shortages in paediatric radiology.
- Ensure mandatory training targets including safeguarding training are achieved.
- Continue to implement the World Health Organisation (WHO) checklist and audit as required.
- Consider ways to improve privacy and dignity for patients attending the diagnostic imaging department.
- Consider communication aids to assist in communication with patients as required.

# Royal Victoria Infirmary

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Tel: 01912336161  
[www.newcastle-hospitals.org.uk](http://www.newcastle-hospitals.org.uk)

## Key facts and figures

Royal Victoria Infirmary (RVI) is located in the centre of the city of Newcastle upon Tyne and has been providing healthcare to communities in Newcastle and the North East for over 250 years.

The RVI provides a wide range of services including accident and emergency, medicine, surgery, maternity, critical care, end of life care, outpatients and diagnostic imaging and a children and young people's service.

Several designated regional centres of expertise are part of this hospital, including the major trauma centre, the specialist referral centre for maternity services in the North East of England and Cumbria and the Great North Children's Hospital, one of the largest children's hospitals in the UK.

During this inspection we inspected the emergency department, end of life care and diagnostic imaging core services.

Our inspection was unannounced (staff did not know we were coming) to enable us to observe routine activity.

Before this inspection we reviewed information about the service and after the inspection we requested further information from the trust.

## Summary of services at Royal Victoria Infirmary

**Outstanding**   

Our rating of services stayed the same. We rated them as outstanding because:

- People were truly respected and valued as individuals and were empowered as partners in their care, practically and emotionally, by an exceptional and distinctive service. Staff went the extra mile to support their patients. Emotional and spiritual support for patients and their families was second to none. Patients told us the care they received exceeded all expectations.
- Services were tailored to meet the needs of individual people and were delivered in a way to ensure flexibility, choice and continuity of care. Care and treatment were holistically planned in collaboration with patients, making them active partners in their care at all levels.
- We saw evidence of strong, innovative multidisciplinary and multiorganisational working. There was a robust strategic plan in place which demonstrated how the hospital worked with other organisations to ensure care was planned and delivered to meet the needs of patients in a sustainable, future proof way.

# Summary of findings

- Specialist knowledge and expertise was readily accessible. Staff were proactively supported to acquire new skills and share best practice. Research and quality improvement were embedded in practice. All staff were actively engaged in monitoring and improving quality and outcomes for patients.
- The leadership, governance and culture were used to drive and improve the delivery of high-quality person-centred care. Leaders set stretching, innovative objectives and conducted in depth analysis and planning as to how they would be achieved.
- Staff were empowered to suggest and deliver changes and were encouraged to be innovative. Staff told us they felt strongly supported and invested in by leadership.



# Urgent and emergency services

Outstanding  

## Key facts and figures

The emergency department (also known as accident and emergency, A&E or ED) is at the Royal Victoria Infirmary (RVI), on the outskirts of Newcastle upon Tyne city centre. It is a major trauma centre, which means that it can treat patients with a very wide range of illnesses and injuries, including those who have been involved in serious accidents and incidents. Patients can arrive on foot, by road or by air ambulance landing on the helipad on the roof of the hospital. Patients who arrive by helicopter are escorted to the department by a dedicated team of staff.

Within the department, there are four distinct areas where patients are treated. The Minors department can treat patients with minor illnesses and injuries such as simple fractures and patients who could be treated by a GP; the paediatric emergency department treats patients under 17 with all types of illnesses and injuries; the Majors department treats patients with more serious illnesses or injuries and the Resuscitation area where patients with life threatening conditions are treated.

The trust also has an eye casualty department, open six days a week where patients with eye injuries are treated.

A wide range of experienced consultants, middle grade and junior doctors, GPs, emergency nurse practitioners, nurses and healthcare assistants staff the department, seven days a week, 24 hours a day.

According to the trust, between July 2017 and June 2018 the department had 202,092 attendances. Of these, approximately 80% were aged 18 or over.

We spoke with staff including doctors, receptionists, nursing assistants, nurses of all grades, domestic and housekeeping staff and paramedics. We also spoke with 32 patients and their relatives. We looked at the records of 28 patients and reviewed information about the service provided by external stakeholders and the trust.

## Summary of this service

Our rating of this service improved. We rated it as outstanding because:

- There were enough medical and nursing staff employed by the department and staffing levels were acceptable. Staff followed safeguarding processes to protect vulnerable adults and children from abuse and referred suspected cases of abuse to the proper authority in a timely way.
- The department had evidence-based policies and procedures relating to care, which were easily accessible to staff and were audited regularly to ensure that staff were following relevant clinical pathways.
- Information about patients (such as test results) was readily accessible and there was a process in place to identify when results were ready and bring this to the attention of staff.
- There was strong evidence of different disciplines of staff from across the trust working well together throughout the department.
- Staff understood their responsibilities in relation to patients giving consent to treatment and the principles of the Mental Capacity Act 2005 that applied where a patient's capacity to consent was in doubt.
- Staff provided holistic care to patients. They maintained patients' privacy and dignity and dealt with people in a kind and compassionate way. Staff treated patients as individuals and the care they provided met people's physical and mental health needs. Families and carers were also offered support when staff identified this was needed.

# Urgent and emergency services

- Patients and relatives were involved in decisions about their care and staff gave them emotional support in difficult situations. Results from national and local surveys and questionnaires about the care patients received were consistently excellent and the department received frequent thank you cards and nominations of thanks.
- Patients who visited the department had their individual needs met. Interpreters were available for people with hearing support needs and those who spoke English as a second language.
- There were facilities available to assist disabled patients and those with specific needs. Staff gave patients pain relief, food and drinks when they needed them.
- The department was mostly meeting the target for patients to be admitted or treated and discharged within four hours, although this was a challenge.
- The trust was performing better than the England average for a number of other performance measures relating to the flow of patients thus indicating patients were receiving the most appropriate care in a timely manner.
- The vision and strategy of the trust were embedded in practice. Managers had robust and strongly evidenced plans in place to ensure the sustainability of the department for the future and to develop the department in line with local need.
- There were robust governance, risk management and quality measurement processes to enhance patient outcomes. These were overseen and reviewed by senior managers across the trust on a regular basis.
- The views and opinions of patients were important and the trust engaged with hard to reach patient groups to improve their patient journey experience.
- Staff felt there was strong supportive, forward thinking, innovative leadership not only in the department but also within the trust.
- There was an inclusive, learning and supportive culture in the department for example by the approach the department took to dealing with incidents and complaints.
- Staff felt appreciated by their colleagues and managers.
- The culture in the department supported staff to deliver good patient care. Staff were encouraged and supported to be innovative and we saw examples of innovative ways of working.

## Is the service safe?

Good ● ↑

Our rating of safe improved. We rated it as good because:

- Patients were assessed quickly by qualified staff and directed to the most appropriate person to deliver their care. When patients arrived by ambulance they were assessed in a dedicated ambulance assessment area overseen by a consultant.
- Patients were thoroughly assessed and information about their condition and needs was comprehensively documented within their records.
- When patients deteriorated this was identified in a timely manner and staff took action to escalate concerns they had about patients to colleagues. The department had introduced robust processes to ensure patients had their condition reassessed regularly. This was in response to concerns identified at our unannounced inspection.

# Urgent and emergency services

- The department was well staffed with both nurses and doctors, there were few vacancies and no impact on patient care. Staff fill rates were high and the department did not have to rely on agency or locum staff to provide cover.
- Staff were encouraged and supported to report incidents and the culture in the department was supportive and learning regarding incidents.
- Medicines were stored safely and securely in line with national and trust guidelines.
- The department had sufficient, suitable and maintained equipment to meet the needs of patients and patients were treated in a clean and tidy environment that met infection prevention and control (IPC) standards. Staff followed IPC standards, used gloves, aprons and masks when appropriate and disposed of clinical waste in the correct manner.
- There was a robust process in place to identify vulnerable patients, refer them to additional support services and ensure they were safe. Staff displayed good knowledge of current safeguarding issues within the local area.
- Staff were meeting the trajectory to complete mandatory training by end of March 2019 and could easily access training as required.

However:

- We did not find evidence that staff in the paediatric department acted every time fridge temperatures exceeded maximum levels to maintain the integrity of temperature sensitive medicines.
- Staff did not always fully complete FP10 information within logs as required and have a robust quality assurance system in place to provide evidence of completion as directed by trust policy.

## Is the service effective?

**Outstanding** ☆ ↑

Our rating of effective improved. We rated it as outstanding because:

- Outcomes for people who use services are consistently better than expected when compared with other similar services. Results from Royal College of Emergency Medicine standards re-audits were better than the England average and had improved since the initial audits were carried out.
- The department had a comprehensive range of policies and clinical guidelines to support staff. These were reviewed regularly and updated as required.
- All staff were actively engaged in activities to monitor and improve quality and outcomes for patients and ensured they had a good experience. This included making sure patient pain relief was well managed and nutrition and hydration needs met. Staff considered patients' holistic needs and promoted a healthy lifestyle to patients.
- The department participated in benchmarking, internal peer review and external peer review of performance and had demonstrable evidence of making improvements as a result.
- Research and quality improvement were important to all staff and embedded in practice. All staff were encouraged and supported to undertake quality improvement projects.
- The continuing development of staff skills, competence and knowledge was recognised as being integral to ensuring high quality care. Staff were proactively supported to acquire new skills and share best practice. The department actively encouraged staff to observe and learn and practice educators delivered additional skills training for staff. Consultants shared experience and involved all staff in unusual presentation cases.

# Urgent and emergency services

- Staff, teams and services were committed to working collaboratively and had found innovative and efficient ways to deliver more joined-up care to people who used services. The department worked closely with the local mental health trust, social workers and local authorities to support vulnerable patients and had put processes in place to follow up these patients at home, by telephone as part of a post discharge package of care.
- Staff had strong links with specialties within the trust and demonstrated multi-disciplinary and multi-agency working to ensure patients received the best care possible and achieved the best outcomes they could. We saw examples of this when the department managed major trauma incidents.

## Is the service caring?

**Outstanding** ☆ ↑

Our rating of caring improved. We rated it as outstanding because:

- Feedback from people who used the service, those who were close to them and stakeholders was continually positive about the way staff treated people. People thought staff went the extra mile and the care they received exceeded their expectations. The department received compliments from patients, relatives and colleagues from other departments about their professional and caring behaviours and scored highly in the friends and family test.
- There was a strong, visible person-centered culture. Staff were highly motivated and inspired to offer care that was kind and promoted people's dignity. Staff saw patients as individuals and not just patients and encouraged them to express their care and support needs not just their health needs. Staff were kind and compassionate and always had a smile.
- Relationships between people who used the service, those close to them and staff were strong, caring and supportive. These relationships were highly valued by staff and promoted by leaders. Patients, staff and relatives had a good rapport which enabled people to ask questions openly. Staff took the time to spend with patients addressing their concerns even when the department was under pressure.
- Staff recognised and respected the totality of people's needs; medical, physical and emotional, both patients and relatives. Staff considered patients and their relatives or carers holistically as well as individuals. They always took people's personal, cultural, social and religious circumstances and needs into account when assessing patients and formulating care and treatment plans. Staff signposted patients and their families to support services.
- People who used services were active partners in their care. Patients were given information and empowered to make decisions about their care. Staff respected their wishes.
- Staff empowered people who used the service to have a voice and discuss their wants, needs and goals. People's individual preferences and needs were always reflected in how care was delivered.
- People's emotional and social needs were highly valued by staff and were embedded in their care and treatment.

## Is the service responsive?

**Outstanding** ☆ ↑

Our rating of responsive improved. We rated it as outstanding because:

# Urgent and emergency services

- The involvement of other organisations and the local community was integral to how services were planned and ensured that services met people's needs. There was a robust strategic plan in place which demonstrated how the department worked with other organisations to ensure care was planned and delivered to meet the needs of patients in a sustainable, future proof way.
- Services were tailored to meet the needs of individual people and were delivered in a way to ensure flexibility, choice and continuity of care. The trust had introduced a trauma rehabilitation ward with close links to the ED. Additionally, patients were streamed to the most appropriate section of the department to ensure they were seen quickly and by the most appropriate person and a GP had been introduced 15 hours every day to see people who required GP services.
- The ambulatory care unit, assessment suite, eye casualty and early pregnancy assessment services all had close links to ED and there were robust pathways in place to ensure patients could access specialties quickly and receive the most appropriate care for their needs.
- The needs of the local community and the wider north east population were considered in the planning of services. Analysis had been carried out to make sure services supported the needs of the public at peak times and during special community events. Services were flexible and could adapt to meet fluctuating demand in the department.
- The organisation as a whole took ownership of flow through the department and specially appointed staff managed the flow of patients to wards. Performance against the England average for patients waiting between four and 12 hours was good and better than the England average. Between October 2017 and September 2018 no patients waited more than 12 hours for a bed on a ward.
- The department was performing better than the England average and the standard for median time from arrival to treatment, patients waiting more than four hours from decision to admit, patients leaving the department without being seen and median total time in the department. The department was performing well against the four hour target, only narrowly missing the target across the year and exceeding the target in April, May and June 2018 and August and September 2018. The department consistently performed better than the England average for the standard.
- The department had robust plans in place to react to major incidents or when critically ill or injured patients were brought to the department. Processes were effective, efficient and ensured patients were treated by health professionals from across the organisation. Specialist knowledge and expertise was readily accessible. We saw an example of this during our inspection when staff from the hospital's other site brought specialist equipment and expertise to support a patient brought to ED critically ill.
- The department was one of only two infectious diseases centres nationally and had robust plans in place to manage outbreaks of diseases such as Ebola.
- There was a proactive approach to understanding the needs of different groups of people and to deliver care in a way that met these needs and promoted equality. The department had worked with vulnerable patient groups to improve their experience in the department and ensure their patient journey experience was a good one.
- There was active review of complaints and how they were managed and responded to, and improvements were made as a result across the services. People who used services were involved in the review and the department had a proactive approach to meeting complainants.

However:

- The environment of the relatives' room was clinical and unwelcoming. It was practical and staff told us it was rarely used however it had no decoration and minimal facilities.

# Urgent and emergency services

## Is the service well-led?

**Outstanding**  

Our rating of well-led improved. We rated it as outstanding because:

- Leadership, governance and culture were used to drive and improve the delivery of high quality person-centred care. Every member of staff we spoke with had a strong patient focus and stressed to us the importance of delivering high quality care.
- The department's strategy and supporting objectives were stretching, challenging and innovative while remaining achievable. The department had undertaken a robust analysis of the challenges it faced and prepared a detailed plan of how it would develop in the future in a sustainable way.
- There was a clear proactive approach to seeking out and embedding new and more sustainable models of care. Plans detailed collaboration with other service providers, the local ambulance trust and social care support services with patients as the focus. The strategy detailed the systematic approach the department was taking to working with other organisations to improve care outcomes, tackle health inequalities and manage best use of resources to maintain the best care and outcomes for patients.
- The department had robust governance and performance management arrangements in place. Senior leaders within the department and across the trust reviewed performance figures and updated staff. This was done in a positive and proactive way to congratulate staff on their excellent performance or to motivate staff when performance dipped. All staff we spoke with told us they felt motivated.
- The department was held to account through a robust system of governance. Deaths and incidents were investigated and the department had to demonstrate action and response to adverse events. Responses and actions were scrutinised by the governance committee structure in place.
- Leaders and managers inspired staff to work hard and be proud of the department. Every member of staff we spoke with told us although it was hard work in ED, they loved their jobs and were proud to work in the department. Students told us they aspired to work in ED once they had graduated and completed their competencies to do so.
- Staff morale was good and there were high levels of staff satisfaction across all staff disciplines and groups within the department.
- There were consistently high levels of constructive engagement with staff through staff meetings and daily huddles. Staff at all levels told us they were actively encouraged to raise concerns and report incidents. Managers and leaders worked with staff to address concerns and communicated openly with staff.
- There was strong collaboration and support across all functions in the department and a common focus on improving quality of care and people's experiences. The trust as a whole worked together to support the department to manage flow and make sure patients received high quality care in a timely way.
- The department gathered feedback from people who used services and the public, including people in different equality groups. We found evidence of patient engagement with hard to reach groups.
- The department took complaints seriously and had a robust process in place to investigate and respond. The head of the department and matron oversaw the process within the department and fed back to any staff involved. Information about complaints was discussed with staff regularly.

# Urgent and emergency services

- The leadership drove continuous improvement and staff were involved and accountable for delivering change. Staff were empowered to suggest and make changes to improve practice, safety and quality within the department. Staff were encouraged to be innovative.
- There was a clear proactive approach to seeking out and embedding new and more sustainable models of care.

However:

- Security staff told us they were waiting for additional training to increase their confidence in supporting patients with mental health concerns however, the trust were working with the local mental health trust to deliver this training.

## Outstanding practice

- The department continued to deliver performance very close to national standards and was consistently better than the England average for all performance metrics.
- The culture around incidents was open, responsive, fair and proactive. All staff took incidents seriously and the feedback and investigation processes were positive and robust.
- The department produced a handbook for new staff detailing previous incidents as a way of improving safety and making sure new starters benefitted from previous lessons learned.
- Clinical audit and clinical effectiveness were given high priority within the department and electronic record systems were effectively used to reduce administrative burden on staff and deliver easily accessible information for analysis.
- Post discharge calls were made to frail, elderly and vulnerable patients to follow up and check whether they needed any extra support once home.
- Rapid Assessment and Treatment (RAT) for ambulance patients made sure patients did not wait in queues in corridors and were handed over quickly. This released ambulance crews quickly and made sure patients started treatment quickly.
- The process for receiving comprehensive handover for patients brought in as a major trauma was professional, well rehearsed, focussed and slick. Every member of staff knew exactly their role.
- Staff looked at the patient and their family unit as a whole and as individuals, identified when relatives or carers needed support, signposted them to support services and gave them information to ensure their needs were supported.
- The department had a stock of clothes for patients to wear had they arrived in soiled clothing. This was to protect their dignity. Vulnerable patients such as the homeless were encouraged to take additional clothes if they needed them.
- The department had prepared information to give to children whose parent or sibling had passed away.
- The extended role of the patient flow coordinator reduced the administrative burden on clinical staff, improved the efficiency of staff once test results had been received and sped up the administrative process when patients were transferred to wards.
- Clinical educators organised or delivered training supported by specialties to improve nurses' medical knowledge of management of patients in the department.
- Clinical research took place in the department and was seen as an important way of improving care for patients.
- The department was highly rated by medical students and junior doctors as a good place to study and work.

# Urgent and emergency services

- The department's strategy was evidence based, used recognised planning techniques and was robust and detailed.

## Areas for improvement

We found areas for improvement in this service.

The provider should:

- Ensure staff continue the trajectory to meet the 95% mandatory training compliance rate for all subjects including safeguarding vulnerable adults and children.
- Ensure the new system for carrying out routine observations of patients is fully embedded within the department.
- Ensure staff within the paediatric department act when fridge temperatures exceed maximum levels to maintain the integrity of temperature sensitive medicines and evidence this action.
- Ensure staff fully complete FP10 information within logs as required and have a robust quality assurance system in place to provide evidence of completion.
- The department may wish to consider the environment of the relatives' room to make it more of a friendly and welcoming place.
- Continue work to address unplanned reattendances.
- Support security staff to access appropriate mental health training and provide them with the facility to debrief with other staff in the department after an incident.



# End of life care

Outstanding  

## Key facts and figures

The trust provided end of life care at the Royal Victoria Infirmary. End of life care covered all care given to patients who are approaching the end of their life and following their death. It could be delivered on any ward or within any area of a trust. It included medical and nursing care, specialist palliative care, bereavement support, chaplaincy and mortuary services.

The trust had 1,800 deaths from July 2017 to June 2018.

*(Source: Hospital Episode Statistics)*

End of life care at the Royal Victoria Infirmary (RVI) was last inspected as part of our comprehensive inspection programme in 2016. We rated safe, effective, caring and responsive as good, and well led as requires improvement.

At the RVI there was no dedicated inpatient end of life ward and patients received end of life care on general wards. General ward staff were supported by specialist end of life teams consisting of nurse specialists, consultants in palliative medicine, Macmillan end of life healthcare assistants and administrative/clerical support staff. Bereavement services, chaplaincy and mortuary teams completed the holistic service. Ward staff received education and training from these teams as well as accessing specialist support.

The end of life service was available 24 hours a day, including access to specialist medical and nursing care, and an on-call chaplaincy and mortuary service.

During this inspection, we visited Wards 30, 31, 41, 46 and 52. We also visited bereavement services, chapels and faith rooms, chapels of rest and the mortuary.

At this inspection we inspected all five domains.

Our inspection was unannounced (staff did not know we were coming) to enable us to observe routine activity.

Before this inspection, we reviewed information about the service and after the inspection we requested further information from the trust.

During our visit, the inspection team spoke with 4 patients and their relatives, and 25 members of staff including consultants, junior doctors, clinical support workers, nurses and therapists. We checked seven sets of patient records and nine 'Do Not Attempt CPR' forms.

## Summary of this service

Our rating of this service improved. We rated it as outstanding because:

- The service had fully implemented the care of the dying patient document and addressed all the issues we previously identified at our last inspection. Additionally, patient care and outcomes had improved, and the team's thorough education offer to staff on wards had meant that at this inspection, we found that care of the dying really was everyone's business.
- People were truly respected and valued as individuals. Staff went the extra mile to support their patients and people were positive about their care and treatment. Emotional and spiritual support for patients and their families was second to none.

# End of life care

- The staff team were stable, experienced and committed. The team's focus on continuous development meant that standards were constantly rising. Topic specific sub groups ensured that any areas in need of improvement remained 'on the radar' and progress was regularly checked. Staff were given sufficient time to develop new and innovative ways to improve.
- There was a 'can-do' approach to end of life care when it came to people's individual needs and preferences. The team were proactive in seeking solutions to barriers to fulfilling these and were not afraid to try new things to ensure patients' care was right for them. People with protected characteristics under the Equality Act (2010) were offered care in a way that was tailored to suit them and empower them to make as many decisions about their care and their death as they wished.
- Safety was a priority that the whole team were engaged with. Incidents were rare, and medicines appropriately managed. Information systems shared with local partners underpinned record keeping with paperless notes and clear audit trails.
- Care and treatment were holistically planned in collaboration with patients and other local providers. Patients were identified earlier than at our last inspection, seen earlier by the specialist team, and discharged home earlier if this was their preference, leading to overall improvements in outcomes.
- Leadership was strong and compassionate. The team's vision and strategy were well articulated and progress against three-year plans was regularly checked. Ward staff had more awareness of the team's key documents than at our previous inspection. Staff contributed to research and the development of national guidance and conducted regular audits of their service.

However:

- The service was not meeting the trust's 90% target for staff receiving an annual appraisal. Medical staff appraisal rates were 62.5% and qualified nursing staff 77% at the time of our inspection.
- Leadership was shared by medical and nursing staff in different directorates. While this was working effectively, the lack of an operations manager had the potential to restrict future development of the service.

## Is the service safe?

Good   

Our rating of safe stayed the same. We rated it as good because:

- The service had enough staff with the right qualifications, skills, training and experience to keep people safe from avoidable harm and to provide the right care and treatment in line with national guidance. We saw evidence of an experienced, stable team who valued teaching and learning highly.
- Staff knew how to report an incident using the trust's electronic system and were aware of the importance of doing this. When things went wrong, staff apologised and gave patients honest information and suitable support. There were clear routes for feedback and learning from incidents to be shared and they were using these effectively.
- Staff understood how to protect patients from abuse and the service worked well with other agencies to do so. Staff had training on how to recognise and report abuse, and they knew how to apply it.
- Staff kept detailed records of patients' care and treatment. Records were clear, up-to-date and easily available to all staff providing care. This extended to colleagues working in the community, hospices, ambulances and GP surgeries.

# End of life care

- All areas we visited were visibly clean and we saw members of the team taking appropriate infection control measures. The mortuary was clean and tidy, and trust cleanliness audits confirmed high standards of cleanliness in areas delivering end of life care.
- Specialist equipment was well maintained and accessible. Syringe drivers, used to give medicines to end of life patients, were looked after by staff with the correct competencies and were always available when needed.
- Medicines were appropriately prescribed and given. Patients received the right medication at the right dose at the right time. The service conducted regular audits to ensure that this remained the case and provided regular support to ward staff on this topic.
- Staff assessed risks to patients daily as part of a routine review of their care and ongoing evaluation, and a consultant was on call 24 hours a day to review patients as needed.

However;

- Mandatory training levels were below the trust's 95% target for nursing, mortuary, chaplaincy and bereavement services staff. At this inspection, information provided by the trust showed compliance for this site had deteriorated, with nursing staff meeting the 95% target in eight of 13 training courses. Staff were meeting the trajectory to complete mandatory training by end of March 2019 and could easily access training as required.

## Is the service effective?

**Outstanding**  

Our rating of effective improved. We rated it as outstanding because:

- End of life care services were well resourced, and we observed a truly holistic approach to the assessment, planning and delivery of care and treatment to patients. Patients in need of end of life care were identified at an early stage. The issues we found with syringe drivers at our previous inspection had been resolved. The trust had now fully implemented the care of the dying patient document which was being used as a guide to delivering high-quality end of life care.
- Staff were well supported to develop in their role, acquiring new skills and sharing best practice. New team members were given extended protected time to enable them to become fully embedded within the team and staff spoke very positively about how they felt 'invested in'. The team's extensive skills and knowledge were effectively cascaded to wider hospital staff through numerous training opportunities.
- All staff were actively involved in monitoring quality and outcomes for patients. The service took part in local and national benchmarking and was one of the pilot organisations developing the national palliative care dataset. Patients had positive and consistent outcomes as a result.
- The service provided care and treatment based on national guidance and evidence of its effectiveness. The trust had an implementation policy for National Institute of Health and Clinical Excellence guidelines and a sub-committee of the trust board was responsible for monitoring compliance. Non-compliance was escalated to the trust board.
- Staff, teams and services were working collaboratively and were using innovative ways of delivering joined up care. People's discharge was discussed and planned at the earliest stage possible and patients received the same quality of care seven days a week.
- People's need for food and drink was assessed and revisited regularly. Staff used special techniques if people had difficulty eating or drinking. Personal preferences were discussed with patients and adjustments made as necessary.

# End of life care

- Staff assessed and monitored patients regularly to see if they were in pain. A suitable assessment tool was in use to support those unable to communicate verbally, and staff gave pain relief when needed.
- Consent to care and treatment was obtained in line with legislation, and staff understood how and when to assess whether someone had the capacity to make decisions about their care. Staff followed trust policies when a person could not give consent.

However:

- The service was not meeting the trust's 90% target for staff receiving an annual appraisal. Medical staff appraisal rates were 62.5% and qualified nursing staff 77% at the time of our inspection. Staff were meeting the trajectory to complete appraisals by end of March 2019.

## Is the service caring?

**Outstanding** ☆ ↑

Our rating of caring improved. We rated it as outstanding because:

- People were truly respected and valued as individuals and were empowered as partners in their care, practically and emotionally by an exceptional and distinctive service.
- Patients and those closest to them were active partners in their care. They knew what the plan was for their care, and where appropriate, had discussed their preferred place of death with staff.
- Staff 'went the extra mile' to support patients and we heard of multiple examples of additional support such as arranging emergency accommodation for vulnerable patients' pet dogs. They also voluntarily provided extra touches such as providing and arranging flowers for the mortuary viewing rooms.
- Feedback from people who used the service and those closest to them was extremely positive and regular surveys showed this was an improving picture. People's communication needs, and experiences were regularly audited and the team were constantly looking to improve practice and learn from this.
- Staff provided multiple examples of how their determination and creativity had overcome obstacles to delivering care. They spoke proudly and passionately about how they worked together with patients to achieve the best outcomes for them, and this respect and compassion continued after the patient's death.
- The mortuary and chaplaincy teams provided exceptional support to families of deceased patients, continuing the highest standards of privacy and dignity after death and ensuring that those closest to the patient were emotionally and spiritually supported.
- Staff were motivated to provide high standards of care for their patients which had been officially recognised by the trust's senior leaders. Ward staff spoke very positively about the team's input and the difference that this had made to patients.

## Is the service responsive?

**Outstanding** ☆ ↑

Our rating of responsive improved. We rated it as outstanding because:

# End of life care

- Services were tailored to meet the needs of individual people and were delivered in a way that ensured flexibility, choice and continuity of care. People's needs, and preferences were central to the planning and delivery of care. People's preferred place of death was recorded and audited regularly, and fulfilled preferences were in line with the national average. The team's recording of preferred place of death had risen from 39% to 99.5% in the last two years.
- The team were proactive in understanding the needs and preferences of different groups. Their innovative work with a charity supporting people who were homeless, and the LGBT community were just two of several examples where the team worked collaboratively and with purpose to improve patients' experience of care.
- Staff were motivated to 'go the extra mile' in their care for patients and would find innovative ways of supporting patients' preferences. As a result, almost all people who wished to die at home were supported to do so.
- Care and treatment were available when needed and the team visited new referrals promptly. The specialist team saw 87% of people the same day, and 97% within 24 hours. Work was ongoing with external local and regional partners to ensure that people received seamless care, treatment and support.
- People's spiritual care was well catered for, and the chaplaincy team could accommodate the preferences and needs of people from all faiths, or no faith.
- Families of people nearing the end of their life in hospital were very well supported by the team's specialist healthcare assistants. They provided reduced fees for car parking, comfort packs, shared diaries and respite breaks for those at the bedside as well as hot drinks and a chance to talk.
- People knew how to give feedback about their experiences and could do so in a variety of ways. The service received very few concerns and complaints, but treated these seriously, investigated them and learned lessons from the results.

## Is the service well-led?

Good  

Our rating of well-led improved. We rated it as good because:

- Leaders were experienced and had the right skills and abilities to provide high quality, sustainable care. Service managers were focussed on the quality issues, priorities and challenges for the team.
- There was a clear vision and three-year strategy that focused on the early identification of patients at the end of life, and the strategy communicated the goal of integrated services at the centre of patient care. This had been co-produced with the regional network and the needs of the local population were carefully considered. A quarterly strategy group meeting monitored progress.
- Managers promoted a positive culture and staff felt valued and supported. There was a clear sense of common purpose based on shared values. Staff at all levels valued their teammates and were collaborative and respectful. The team's ethos that caring for the dying was everyone's business was embedded across the hospital.
- The team had a comprehensive approach to continually improving the quality of its services, underpinned by a robust audit programme. High standards of care were secured by promoting an environment in which excellence in clinical care would flourish. Governance provided continuing assurance up to board level.
- The team had effective systems for identifying risks, planning to eliminate or reduce them, and coping with both the expected and unexpected. The team's risk register was part of a wider document but easily filtered, and staff knew their current risks, which all related to short term project funding.

# End of life care

- The team collected, analysed, used and managed information well to support its activities, using secure electronic systems with security safeguards.
- The service engaged well with patients, staff, the public and local organisations to plan and manage appropriate services and collaborated with partner organisations effectively.
- The team were passionate about continuous improvement and had been nominated for and won regional and national awards. Learning from practice, both positive and negative, was central and discussed at each team meeting. The team had made positive improvements since our last inspection and had addressed all the issues previously highlighted.

However:

- Leadership was shared by medical and nursing staff in different directorates. While this was working effectively, the lack of an operations manager had the potential to restrict future development of the service.

## Outstanding practice

- The team were part of the pilot to develop a Public Health England dataset for palliative care in 2015. As early adopters, they have continued to use this dataset to inform their daily discussions of patient care.
- Nurse specialists entering the end of life team were supernumerary for the first six months in post. They did see patients but were also offered extensive shadowing and development opportunities and given the chance to develop their own interests.
- Mortuary and chaplaincy staff provided exceptional support to families of deceased patients, continuing the highest standards of privacy and dignity after death and ensuring that those closest to the patient were emotionally and spiritually supported. The viewing rooms in the mortuary provided bespoke environments to meet individual needs.
- The team worked with a local domestic gas company to provide emergency gas safety certificates for people whose discharge home could be delayed because they had a gas appliance in the room where their bed would need to be. The gas company provided this service the same day or early the following morning, free of charge.
- Links had been established with a local charity supporting homeless people and some workers had been trained to assess whether people they supported could be nearing the end of their life. A local hostel worked with the charity and team to provide end of life care in a safe environment. Chaplaincy services could refer people's dogs for emergency accommodation if needed.
- The team attended group supervisions with a clinical psychologist. This was an opportunity to discuss troubling or difficult cases in a safe environment. These sessions were protected time and ensured that the emotional wellbeing of staff was always a high priority.
- The team had led nationally on a piece of work overseeing the withdrawal of ventilation for end of life patients in a home setting. They have conducted more withdrawals than anywhere in the county and findings were presented internationally.

## Areas for improvement

We found areas for improvement in this service.

The provider should:

- Consider whether an operations manager or other operational resource would strengthen the team's leadership and governance.

# Diagnostic imaging

Good 

## Key facts and figures

The imaging specialties at the RVI included computed tomography (CT), magnetic resonance imaging (MRI), Ultrasound, Plain Film X-ray, Fluoroscopy, Gamma cameras and single photon emission computed tomography (SPECT) CT.

Interventional Radiology was provided at the Royal Victoria Infirmary (RVI) site and there was a nuclear medicine department at the RVI.

Diagnostic imaging provided services to adults and children across the department and had a dedicated x-ray area with a waiting room for children.

There were around 499,985 examinations provided across the trust for diagnostic imaging between April 2017 and March 2018. This included approximately 66,780 CT examinations, approximately 81,970 diagnostic ultrasonography, approximately 28,370 fluoroscopy examinations, 52,375 MRI examinations, Approximately 260,000 plain film x-rays and approximately 575 SPECT CT examinations.

The nuclear medicine department carried out approximately 12,000 procedures across the trust each year.

*(Source: Acute provider information request – context)*

We previously inspected diagnostic imaging jointly with outpatients, so we cannot compare our new ratings directly with previous ratings.

The service had an ionising radiation medical exposure regulation (IR(ME)R) inspection from the Care Quality Commission (CQC) in July 2018. Following the IR(ME)R inspection an improvement notice was issued, and this was removed prior to this inspection following submission by the trust of a compliant action plan.

Diagnostic imaging provided services to adults and children across the department and had a dedicated x-ray area with a waiting room for children.

During the inspection we visited the main x-ray department, which included a children's x-ray area, fluoroscopy, electroencephalogram (EEG), ultrasound, Magnetic Resonance Imaging (MRI), Computed Tomography (CT) and the lung function department at the Royal Victoria Infirmary.

During the inspection we spoke with 28 staff, 14 patients and reviewed eleven records and safety forms.

Our inspection was unannounced (staff did not know we were coming) to enable us to observe routine activity.

## Summary of this service

We previously inspected diagnostic imaging jointly with outpatients, so we cannot compare our new ratings directly with previous ratings.

We rated this service as good because:

- Staff understood how to protect patients from abuse and the service worked well with other agencies to do so. Staff had training on how to recognise and report abuse, and they knew how to apply it.
- The service controlled infection risk well. Staff kept themselves, equipment and the premises clean. They used control measures to prevent the spread of infection.

# Diagnostic imaging

- The service had suitable premises and equipment and looked after them well.
- The service had enough staff with the right qualifications, skills, training and experience to keep people safe from avoidable harm and to provide the right care and treatment.
- Staff kept detailed records of patients' care and treatment. Records were clear, up-to-date and easily available to all staff providing care.
- The service followed best practice when prescribing, giving, recording and storing medicines. The service managed patient safety incidents well.
- The service provided care and treatment based on national guidance and evidence of its effectiveness. Managers monitored the effectiveness of care and treatment and used the findings to improve them. Staff of different kinds worked together as a team to benefit patients.
- Staff understood how and when to assess whether a patient had the capacity to make decisions about their care.
- Staff cared for patients with compassion. Feedback from patients confirmed that staff treated them well and with kindness. Staff provided emotional support to patients to minimise their distress. Staff involved patients and those close to them in decisions about their care and treatment.
- The service planned and provided services in a way that met the needs of local people. The service took account of patients' individual needs. People could access the service when they needed it.
- The service treated concerns and complaints seriously, investigated them and learned lessons from the results, and shared these with all staff.
- Managers at all levels in the service had the right skills and abilities to run a service providing high-quality sustainable care. The service had a vision for what it wanted to achieve and workable plans to turn it into action.
- Managers across the service promoted a positive culture that supported and valued staff, creating a sense of common purpose based on shared values.
- The service systematically improved service quality and safeguarded high standards of care by creating an environment for excellent clinical care to flourish.
- The service had good systems to identify risks, plan to eliminate or reduce them, and cope with both the expected and unexpected.
- The service collected, analysed, managed and used information well to support all its activities, using secure electronic systems with security safeguards.
- The service engaged well with patients, staff, the public and local organisations to plan and manage appropriate services and collaborated with partner organisations effectively.
- The service was committed to improving services by learning from when things went well or wrong, promoting training, research and innovation.

However:

- The service did not meet the diagnostic imaging reporting time targets. To assist in addressing challenges with reporting times, the trust had recently started to outsource some MRI and CT elective reporting work.
- The service did not always meet the two-week urgent waiting time targets.



# Diagnostic imaging

- While mandatory training was provided to all staff and managers told us staff were being asked to complete it, mandatory training compliance rates were not achieving the 95% target the trust set. Mandatory safeguarding training compliance did not achieve the trust target. Mandatory training and safeguarding training compliance was between April 2018 and April 2019 and therefore was expected to improve as the year progressed.
- Resuscitation trolley checks had not been consistently completed between 1 October 2018 and 16 January 2019.
- The service had challenges with paediatric radiologist staffing levels and were under resourced by three paediatric radiologists.
- The interventional radiology department used the World Health Organisation (WHO) safety checklist. However, audit of the checklist had only recently commenced
- While privacy and dignity was maintained in department areas visited, there were occasions during the inspection where patients were waiting to be seen on beds in the corridors on the main x-ray department which did not support a patient's privacy and dignity whilst in the department.
- During the inspection there was limited evidence staff had access to communication aids to enhance communication with people with additional needs where required.

## Is the service safe?

**Good** ●

We previously inspected diagnostic imaging jointly with outpatients, so we cannot compare our new ratings directly with previous ratings.

We rated safe as good because:

- Staff understood how to protect patients from abuse and the service worked well with other agencies to do so. Staff had training on how to recognise and report abuse, and they knew how to apply it.
- The service controlled infection risk well. Staff kept themselves, equipment and the premises clean. They used control measures to prevent the spread of infection.
- The service had suitable premises and equipment and looked after them well.
- Overall, the service had enough staff with the right qualifications, skills, training and experience to keep people safe from avoidable harm and to provide the right care and treatment.
- Staff kept detailed records of patients' care and treatment. Records were clear, up-to-date and easily available to all staff providing care.
- The service followed best practice when prescribing, giving, recording and storing medicines. The service managed patient safety incidents well.

However:

- While mandatory training was provided to all staff and managers told us staff were being asked to complete it, mandatory training compliance rates were not achieving the 95% target the trust set. Mandatory safeguarding training compliance did not achieve the trust target. Although, Staff were meeting the trajectory to complete mandatory training by end of March 2019 and could easily access training as required.
- Resuscitation trolley checks had not been consistently completed between 1 October 2018 and 16 January 2019.

# Diagnostic imaging

- The service had challenges with paediatric radiologist staffing levels and were under resourced by three paediatric radiologists.

## Is the service effective?

We do not rate effective in diagnostic imaging, however we found:

- The service provided care and treatment based on national guidance and evidence of its effectiveness. Managers monitored the effectiveness of care and treatment and used the findings to improve them. Staff of different kinds worked together as a team to benefit patients.
- Audits were completed across the department including diagnostic reference level audits. Staff had access to radiation protection supervisors, a radiation protection advisor and a medical physics expert on site. The services completed annual radiation protection reports.
- Food and drinks were available to patients waiting in the departments for a period of time or where required and staff could provide food and drink as needed.
- Staff were supported to develop in their roles and were supported to complete further training to increase skills and knowledge.
- The service had 24 hours, 7 day a week opening in the radiology department and provided rapid access to CT scanning.
- Staff understood how and when to assess whether a patient had the capacity to make decisions about their care.

However:

- The interventional radiology department used the World Health Organisation (WHO) safety checklist. However, audit of the checklist had only recently commenced.

## Is the service caring?

**Good** ●

We previously inspected diagnostic imaging jointly with outpatients, so we cannot compare our new ratings directly with previous ratings.

We rated caring as good because:

- Staff cared for patients with compassion. Feedback from patients confirmed that staff treated them well and with kindness.
- Staff provided emotional support to patients to minimise their distress. Staff involved patients and those close to them in decisions about their care and treatment.
- Feedback from patients was positive and told us they felt involved in the decision-making process where applicable and felt their privacy and dignity had been respected in diagnostic imaging.
- There was a chaperone policy and chaperones were available to patients as needed. Staff were aware of patients who may be anxious of claustrophobic and supported patients as needed. Patients could visit the department before an appointment to reduce anxiety if required.

# Diagnostic imaging

- The service had access to a mental health first aider to provide additional support and care to patients and overall, patients we spoke with also felt they had been offered adequate psychological and emotional support where relevant in the department. Quiet rooms were available if required.
- The neuroradiology department had three play therapists and specialists who had assisted in training staff in disruption techniques for relevant patients attending the service.

However:

- While privacy and dignity was maintained in department areas visited, there were occasions during the inspection where patients were waiting to be seen on beds in the corridors on the main x-ray department which did not support a patient's privacy and dignity whilst in the department.
- During the inspection there was limited evidence staff had access to communication aids to enhance communication with people with additional needs where required.

## Is the service responsive?

**Requires improvement** ●

We previously inspected diagnostic imaging jointly with outpatients, so we cannot compare our new ratings directly with previous ratings.

We rated responsive as requires improvement because:

- The service did not meet the diagnostic imaging reporting time targets. To assist in addressing challenges with reporting times, the trust had recently started to outsource some MRI and CT elective reporting work.
- The service did not always meet the two-week urgent waiting time targets.

However:

- The service planned and provided services in a way that met the needs of local people. The service took account of patients' individual needs. People could access the service when they needed it. The service treated concerns and complaints seriously, investigated them and learned lessons from the results, and shared these with all staff.
- Between September 2017 and March 2018, the percentage of patients waiting more than six weeks to see a clinician was similar to the England average, but reduced and was generally better during 2018 whereas the England average has risen.

## Is the service well-led?

**Good** ●

We previously inspected diagnostic imaging jointly with outpatients, so we cannot compare our new ratings directly with previous ratings.

We rated well-led as good because:

- Managers at all levels in the service had the right skills and abilities to run a service providing high-quality sustainable care. The service had a vision for what it wanted to achieve and workable plans to turn it into action.

# Diagnostic imaging

- Managers across the service promoted a positive culture that supported and valued staff, creating a sense of common purpose based on shared values.
- The service systematically improved service quality and safeguarded high standards of care by creating an environment for excellent clinical care to flourish.
- The service had good systems to identify risks, plan to eliminate or reduce them, and cope with both the expected and unexpected.
- The service collected, analysed, managed and used information well to support all its activities, using secure electronic systems with security safeguards.
- The service engaged well with patients, staff, the public and local organisations to plan and manage appropriate services and collaborated with partner organisations effectively.
- The service was committed to improving services by learning from when things went well or wrong, promoting training, research and innovation.

## Outstanding practice

We found examples of outstanding practice in this service.

- The service was committed to improving services by learning from when things went well or wrong, promoting training, research and innovation. The service participated in research and developed its services and staff to provide care and treatment to patients.
- There was evidence in the departments of quality improvement and innovation to provide a better service to patients.

## Areas for improvement

We found areas for improvement in this service.

The provider must:

- Ensure resuscitation trolley checks are completed as required.
- Continue to address waiting times and reporting times and achieve their targets.

The provider should:

- Continue to address staffing shortages in paediatric radiology.
- Ensure mandatory training targets including safeguarding training are achieved.
- Continue to implement the World Health Organisation (WHO) checklist and audit as required.
- Consider ways to improve privacy and dignity for patients attending the diagnostic imaging department.
- Consider communication aids to assist in communication with patients as required.

# Community end of life care

**Outstanding** ☆ ↑

## Key facts and figures

End of life care was provided by all staff in the trust. In the community setting care is provided by the specialist palliative care nurses, district nurses and allied health care professionals, and healthcare assistants. Community nursing provide a twenty-four hour, seven days' a week service and community specialist palliative care nursing a seven-day service, between 8.30am and 5pm. The team aimed to contact new community patients within three days of referral. Patients were triaged and those with the higher priority level received a rapid response within an hour.

There was a dedicated 0.8 whole time equivalent (WTE) nurse specialist in palliative care to work alongside care homes. The specialist palliative care service was also commissioned to provide specialist palliative care and end of life support to patients in in-patient beds in Newcastle under the care of Northumberland Tyne and Wear NHS Foundation Trust.

At this inspection we inspected all five domains.

Our inspection was unannounced (staff did not know we were coming) to enable us to observe routine activity.

Before this inspection, we reviewed information about the service and after the inspection we requested further information from the trust.

During our visit, the inspection team spoke with two patients and their relatives, and 32 members of staff including consultants, junior doctors, clinical support workers, nurses and therapists. We checked six sets of patient records.

## Summary of this service

Our rating of this service improved. We rated it as outstanding because:

- Staff knew how to report an incident using the trust's electronic system and were aware of the importance of doing this. There were clear routes for feedback and learning from incidents to be shared and these were being used effectively.
- Staff understood how to protect patients from abuse. Safeguarding was well understood with comprehensive training delivered to staff.
- There was evidence of well worked out systems for multidisciplinary working between different staff groups, between different parts of the trust, and with external agencies; such as hospices and the ambulance service.
- There was good input from general practitioners and pharmacies. Systems for the provision of out-of-hours and anticipatory medicines were in place.
- Staff assessed risks to patients during their visits and advice from a consultant was always available.
- The service worked towards a standard based on the principles of the national palliative care 'Gold Standards' framework.
- Evidence from surveys, statements by relatives, and our conversations with patients, and staff, showed the highest degree of compassion, emotional support, understanding and involvement of patients and those close to them.
- The service linked into a general practitioner risk register used to identify patients who were in need of end of life care input.

# Community end of life care

- Consent was informed and discussed with patients. 'Do not attempt cardiopulmonary resuscitation' (DNACPR) forms we reviewed were signed and dated
- We observed compassionate care that met patients' emotional needs. We saw the team engaging with patients, and understanding their needs, and involving them and those closest to them.
- There was evidence of a high level of responsiveness in the way the service linked with patients from different backgrounds and facilitated the inclusion of hard to reach groups. The latter being seen clearly in the work done, in collaboration with a local charity, to reach homeless people.
- The service fully supported patients in helping them choose their final place of care. This included the compassionate way in which they supported a patient who was considering using the Dignitas service.
- There was an effective referral system from the in-patient hospital team to ensure new patients accessed the community team quickly and effectively. There was a system of triage to ensure patients got the care and support at the right time.
- There were explanatory leaflets for patients and those close to them that was written in an empathetic and jargon free style. These were also available in different languages.
- There was a culture of everybody working together in a non-hierarchical manner for a common goal.

However:

- The trust had a mandatory training target of 95%. In the case of qualified nursing staff ten out of fourteen training modules exceeded the target with a compliance rate of 100%. Although the target was not achieved in the training modules of; anti-bribery and corruption, fire safety, health and safety, and Prevent (Prevent is part of the UK's Counter Terrorism Strategy that works to stop individuals from getting involved or supporting terrorism or extremist activity). These latter areas had a compliance rate of 89%.
- Staff were aware of the principles of cleanliness and infection control. However, because of the nature of the work being undertaken in patients' homes we could not observe staff providing clinical care to patients that required a clean or aseptic environment. Staff did not always keep detailed records of patients' care and treatment. A review showed that not all paper records had signatures and that conversations with patients were not always recorded.
- Although we saw evidence that consent was being sought it was not recorded in all the records that there had been a full discussion with the patient and their family.
- We saw one record where the use of bed sides was not recognised as a possible use of restraint.
- There was a lack of provision of end-of-life care provision for children although this was a commissioning issue outside of the responsibilities of the service. It was noted that one of the consultants worked pro-bono in their own time to help the service meet patients' needs.
- There was no operational manager post within the team, that was jointly consultant and nurse led. The team recognised that this role would further strengthen their leadership, and conversations had taken place at an executive level with a view to implementing this.

## Is the service safe?

Good   

Our rating of safe stayed the same. We rated it as good because:

# Community end of life care

- The service had enough staff with the right qualifications, skills, training and experience to keep people safe from avoidable harm and to provide the right care and treatment in line with national guidance.
- Staff knew how to report an incident using the trust's electronic system and were aware of the importance of doing this. When things went wrong, staff apologised and gave patients honest information and suitable support. There were clear routes for feedback and learning from incidents to be shared and these were being used effectively.
- The service had a risk register that was reviewed and updated at the time of the inspection.
- Staff understood how to protect patients from abuse. Safeguarding was well understood with comprehensive training delivered to staff. There was good reporting and learning from incidents across the end of life care pathway, including with hospices and general practitioners.
- Specialist equipment was well maintained and accessible. Syringe drivers, used to give medicines to end of life patients, were looked after by staff with the correct competencies and were always available when needed.
- There was good input from general practitioners and pharmacies. Systems for the provision of out-of-hours and anticipatory medicines were in place.
- Staff assessed risks to patients during their visits and advice from a consultant was always available.
- There were links with hard to reach groups, including the homeless where engagement work was undertaken with a local homeless charity.

However:

- The trust had a mandatory training target of 95%. In the case of qualified nursing staff ten out of fourteen training modules exceeded the target with a compliance rate of 100%. Although the target was not achieved in the training modules of; anti-bribery and corruption, fire safety, health and safety, and Prevent (Prevent is part of the UK's Counter Terrorism Strategy that works to stop individuals from getting involved or supporting terrorism or extremist activity). These latter areas had a compliance rate of 89%.
- Staff were aware of the principles of cleanliness and infection control. However, because of the nature of the work being undertaken in patients' homes we could not observe staff providing clinical care to patients that required a clean or aseptic environment. Staff did not always keep detailed records of patients' care and treatment. A review showed that not all paper records had signatures and that conversations with patients were not always recorded.

## Is the service effective?

Good   

Our rating of effective stayed the same. We rated it as good because:

- Assessments were holistic and person-centred care was delivered in line with National Institute for Health and Care Excellence (NICE) guidance.
- Personalised care plans were used.
- Staff had completed training in the Mental Capacity Act 2005 and the related deprivation of liberty safeguards (DoLS).
- There were many ways in which patients could access help and advice from the community service or through signposting to other organisations with which the service engaged.
- There were evidence-based tools for the assessment of performance.

# Community end of life care

- The service contributed to national data sets.
- The service worked towards a standard based on the principles of the national palliative care 'Gold Standards' framework.
- There was multidisciplinary working with hospices, general practitioners and Macmillan Cancer Support.
- District nurses could refer directly to the 'Hospice at Home' day hospice service.
- The service linked into a general practitioner risk register used to identify patients who needed end of life care input.
- Consent was informed and discussed with patients. 'Do not attempt cardiopulmonary resuscitation' (DNACPR) forms we reviewed were signed and dated.

However:

- Although we saw evidence that consent was being sought it was not recorded in all the records that there had been a full discussion with the patient and their family.
- We saw one record where the use of bed sides was not recognised as a possible use of restraint.

## Is the service caring?

**Outstanding** ☆ ↑

Our rating of caring improved. We rated it as outstanding because:

- We observed compassionate care that met patients' emotional needs. We saw the team engaging with patients, and understanding their needs, and involving them and those closest to them.
- At a focus group meeting of palliative care nurses we were told how they liaised with national charities and support organisations to get emotional support for their patients. This included organising holidays for families who had children under the age of 18. They also told us they had helped organise weddings, nights 'out on the town', and beauty therapy amongst other things for their patients.
- In the discussion with the specialist palliative care team they gave us examples where they had supported the families of patients for extended periods when the patient had died. They also sought additional support services for families when needed. They gave two examples of where family members had rung them after their loved one's death and were considering ending their own lives. The team had supported them to access additional support services and then liaised with that service to offer any support that they could.
- Evidence from surveys, statements by relatives, and our conversations with patients, and staff, showed the highest degree of compassion, emotional support, understanding and involvement of patients and those close to them. This was supported by written compliments that formed part of these surveys.
- Staff communicated verbally and in writing with patients and those close to them. Translation and interpretation services were available if required.
- All patients were given the opportunity to complete an advance care plan.
- Patient and carer questionnaires were used to measure the quality of service provision.



# Community end of life care

## Is the service responsive?

**Outstanding**  

Our rating of responsive improved. We rated it as outstanding because:

- People who were nearing the end of life had access for care and support in a timely manner 100% of urgent referrals between April 2017 and March 2018 were seen in 24 hours.
- There was good communication between the trust teams and with general practitioners, hospices and other partners to ensure individual patients needs were met.
- Access to the service for patients and the flow of patients through the system was effective and efficient. It consisted of a pathway that included both community and in-patient end of life care service teams and was easy to access. Assessment could be obtained within 24 hours if required.
- There were suitable and appropriate patient information leaflets that explained the end of life pathway and the care involved in the community. The leaflets were empathetic and included signposting to other services. Patient information leaflets were available in other languages, we saw a leaflet in Arabic. If not immediately available, leaflets could be produced in any language required.
- There was a named specialist palliative care nurse for every patient who supported them through the end of life pathway. Personalised care planning was in place. Full patient choice was shown through advanced care plans.
- There was a link nurse for care homes and nursing homes.
- People with disabilities were assisted through the process and any support from other agencies was facilitated.
- People living with dementia, and those close to them, were assisted through the end of life care pathway by specially trained staff.
- There was close working with the two local hospices, at one of which the community palliative care consultant was an honorary consultant.
- We found that staff helped patients obtain help from other services and supported hobbies and other activities.
- The team ensured that where the patient wanted to die was always respected.
- There were projects to reach hard to reach groups and there was an appreciation of those groups of people who did not access end of life care services. One project was working with a homeless charity to ensure homeless people had equal access to the end of life care pathway.
- There was a pathway for the withdrawal of ventilatory support that was fully consented. We were told of examples where this had been facilitated at home because that was the wish of the patient
- There was an out-of-hours support line that was available through the hospices. Although this was not always staffed by the palliative care consultants, those taking part in the rota were general practitioners and other clinicians trained and supported by the consultants. This out-of-hours support line linked into the out-of-hours general practitioner service and the hospices.
- There was a team of clinical psychologists to support patients and staff when required.
- The team attended group supervisions with a clinical psychologist. This was an opportunity to discuss troubling or difficult cases in a safe environment.

# Community end of life care

- There were links with the ambulance service through work on a joint committee. This work had led to cohesive do not attempt pulmonary resuscitation (DNACPR) guidelines that ensured the patients' wishes were respected throughout the care journey. There was also a specialist end of life care ambulance.

## Is the service well-led?

Good   

Our rating of well-led stayed the same. We rated it as good because:

- The clinical lead for the community end of life service was a palliative care consultant. They worked on a daily basis with the nursing lead for the community team, and their colleagues in the hospital. They understood the challenges the service presented and planned for future provision. This planning included pro-actively engaging with other stakeholders within and outside of the trust.
- There was a dedicated non-executive and executive director aligned to the team. While the current non-executive director was new in post, the team had made contact with them and invited them to team meetings.
- There was a clinical governance and corporate governance framework for the specialist palliative care and end of life teams, that encompasses the community service.
- There was a clinical governance framework for the specialist palliative care and end of life teams, that encompassed the community service.
- The service was part of the regional end of life care network and took a leading role in the network.
- We found a very supportive and open culture. There was a culture of everybody working together in a non-hierarchical manner for a common goal.
- The sometime stressful nature of the work was appreciated and clinical psychologists were available to support the team.
- The service lead who was a palliative care consultant made themselves available to all of the team either through meetings or on a one-to-one basis. This allowed all grades to contribute to the effective running of the service.
- The leadership of the service were aware of areas of risk that were recorded in a risk register that was up-to-date, appropriate and regularly reviewed.
- There was a palliative, end of life and bereavement care strategy for 2018 to 2021.

However:

- There was a lack of provision of end-of-life care provision for children although this was a commissioning issue outside of the responsibilities of the service. It was noted that one of the consultants worked pro-bono in their own time to help the service meet patients' needs.
- There was no operational manager post within the team, that was jointly consultant and nurse led. The team recognised that this role would further strengthen their leadership, and conversations had taken place at an executive level with a view to implementing this.

## Outstanding practice

- There was evidence of well worked out systems for multidisciplinary working between different staff groups, between different parts of the trust, and with external agencies; such as hospices and the ambulance service.

# Community end of life care

- Evidence from surveys, statements by relatives, and our conversations with patients, and staff, showed the highest degree of compassion, emotional support, understanding and involvement of patients and those close to them.
- There was support from easily accessible translation and interpretation service for patients who could not speak English or communicated in British Sign language.
- There was evidence of a high level of responsiveness in the way the service linked with patients from different backgrounds and facilitated the inclusion of hard to reach groups. The latter being seen clearly in the work done, in collaboration with a local charity, to reach homeless people.
- The service fully supported patients in helping them choose their final place of care. This included the compassionate way in which they supported a patient who was considering using the Dignitas service.
- There was an effective referral system from the in-patient hospital team to ensure new patients accessed the community team quickly and effectively. There was a system of triage to ensure patients got the care and support at the right time.
- There were explanatory leaflets for patients and those close to them that was written in an empathetic and jargon free style. These were also available in different languages.
- There was a culture of everybody working together in a non-hierarchical manner for a common goal.

## Areas for improvement

- There was a lack of provision of end-of-life care provision for children although this was a commissioning issue outside of the responsibilities of the service. It was noted that one of the consultants worked pro-bono in their own time to help the service meet patients' needs.

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 the service provider was not meeting. The provider must send CQC a report that says what action it is going to take to meet these requirements.

For more information on things the provider must improve, see the Areas for improvement section above.

**Please note:** Regulatory action relating to primary medical services and adult social care services we inspected appears in the separate reports on individual services (available on our website [www.cqc.org.uk](http://www.cqc.org.uk))

**This guidance** (see [goo.gl/Y1dLhz](http://goo.gl/Y1dLhz)) describes how providers and managers can meet the regulations. These include the fundamental standards – the standards below which care must never fall.

#### Regulated activity

Treatment of disease, disorder or injury

#### Regulation

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

# Our inspection team

Sarah Dronsfield, Head of Hospital Inspections, chaired this inspection and Victoria Head, Inspection Manager, led it. Nigel Acheson, Deputy Chief Inspector of Hospitals, supported our inspection of well-led for the trust overall.

The team included 8 [further] inspectors, 2 executive reviewers and 5 specialist advisers.

Executive reviewers are senior healthcare managers who support our inspections of the leadership of trusts. Specialist advisers are experts in their field who we do not directly employ.