# South Tees Hospitals NHS Foundation Trust

## Quality Report

The James Cook University Hospital
Marton Road
Middlesbrough
TS4 3BW
Tel: 01642-850-850
Website: www.southtees.nhs.uk

Date of inspection visit: 8 -10 June and 21 June 2016
Date of publication: 28/10/2016

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

## Ratings

| | |
|---|---|
| Overall rating for this trust | Good |
| Are services at this trust safe? | Good |
| Are services at this trust effective? | Good |
| Are services at this trust well-led? | Good |

# Summary of findings

## Letter from the Chief Inspector of Hospitals

We inspected the trust from 8 to 10 June 2016 and undertook an unannounced inspection on 21 June 2016. We carried out this inspection as part of the Care Quality Commission's (CQC) follow-up inspection programme to look at the specific areas where the trust was previously rated as 'requires improvement' when it was last comprehensively inspected on the 9-12 and 16 December 2014.

At the comprehensive inspection in 2014 the trust overall was rated as requires improvement for their acute and community services. It was requires improvement for the safe and effective key questions at both hospital locations. The remaining key questions were rated good overall. Community health services were rated good overall, with requires improvement for the urgent care centre.

During this inspection, the team looked at one key question in urgent and emergency care, medicine and outpatients at both hospital locations. One key question in children's and young people at one of the hospitals, three key questions in end of life care at both hospitals, plus two key questions in the urgent care centre and one in community inpatients at one other location. All these services had previously been rated as requires improvement, and all came out as good following the June inspections.

We included the following locations as part of this inspection:

**James Cook University Hospital**

- Urgent and Emergency services;
- Medical Care;
- Services for Children and Young People;
- End of Life Care;
- Outpatients and Diagnostic Imaging.

**The Friarage Hospital**

- Urgent and Emergency Services;
- Medical Care;
- End of Life Care;
- Outpatients and Diagnostic Imaging.

**Redcar Primary Care Hospital**

- Urgent Care Centre;
- Community Inpatients

Our key findings were as follows:

- Patients received appropriate pain relief and were able to access suitable nutrition and hydration as required.
- There were defined and embedded systems and processes to ensure staffing levels were safe. Nurse staffing in neonates did not fully comply with British Association of Perinatal Medicine (BAPM) standards. However, there was a period of sustained improvement in recruitment and increased staffing compliance rates since April 2016. During this inspection, we did not observe any evidence to suggest the level of nurse staffing was inadequate or caused risk to patients in the areas we visited.
- The trust had infection prevention and control procedures, which were accessible and understood by staff. Across both acute and community services patients received care in a clean, hygienic and suitably maintained environment. However, there were some issues with cleanliness in the discharge lounge at the Friarage Hospital.
- Patient outcome results had improved in areas of sepsis, senior review of patients in A&E with non-traumatic chest injury, febrile children and unscheduled return of A&E patients.
- Staff understood the basic principles of the Mental Capacity Act (MCA) and Deprivation of Liberty Safeguards and could explain how these worked in practice.
- There was consistency in the checking and servicing of equipment. However, there was one piece of equipment used in the mortuary at the Friarage Hospital, which had not been adequately maintained.
- Competent staff that followed nationally recognised pathways and guidelines treated patients. There was audit of records to make sure pathways and guidelines were followed correctly.
- Arrangements for mandatory training were good and significant improvements had been made for staff to attend.
- Medication safety was reported as a quality priority in 2016/17 and improvement targets had been set. There were improvements in the management of medicines

# Summary of findings

since our last inspection particularly around effective audit and reconciliation of medicines. However, we found some inconsistencies in the storage of medicines. The trust nursing and pharmacy team acted promptly and these issues were addressed.
- There was an open culture around safety, including the reporting of incidents. Staff were aware of the duty of candour and there were systems to ensure that patients were informed as soon as possible if there had been an incident that required the trust to give an explanation and apology.
- The trust had developed action plans to improve performance of the 4 hour A&E target, 18 week referral to treatment times, c. difficile and 62 day cancer waiting times. These plans provided the necessary assurance that the trust had the actions and capacity to ensure compliance in 2016/2017.
- The trust had commenced a significant period of transformation and organisational redesign in 2015. There was a newly established senior executive team, and there was a clear ambition from the Board to be an outstanding organisation.
- From 1 April 2016, the trust had moved to a new clinical centre structure. There were five centres, which replaced the existing seven centres. Clinical leadership was strengthened.
- The trust had been in breach for governance and finances; however, they had made significant progress against their enforcement undertakings for both elements.
- The recent changes to the executive team were seen by staff to be very positive. There were improvements in the speed of decision-making and visibility of the senior team in clinical areas.
- The trust was strengthening the patient voice and developing strategies to enhance patient and staff engagement.

We saw several areas of outstanding practice including:

- The trust was developing a detailed programme around patient pathways/flow/out of hospital models. This included developing a detailed admission avoidance model to establish pilot schemes in acute, mental health, community and primary care services. This would ensure patients were virtually triaged earlier in their pathway rather than being admitted to A&E. This would support patients closer to home and in more appropriate facilities, and reserve acute capacity for patients who required it.
- The Lead Nurse for End of Life Care was leading on a regional piece of work for the South Tees locality looking at embedding and standardising education around the 'Deciding Right' tools (a North East initiative for making care decisions in advance).

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

Importantly, the trust should:

- Ensure that processes are in place and understood by mortuary staff at the Friarage Hospital for the maintenance, moving and handling of equipment and transfer of deceased patients particularly out of hours.
- Ensure that the emergency nurse call bell in wards 10 and 12 is reviewed to ensure it is fit for purpose.
- Continue to review the level and frequency of support provided by pharmacists and pharmacy technicians to ensure consistency across wards.
- Ensure medication processes are followed consistently particularly 'do not disturb' procedures for staff completing medicine rounds.
- Ensure that that the frequency of controlled drug balance checks are carried out in line with national guidance.
- Ensure that the end of life strategy is approved and implemented and move to develop a seven-day palliative care service.
- Continue to develop plans to ensure appropriate staffing levels on wards, particularly in the neonatal unit to meet the British Association of Perinatal Medicine guidelines.
- Review arrangements for the discharge lounge at the Friarage Hospital in terms of maintaining and cleaning equipment and ensuring the environment was suitable for patients and purpose.

**Professor Sir Mike Richards**
**Chief Inspector of Hospitals**

# Summary of findings

## Background to South Tees Hospitals NHS Foundation Trust

The trust is the largest hospital trust in the Tees Valley with two acute hospitals, at James Cook University Hospital and The Friarage Hospital, providing district general hospital services for the local population. The trust also offers services in a number of community hospitals, delivering community health services in Hambleton, Redcar, Richmondshire, Middlesbrough and Cleveland. In addition, the trust provides a range of specialist regional services to 1.5 million people in the Tees Valley and parts of Durham, North Yorkshire and Cumbria, providing expertise in areas as diverse as neurosciences to cancer services. The trust is the major trauma centre for the southern part of the northern region.

The trust has links with the Universities of Teeside, Durham and Newcastle and uses its purpose-built academic centre to support medical students, and nursing and midwifery students to do their clinical placements on-site. The trust is also a member of the academic health science network for the North East and North Cumbria.

The trust has made significant changes to its management and governance structures since the last comprehensive inspection and during our follow-up inspection, it was clear that those changes were continuing under the management of the new chief executive. In the period 2014-2017, the trust was committed to delivering on a significant financial recovery programme.

## Our inspection team

Our inspection team was led by:

Chair: Amanda Stanford, Head of Hospitals Inspections, Care Quality Commission

Inspection Lead: Helena Lelew, Inspection Manager, Care Quality Commission

The team included CQC inspectors and a variety of specialists including an A&E nurse, a doctor in medicine, a nurse in medicine, a community nurse specialising in end of life care, a paediatric nurse, hospital managers and a nurse specialising in outpatient care.

## How we carried out this inspection

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

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

The inspection team inspected the following core services at James Cook University Hospital and The Friarage Hospital:

- Urgent and emergency care
- Medical care (including older people's care)
- Services for children and young people (James Cook only)
- End of life care
- Outpatient and diagnostic services

The community health services were also inspected for the following core services:

- Urgent care centres
- Community services for adults

# Summary of findings

Prior to the announced inspection, we reviewed a range of information that we held and asked other

organisations to share what they knew about the hospital. These included the clinical commissioning

group (CCG), Monitor, NHS England, Health Education England (HEE), the General Medical Council (GMC), the Nursing and Midwifery Council (NMC), Royal Colleges, Overview and Scrutiny Committees and the local Healthwatch.

We held a listening event on 1 June 2016 in The James Cook University Hospital to hear people's views about care and treatment received at the hospitals. We used this information to help us decide what aspects of care and treatment to look at as part of the inspection.

We carried out the announced inspection visit from 8 to 10 June 2016 and undertook an unannounced inspection on 21 June 2016.

## What people who use the trust's services say

- The results of the annual CQC Inpatient Survey 2015 showed the trust was rated among the best performing trust in two areas, emergency/A&E department and care and treatment and for the other nine indicators the trust was ranked in the upper end of the 'about the same as other trusts' category.
- The percentage of people recommending the trust according to the Friends and Family test was 96% at March 2016 compared to the England average of 95%.
- The Cancer Patient Experience Survey results for 2014 for inpatient stays showed that the trust was in the top 20% for 18 out of 34 indicators, with one indicator in the bottom 20%. This indicator was about whether a patient's health got better or remained about the same while waiting; the trust scored 77 with the top 20% score for all trusts being 83.
- Results of the Patient-Led Assessments of the Environment (PLACE) 2015 showed that the trust scored for cleanliness 99% (England average 98%), food 85% (England average 88%), privacy, dignity and wellbeing 83% (England average 86%) and facilities 93% (England average 90%).

## Facts and data about this trust

- For the period 2014-2015, the trust had 30,897 inpatient admissions, 783,596 outpatient attendances, and in accident and emergency, 242,722 attendances. It had 7571 staff and 1037 beds (927 general and acute, 72 maternity and 38 critical care).
- The catchment area of South Tees Hospitals NHS Foundation Trust included people in Middlesbrough, Redcar & Cleveland, Richmondshire and Hambleton Local Authorities (LA). The LAs of Middlesbrough, Redcar and Cleveland were in the most deprived quintile compared to other LA districts with Middlesbrough being the most deprived district nationally. In comparison, Richmondshire and Hambleton were both in the second least deprived quintile compared to other LA districts.
- Between March 2015 and February 2016, the trust had one never event (in surgery) and 65 serious incidents the majority of which related to pressure ulcers.
- The trust reported 10,342 incidents with 98% categorised as low or no harm.
- The number of reported NRLS incidents was slightly lower (worse) than the England average (7.4 per 100 admissions compared to the England average of 8.6).
- There were three cases of MRSA between August 2014 and August 2015. There were no MRSA bacteraemia cases since January 2016.
- There were 86 cases of c.difficile in the same period. The number of cases per 10,000 bed days was

# Summary of findings

generally worse than the national rate but there had been improvements during 2016. There were four cases of Clostridium Difficile in April 2016 against a trajectory of five.

- There were 31 cases of MSSA between August 2014 and August 2015. The rate per 10,000 bed days was similar to the national average.
- There were 2,100 deaths between April 2014 and March 2015 across acute and community services.
- The number of written complaints had increased between 2010/2011 and 2014/2015 from 308 to 471, an increase of 53%. New complaints for 2015/2016 showed the trust had lower numbers compared to other trusts of a similar size.
- The trust performed within expectations for all questions in the 2015 GMC National Training Survey.
- The trust had a mixed performance in the 2015 NHS staff survey with three indicators being above and three indicators being below the national average.
- The financial position for 2014/2015 showed:

  Revenue: £559,100,000

  Full Cost: £576,400,000

  Surplus (deficit): (£17,300,000)

# Summary of findings

## Our judgements about each of our five key questions

| | Rating |
|---|---|
| **Are services at this trust safe?**<br>During our inspection in 2014, the trust required improvement for this domain in medical care, services for children and young people, end of life care, outpatients and diagnostic imaging and community inpatients. This included areas of nurse staffing levels, infection control, mandatory training, management of medicines and the checking of equipment.<br><br>At this inspection we found improvements had been made against the regulations and safe was rated as good because:<br><br>• There were processes to ensure safe staffing levels on wards. If staffing levels fell short of those planned this included reducing capacity if safe staffing could not be maintained. There was continuing recruitment including recruitment from overseas. During the inspection we did not observe any evidence to suggest the level of nurse staffing was inadequate or caused risk to patients in the areas we visited.<br>• There was consistency in practice for the checking and servicing of equipment according to trust policy and manufacturers guidance. However, there was some equipment used in the mortuary at the Friarage Hospital, which had not been adequately maintained.<br>• We found an open culture around safety, including the reporting of incidents. Staff were aware of the duty of candour and there were systems to ensure that patients were informed as soon as possible if there had been an incident that required the trust to give an explanation and apology.<br>• Mandatory training levels had improved. Wards were on target to achieve attendance targets.<br><br>**Duty of Candour**<br><br>• The Director of Quality and Risk was responsible for duty of candour and the lead person for day-to-day management of this was the Patient Safety Manager. The duty of candour is a regulatory duty that relates to openness and transparency and requires providers of health and social care services to notify patients (or other relevant persons) ofcertain 'notifiable safety incidents'andprovide reasonable support to that person. The patient safety team ensured duty of candour was discharged for every incident where moderate or above harm had occurred. | Good  |

- The trusts Being Open (Duty of Candour) policy gave guidance and example templates for staff and showed levels of responsibility for different groups of staff in respect of different types of incidents.
- An update on compliance with duty of candour was supplied on a monthly basis as a performance measure to the clinical commissioning group and an annual update was presented to the Quality Assurance Committee (October 2015).This annual report included the results of an audit of 10 sets of case notes, which related to patients that had suffered harm following a patient safety incident.
- The trust held an awareness event in May 2015, which was attended by over 100 members of consultants and other senior staff.Duty of Candour training was incorporated into root cause analysis and complaints investigation training, which had been undertaken with a core group of staff.The Patient Safety Manager at clinical centre governance meetings facilitated other un-planned sessions.On-going advice and support was provided as an incident occurred.
- We reviewed five serious incident investigation reports and found that duty of candour was applied.

**Safeguarding**

- The Board lead for safeguarding was the Director of Nursing. The trust had a Safeguarding and Looked after Children Governance Group and Safeguarding Adults Steering group. Both groups report to the overarching strategic safeguarding group chaired by the Director of Nursing and reports to the Quality Assurance Committee.
- The trust sat on two inter-agency Safeguarding Adults Boards and had a board member on two safeguarding children's boards.
- The team worked closely with multi-agencies and represented the trust by attending multi-agency sexual exploitation reviews, domestic homicide reviews, multi-agency police protection arrangements (MAPPA) and PREVENT – a government counter terrorism strategy which focuses on the potential radicalisation of staff or patients.
- In the Safeguarding Annual Report published in May 2015, the trust reported 2974 child safeguard consultations with the safeguarding team in 2014/15. The report re-inforced the trust's statutory, regulatory and contractual responsibilities to safeguarding children.
- Trust mandatory training on safeguarding included signs and symptoms of child sexual exploitation (CSE), female genital mutilation (FGM) and learning from serious case reviews (SCR).

# Summary of findings

- The trust was compliant with the recommendations of the Lampard Report following the Savile inquiry.
- Safeguarding training had improved. Data for June 2016 showed 87% of staff had received level one children's safeguarding training and 87% had received safeguarding level 1 training for adults against a trust target of 90%. Those staff requiring level three training had achieved 100%.

**Incidents**

- Between March 2015 and February 2016, the trust had one never event (in surgery) and 65 serious incidents, the majority of which related to pressure ulcers.
- A comprehensive investigation report was completed using national guidance for the never event relating to wrong site surgery. Learning was identified and the action plan completed.
- The trust reported 10,342 incidents with 98% categorised as low or no harm.
- The number of reported NRLS incidents was slightly lower (worse) than the England average (7.4 per 100 admissions compared to the England average of 8.6).
- The trust had an incident reporting policy and staff reported incidents of harm or risk of harm using the trust risk management reporting system. Medical and nursing staff said they felt confident reporting incidents and near misses.
- The policy for incident management was appropriate and within date.

**Cleanliness, infection control and hygiene**

- The trust had infection prevention and control (IPC) policies, which were accessible, understood and used by staff.
- Health Care Associated Infections (HCAI) action plans were reviewed regularly by the Infection Prevention Action Group (IPAG). Monthly reports went presented to the board.
- Results of the Patient-Led Assessments of the Environment (PLACE) 2015 showed that the trust scored, for cleanliness: 99 (the England average was 98).
- There was a seven-day infection prevention control service. Weekly meetings were held with matrons to discuss IPC issues.
- There were three cases of Methicillin Resistant Staphylococcus Aureus infection (MRSA) between August 2014 and August 2015. There were no MRSA bacteraemia cases since January 2016.
- There were 86 cases of Clostridium Difficile (c.difficile) in the same period. The number of cases per 10,000 bed days was generally worse than the national rate but there had been improvements during 2016. There were four cases of c.difficile in April 2016 against a trajectory of five.

- There was an antibiotic pharmacist and IPC consultant to champion stewardship. The IPC consultant, nurse and pharmacist carried out daily antibiotic ward rounds. A new antibiotic prescription chart with a 72-hour stop review helped to stop antibiotics being prescribed for too long. Audit results showed prescribing was good.

**Environment and Equipment**

- There were processes in place for the checking of resuscitation equipment. Records showed daily checks were completed. There were some issues with equipment checks and maintenance in the mortuary at the Friarage Hospital.
- A discharge lounge had been established in a bay of Ainderby ward. It was untidy and cluttered with broken bed frames and chairs. Items of equipment were not clean and the environment had not been adapted for the needs of patients using a discharge lounge.
- In the 2014 children's survey, parents responded to questions about safety on the ward and the appropriateness and safety of equipment. All questions relating to safety scored 'about the same' as other trusts.
- There was a seven year planned programme of refurbishment for the tower block wards. Ward 3 refurbishment was an excellent example of this. Ward 9, 10 and 12 were yet to be refurbished.
- We noted that the nurse call system in wards 10 and 12 sounded the same as the cardiac arrest alert. Staff we spoke with told us that this continued to cause confusion and false alarms amongst staff. Ward 3 had been refurbished and the nurse and emergency call systems issue had been resolved as part of the programme.
- Ward matrons performed a regular environmental audit. Action plans were developed to improve standards against the environmental audit.

**Mandatory Training**

- Mandatory training provision had been re-designed to include a wider range of subjects over a single day study and as online modules. Staff we spoke with told us the new system was improved and working well to support staff achievement and attendance to essential training.
- Senior staff had clear objectives to achieve annual targets for appraisal and mandatory training for staff. Wards were comparable and on target to achieve attendance targets.
- Achievement of mandatory training targets was a trust priority and had been reported in the risk register in October 2015.

# Summary of findings

**Nurse staffing**

- During 2015, an external nursing workforce review was undertaken and the recommendations formed the basis for agreed templates setting out the number of nurses required per shift and the skill mix.
- Associate directors of nursing within the clinical centres were assured that safe care was delivered and systems and processes were in place should staffing levels fall short of those planned. This included reducing capacity if safe staffing could not be maintained. A number of centres reduced bed capacity during March on a temporary basis due to a combination of sickness and vacancies (average number of beds closed: 31).
- Staffing fill rates were reported to the Board every month and the Safer Nursing Care Tool used to review establishments every six months.
- Nursing 'Red Flag' events continued to be recorded on the incident reporting system. This included areas with less than two registered nurses (RN) present on a ward during any shift or a shortfall of more than 8 hours or 25% of registered nurse time available compared with the actual requirement for the shift.
- Some wards had registered nurse fill rates below 80% including wards 7, 9 and 34 at JCUH, Romanby at FHN and Zetland ward at Redcar Community Hospital. All maintained a maximum 1:8 RN to patient ratio supported by assistant practitioners and the therapeutic care team.
- There was continuing recruitment. A revised process for Band 5 recruitment had been implemented resulting in the appointment of 22.48 WTE (whole time equivalent). Overseas recruitment was also taking place: these nurses would be working at band 3 until their NMC registration arrived and had been placed in surgery (wards 5, 6 and 7) and orthopaedics (ward 34) at JCUH and two wards at FHN.
- At the last inspection, we noted that improvements were required in staffing levels on the children's wards. During this inspection, we did not observe any evidence to suggest the level of nurse staffing was inadequate or caused risk to children in the areas we visited. Fill rates for ward 21 between March and May 2016 averaged 93% for registered nurses covering days and 139% for nights. Healthcare assistants fill rates were 61% on days and 96% on nights. Ward 22 figures were better at 104% for registered nurses covering days and 99% at night with healthcare assistants at 101% and 108%.
- 15 nursing staff, (10 whole time equivalent) were being phased into the neonatal unit, which would bring staffing levels up to meet the British Association of Perinatal Medicine (BAPM, 2010) guidance.

- A&E had recruited nursing staff and filled junior doctor vacancies. There was a team of staff dedicated to the resuscitation area. Staff and managers told us that although the department was busy, there were no concerns about the level of staffing in the department. A senior nurse and consultant who co-ordinated activity and moved staff to the busiest areas as and when necessary oversaw the teams in the department.

**Medicines**

- Over the last two years, the trust had invested £750,000 in additional clinical pharmacists. Pharmacy staff provided medicines management support. Their role included medicines reconciliation on patient admission, regular prescription reviews and stock management in wards.
- Medication safety was reported as a quality priority in 2016/17 and improvement targets had been set. There was monitoring through quality dashboards.
- We previously reported 60% compliance against The National Institute of Health and Care Excellence (NICE) guidance with medicine reconciliation for patients within 24 hours of admission. During this follow-up inspection, compliance had improved to 90%.
- Controlled drugs (CDs - medicines that require extra checks and special storage arrangements because of their potential for misuse) were stored securely and checked regularly. This included the Critical Care unit. This was an improvement from our previous inspection, however due to the frequency of use on the ward environment the frequency of reviews of controlled drug balance checks were not always carried out in line with national guidance. We saw that patients own controlled drugs were not always transferred with them if they moved wards or if they were discharged.
- Management of medicines was routinely audited across the trust as part of an audit programme. This included medicines reconciliation, safe and secure storage of medicines, controlled drugs, antibiotic prescribing and omitted doses. Audit results were shared through appropriate groups and action plans were prepared and acted upon. We saw plans to implement omitted doses and nil by mouth policies as a result of an omitted doses audit.
- During the inspection, we found out of date patient own medicines stored in cupboards in ward 10 and 12. We found out of date medicines and bottles of liquid medicines open with no system to inform staff of the date of opening. This increased the risk that the drug could be administered beyond its expiration date.

# Summary of findings

- Systems to monitor the storage of medicines requiring refrigeration were inconsistent across wards. Staff we spoke with did not understand when they would ask for advice from pharmacy staff or if recorded temperatures were outside an indicated safe range. We brought this to the attention of senior staff.
- The Director of Pharmacy had a clear vision of the future of the pharmacy service. There was an open discussion around the issues the trust had faced around significant diversion of medicines. We saw a comprehensive plan was in place and actions being taken to address these issues. There was regular reporting at board level about these issues. A large investment had been made in the clinical pharmacy service and there was a medicines optimisation plan being taken forward within the trust now the diversion of medicines issues were being addressed.
- During the unannounced inspection on the 21st June 2016, we found that managers, pharmacy and nursing staff had promptly put an action plan in place to address the inconsistent practices across the trust. This was implemented to include, use of a date opened sticker system for bottled liquid medicines, additional checks as part of ward audits and a new system for fridge temperature and room temperature recording. The drug fridge was removed from ward 12 and a replacement ordered. There were new room temperature thermometers installed. Staff we spoke with had been informed of the changes and communication to staff about the improvements were on-going, however the actions had been taken and new systems implemented across the trust.

**Are services at this trust effective?**

Good

During the inspection in 2014, the trust required improvement for this domain in urgent and emergency care, end of life care and the urgent care centre. It showed improvements were required in patient outcomes, staff competences in the use of syringe drivers and assessment of nutrition and hydration for end of life care, application of the Mental Capacity Act and the recording of Do Not Attempt Cardiopulmonary Resuscitation (DNACPR).

At this inspection we found improvements against the regulations had been made and effective was rated as good because:

- Patient outcome results had improved in areas of sepsis, senior review of patients in A&E with non-traumatic chest injury, febrile children and unscheduled return of A&E patients.

- National targets for patients with a severe head injury showed the median time patients waited in A&E was 30 minutes, which was better than the national target of 60 minutes.
- Across the trust, the unplanned re-admission rate to A&E within seven days was better than the England average of 7.5%.
- Staff understood the basic principles of the Mental Capacity Act (MCA) and Deprivation of Liberty Safeguards and could explain how the principles worked in practice.
- There were improvements in the audit of Do Not Attempt Cardiopulmonary Resuscitation, nutrition and hydration and pain relief assessments for patients receiving end of life care.

**Evidence based care and treatment**

- Departmental policies were based upon the National Institute for Health and Clinical Excellence (NICE) and Royal College guidelines. We looked at a reference tool available to staff and found that guidelines reflected recent updates to NICE guidance.
- Care was provided in line with 'Clinical Standards for Emergency Departments' guidelines and there were audits in place to ensure compliance. Staff acknowledged that results to some audits had been poor in the past but could give examples of work undertaken to make improvements such as introducing new documentation and changing treatment pathways to ensure compliance.
- The trust participated in the implementation of a person centred holistic nursing assessment (core care plan 25), which was in development at the time of the 2014 inspection and was implemented in January 2015 and included clear assessment of nutritional and hydration and pain relief for patients at the end of life. Audits showed good results in these areas.
- During 2014/2015, the trust participated in 100% of the national clinical audits and 100% of the national confidential enquiries of the national clinical audits and national confidential enquiries, which it was eligible to participate in.

**Patient outcomes**

- At our last inspection, we identified that the A&E department was not meeting some of the standards identified in RCEM audits. The department had since carried out a local re-audit. This showed that although there was still not 100% compliance, results had improved. The audit was completed in March 2016 and therefore a re-audit was yet to be planned using the newly introduced electronic recording system.

- A re-audit of the sepsis standards following the results of the RCEM sepsis audit showed that 11 of the 12 indicators had improved. One indicator had deteriorated.
- The re-audit of consultant sign off in 2015 showed that 91% of non-traumatic chest injury patients received senior review (previously 33%), 100% of febrile children received review (previously 37.5%) and 96% of unscheduled return patients (previously 80%) had been reviewed by a consultant. This shows an improved position to the previous audit.
- Staff had undertaken a recent re-audit of prescribing of steroids for children with an exacerbation of asthma. The re-audit was because of poor performance in the RCEM audit in 2013-2014. The results showed that although the standard was not fully met, compliance had improved from 42% to 67%. A further action plan was being developed at the time of our inspection.
- Trauma Audit Research Network (TARN) informationshowed that in 2014/2015, there were 0.2% additional survivors per 100 patients than were expected to survive. This means that more patients survived than expected between April 2014 and March 2015.
- TARN data showed that a consultant saw 88% of chest injury patients compared to the national figure of 66%.
- National targets for patients with a severe head injury showed the median time patients waited in A&E was 30 minutes, which was better than the national target of 60 minutes.
- Across the trust, the unplanned re-admission rate to A&E within seven days was better than the England average of 7.5%.
- The trust had developed action plans to improve performance of the 4 hour A&E target, 18 week referral to treatment times, c. difficile and 62 day cancer waiting times. These plans provided the necessary assurance that the trust had the necessary actions and capacity to ensure compliance throughout 2016/2017.

**Consent, Mental Capacity Act & Deprivation of Liberty safeguards**

- Staff understood the basic principles of the Mental Capacity Act (MCA) and Deprivation of Liberty Safeguards and could explain how the principles worked in practice.
- Trust wide audit led by elderly care in January 2016 showed 100% compliance with the requirement for patients who lack the capacity to make a decision about resuscitation to have a documented mental capacity assessment.
- Training figures for MCA training for the trust was 65% against a target of 90%.

# Summary of findings

- There were concerns raised at the last inspection relating to patient restraint in A&E. During this inspection, staff told us that they would always use the least restrictive option and would only use physical restraint as a last resort. This was in line with the trust policy. Whenever restraint was used, this was reported as an incident and monitored to ensure that correct procedures were applied.

**Are services at this trust well-led?**

Good

Well-led was rated as good because:

- The trust had commenced a significant period of transformation and organisational re-design in 2015. There was a newly established senior executive team, the majority of whom including the Chief Executive had been in post for less than a year. There was a clear ambition to be an outstanding organisation.
- From 1 April 2016, the trust had moved to a new clinical centre structure. There were five centres, which replaced the existing seven centres. Clinical leadership was strengthened. Performance and development objectives were aligned to the strategic drivers of the organisation.
- The trust had been in breach for governance and finances; however, they had made significant progress against their enforcement undertakings for both elements.
- The recent changes to the executive team were seen by staff to be very positive. There were improvements in the speed of decision-making and visibility of the senior team in clinical areas.
- The trust was strengthening the patient voice and developing strategies to enhance patient and staff engagement.

**Vision and strategy**

- The trust held two strategy dialogue days per year. One hundred and forty senior managers had attended and bought into the strategy of the organisation. Each centre presented their strategic direction and development plans.
- The trust was working closely with local commissioners to develop alternative models of care to reduce admissions to hospital and move care closer to home. During 2015/16, the focus of this work was the Emergency Care Pathway programme. This had resulted in improvements in patient flow, reduced admissions, reduced cancellations, reduced delayed transfers of care and improved discharge.

# Summary of findings

- An Integrated Programme Board had been established with CEOs of the trust and Tees CCG and social care to identify a programme of work, which was mapped to the trust's transformation programme.
- The regional strategic transformation plan (Better Health Programme) was currently scoping the flow of patients across the region with agreed service quality standards with a view to re-designing services across Tees, Durham, Darlington and Hambleton and Richmondshire.

**Governance, risk management and quality measurement**

- Assurance was provided through a number of sub–committees reporting to the Board. To strengthen this area, the Board had agreed to establish two new committees, the Risk Committee and Workforce Committee.
- The measurement and monitoring of quality was supported by a system of quality dashboards, which included patient safety and experience and workforce metrics. Each ward had a monthly quality dashboard and quality performance was monitored through performance reviews with each clinical centre through the Quality Assurance Committee (QAC).
- All clinical centres held local risk registers. Where risks met thresholds these were reviewed by the QAC and escalated to the corporate risk register where required. The top three risks were ensuring patient safety, workforce and finances. The Board was signing off a revised Board Assurance Framework in June 2016.
- The board assurance framework was being refreshed to identify the principle risks to the achievement of the 2016/2017 trust's annual plan; the Board was approving this in June 2016.
- The CQC improvement plan was discussed at relevant steering groups and was a standing agenda item on the QAC.
- There was a mortality review process, which was further being developed in line with national guidance on mortality surveillance. The integrated performance report provided a monthly summary of the trusts mortality measures and the Board received a detailed quarterly report.
- An annual complaints report was presented to the Board. During 2015/2016, the total number of formal complaints received by the trust was 430, a decrease of 9% on the previous year. From October 2015, there was a triage system where the Patient Safety Manager or Patient Safety Specialist reviewed every complaint received by the Patient Safety Team. This

involved grading, coding, consent, and the best option for resolving the complaint, for example through PALS or a formal route. There was a 1% decrease in the number of re-opened complaints in 2015/2016.
- In 2015/2016, the trust received 24 enquiries from the Parliamentary and Health Service Ombudsman (PHSO). Of those closed, three were not upheld and two were partially upheld.
- We reviewed five root cause analysis reports from serious incident investigations. Action plans were concise and effective and changes to reduce the risk of recurrence was evidenced. Duty of candour was addressed with specific details of when the patient and/or family were communicated with and an apology given.
- Executive and non-executive directors carried out monthly patient safety walkabouts.
- The trust had a business continuity policy. This described the roles, responsibilities, and processes to ensure continuity of services, protection of patients and staff and the reputation of the organisation. Staff were aware of the process for identifying and escalating an incident that was causing service disruption.

**Leadership of the trust**

- There was a newly established senior executive team, the majority of whom including the Chief Executive had been in post for less than a year.
- From 1 April 2016, the trust had moved to a new clinical centre structure. There were five centres, which replaced the existing seven centres. A medical director, associate director of nursing and an operations director led these.
- Clinical leadership was strengthened by having five medical directors who had presence and voting rights on the Board. Medical directors said that there was an atmosphere of shared understanding at Board level with effective challenge where necessary. Medical Directors could give information to allow for immediate decisions and worked closely with non-executive directors.
- There were executive director meetings each week, medical directors met three times a week and with the Chief Executive each week.
- Performance and development objectives were aligned to the strategic drivers of the organisation.

**Culture within the trust**

- Staff felt the recent changes to the executive team were very positive. We received feedback that there had been improvements in the speed of decision-making and visibility of the senior team out in the clinical areas that we visited had improved.
- There was a strong drive to devolve accountability to clinical areas**.**

**Equality and Diversity**

- Board reports showed that the trust had carried out the monitoring requirements of the Public Sector Equality Duty of the Equality Act 2010.
- The trust Workforce Race Equality (WRES) report (July 2015) provided baseline data in response to each of the nine WRES indicators. From July 2016, a new standardised template was introduced for each trust and submission was made via UNIFY 2, the system used for sharing and reporting NHS performance information. Following this submission an action plan was being developed and refreshed annually with the data to be published on the trust's internet site.
- The trust had commenced 'values based recruitment' for all new starters joining the trust, to promote equality and consistency. The trust was also working on a broader equality and diversity plan to be completed this year.
- In the 2015 staff survey the trust scored positive findings for the percentage of staff experiencing discrimination at work in the last 12 months (Trust 8% compared to national average of NHS Trusts 10%) and percentage of staff believing that the organisation provides equal opportunities for career progression ( Trust 89% compared to the national average of NHS Trusts 87%).
- Equality and Diversity was presented at monthly corporate induction for new staff and was included in the mandatory training programme.

**Fit and Proper Persons**

- The trust met the Fit and Proper Persons Requirement (FPPR) (Regulation 5 of the Health and Social Care Act (Regulated Activities) Regulations 2014). This regulation ensures that directors of NHS providers are fit and proper to carry out this important role.
- We looked at employment files for all executive and non-executive directors, which contained the required employment checks and were completed in line with the FPPR regulations.

**Public engagement**

# Summary of findings

- The chair of the trust told us they were keen to recruit a non-executive director with customer care experience to enhance patient engagement at board level.
- The trust was working with governors to introduce a mystery shopper programme. Governors, volunteers and patients were involved in developing the patient engagement strategy.
- The trust hosted a number of carer drop-in events to launch new carer's information. The trust promoted the 'John's Campaign' enabling the right of carers to stay with a patient admitted to hospital with dementia.
- The results of the annual survey of inpatients 2015 showed the trust was rated among the best performing trust in two areas, emergency/A&E department and care and treatment. In the other indicators the trust was ranked in the upper end of the 'about the same as other trusts' category.

**Staff engagement**

- The overall staff engagement indicator for the trust in 2015 was 3.71; this was a marginal deterioration on the 2014 staff engagement indicator. There was a sense from staff and senior managers that staff survey results in this area would improve at the next survey.
- A number of actions had been taken including: the introduction of the CEO weekly update and changes to the blog supports; ongoing work relating to improving communications between front line staff and senior management; Maintaining a Healthy Workforce training programme; and improvements to the occupational health facility, in that there was now fast track access to an Occupational Health Physician.
- A bespoke leadership development programme had been rolled out in a number of clinical centres, which included staff leading on an improvement project.
- There were improvements to the induction and mandatory training programme including increased accessibility and flexibility as to how an employee could complete the programme.

**Innovation, improvement and sustainability**

- The trust had financial challenge; however, it was in the final stages of preparing its schemes for 2016/17, which focused on improving productivity and a better alignment between demand and capacity for all services. Assurances processes focused on assessing impact pre, during, and post cost improvement programme (CIP) development and delivery.

# Summary of findings

- The trust had been in breach for governance and finances; however, they had made significant progress against their enforcement undertakings for both elements. In 2015/2016, there was a 30% improvement in the underlying deficit.
- The trust had developed action plans to improve performance of the 4 hour A&E target, 18 week referral to treatment times, c. difficile and 62 day cancer waiting times. These plans provided the necessary assurance that the trust had the necessary actions and capacity to ensure compliance throughout 2016/ 2017.
- The trust was currently focusing on creating greater alignment between its out of hospital models of care for its JCUH locality with those delivered around its FH locality, with those in its FH locality being more advanced, in terms of the shift in care settings and aspects of integrated care, particularly for care of the elderly.
- The trust was developing a detailed programme around patient pathways/flow/out of hospital models. This included developing a detailed admission avoidance model to establish pilot schemes in acute, mental health, community and primary care services. This would ensure patients were virtually triaged earlier in their pathway rather than being admitted to A&E. This would support patients closer to home and in more appropriate facilities, and reserve acute capacity for patients who required it.

# Overview of ratings

## Our ratings for James Cook University Hospital

| | Safe | Effective | Caring | Responsive | Well-led | Overall |
|---|---|---|---|---|---|---|
| Medical care | Good | N/A | N/A | N/A | N/A | Good |
| Services for children and young people | Good | N/A | N/A | N/A | N/A | Good |
| End of life care | Good | Good | N/A | N/A | Good | Good |
| Outpatients and diagnostic imaging | Good | Not rated | N/A | N/A | N/A | Good |
| **Overall** | Good | Good | N/A | N/A | Good | Good |

## Our ratings for The Friarage Hospital

| | Safe | Effective | Caring | Responsive | Well-led | Overall |
|---|---|---|---|---|---|---|
| Urgent and emergency services | N/A | Good | N/A | N/A | N/A | Good |
| Medical care | Good | N/A | N/A | N/A | N/A | Good |
| End of life care | Good | Good | N/A | N/A | Good | Good |
| Outpatients and diagnostic imaging | Good | Not rated | N/A | N/A | N/A | Good |
| **Overall** | Good | Good | N/A | N/A | Good | Good |

## Our ratings for South Tees Hospitals NHS Foundation Trust

| | Safe | Effective | Caring | Responsive | Well-led | Overall |
|---|---|---|---|---|---|---|
| Overall | Good | Good | N/A | N/A | Good | Good |

# Overview of ratings

## Our ratings for Community Services

| | Safe | Effective | Caring | Responsive | Well-led | Overall |
|---|---|---|---|---|---|---|
| **Community health inpatient services** | Good | N/A | N/A | N/A | N/A | Good |
| **Community health urgent care services (MIU)** | N/A | Good | N/A | N/A | N/A | Good |
| **Overall Community** | Good | Good | N/A | N/A | N/A | Good |

### Notes

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

# Outstanding practice and areas for improvement

## Outstanding practice

- The trust was developing a detailed programme around patient pathways/flow/out of hospital models. This included developing a detailed admission avoidance model to establish pilot schemes in acute, mental health, community and primary care services. This would ensure patients were virtually triaged earlier in their pathway rather than being admitted to A&E. This would support patients closer to home and in more appropriate facilities, and reserve acute capacity for patients who required it.
- The Lead Nurse for End of Life Care was leading on a regional piece of work for the South Tees locality looking at embedding and standardising education around the Deciding Right tools (a northeast initiative for making care decisions in advance).

## Areas for improvement

**Action the trust MUST take to improve**

Please refer to the location reports for details of areas where the trust SHOULD make improvements.