South Tees Hospitals NHS Foundation Trust

The James Cook University Hospital

Quality Report

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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 hospital. It is based on a combination of what we found when we inspected, information from our 'Intelligent Monitoring' system, and information given to us from patients, the public and other organisations.

Ratings

Overall rating for this hospital	Good
Urgent and emergency services	Good
Medical care (including older people's care)	Good
Services for children and young people	Good
End of life care	Good
Outpatients and diagnostic imaging	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 the 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 (adults).

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.
- 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.

Summary of findings

- 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.
- 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 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 commenced a significant period of transformation and organisational re-design 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.

In addition the trust should:

- Ensure that the emergency nurse call system 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 is 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 that staffing levels particularly in the neonatal unit meet the British Association of Perinatal Medicine guidelines.

Professor Sir Mike Richards

Summary of findings

Chief Inspector of Hospitals

Summary of findings

Our judgements about each of the main services

Service	Rating	Why have we given this rating?
Urgent and emergency services	Good 	We rated effective for urgent and emergency care as good because: At our last inspection in December 2014, we identified concerns about the results of Royal College of Emergency Medicine (RCEM) audits. We also identified that staff had not received training on how to safely restrain patients. During this inspection although RCEM audits had not been repeated, the department had completed local audits based on RCEM guidance and we identified significant improvement in compliance in these areas. Patients were able to access treatment seven days a week, 24 hours a day. Competent staff who followed nationally recognised pathways and guidelines treated patients. Records were audited to make sure that pathways and guidelines were followed correctly. Overall, patients received pain relief in a timely way and were able to access food and drinks as required. Staff understood their responsibilities in relation to the Mental Capacity Act (2005), restraint of patients and the treatment of detained patients.
Medical care (including older people's care)	Good 	We rated safe for medicine as good because: We found significant improvements since the comprehensive inspection of the hospital in December 2014. There were processes to ensure safe staffing levels on wards and capacity had been reduced to support nurse to patient ratios being safely maintained. Arrangements for mandatory training were good and significant improvements had been made for staff to attend. Trust targets were being met or plans were in place to achieve them. There were some inconsistency in the storage of medicines; however, the trust nursing and pharmacy team acted promptly and issues were addressed with an improvement action plan to ensure out of date drugs were not stored in wards, liquid medications were labelled to identify when they were opened and arrangements for drug fridges and temperature recordings were improved.

Summary of findings

Services for children and young people

Good

We rated safe for children and young people as good because:
Staff ensured the ward environment and clinical areas were 'child-friendly', secure, clean and well maintained. Equipment was checked, labelled and safely stored. Medicines and clinical records were stored securely. Documentation was good with each child and young person having an individualised plan of care.
The service had good local procedures to monitor changes in a child's condition and arrangements with network colleagues to escalate care when a child deteriorated.
Staff followed trust mandatory training requirements. Managers were working to ensure all staff completed necessary training and to meet trust targets.
There had been an improvement in staffing levels in all paediatric areas since the inspection in December 2014. Additional recruitment was planned to re-enforce staffing in the neonatal unit to ensure compliance with national staffing guidelines. Staffing levels were managed appropriately to ensure they were safe.
Staff reported concerns and incidents where they felt this compromised a child's safety and wellbeing. Outcomes and lessons learnt from investigations were shared with all staff.

End of life care

Good

We rated safe, effective and well-led for end of life care as good because:
The service had made significant improvements in audit and completion of DNACPR forms. Nutrition and hydration assessments were included in an individualised patient assessment tool for patients at the end of life.
Staff delivering end of life care understood their responsibilities with regard to reporting incidents and ensured information and lessons learnt were shared proactively with other colleagues within the hospital.
We saw clear, well-documented and individualised care of the dying documents. The referral process was clear and responsive and staff ensured that patient's wishes were central to the care planning process.
However, although there was a clear vision for the service, which specialist palliative care staff had developed, the trust specific strategy for end of life care was in draft and under review and it was not clear when Board approval would be finalised.

Summary of findings

The trust did not have an overall strategic lead for palliative care but this was identified as a future development. There was no action date to implement this role but the Board were keen to ensure that this happened.

Outpatients and diagnostic imaging	**Good**	We rated safe for outpatients and diagnostic services as good because: There had been improvements in all areas identified during the 2014 inspection. There were processes to ensure that resuscitation equipment was checked each day. Staff had enough personal protective equipment in all the areas and staff knew how to dispose of items safely and within guidelines. There were sufficient staff of all specialties and grades to provide a good standard of care in the departments we visited. There were processes to ensure medicines were managed safely. Practices were monitored and improvements made where required. Staff identified and responded appropriately to changing risks to patients, including deteriorating health and medical emergencies.

The James Cook University Hospital

Detailed findings

Services we looked at

Urgent and emergency services; Medical care (including older people's care); Services for children and young people; End of life care; Outpatients and diagnostic imaging.

Detailed findings

Contents

Background to The James Cook University Hospital

The trust is the largest hospital trust in the Tees Valley with two acute hospitals, at James Cook University Hospital (JCUH) and The Friarage Hospital (FH), 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 including neurosciences, cancer services heart disease, trauma, renal services, and spinal injuries. 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.

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

Detailed findings

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 services

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

• Urgent care centres

• Community services for adults

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 at 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.

Facts and data about The James Cook University Hospital

- James Cook University Hospital provides services to 1.5 million people in the Tees Valley and parts of Durham, North Yorkshire and Cumbria.
- Between April 2014 and February 2016, the urgent and emergency care department saw 201,499 attendances. Of these, 78% were aged 17 or over (158,100) and 22% (43,399) were aged under 17.
- The trust reported 9,869 admissions into children's service between September 2015 and August 2015. 8,496 (86%) of all admissions were to JCUH. 84% of these were classified as emergency admissions, 10% elective and 6% recorded as day case spells.
- Between July 2014 and June 2015, there were 622,886 outpatient attendances.

Our ratings for this hospital

Our ratings for this hospital are:

Detailed findings

	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
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	N/A	N/A	N/A	N/A	Good
Overall	Good	N/A	N/A	N/A	N/A	Good

Urgent and emergency services

Effective	Good
Overall	Good

Information about the service

The emergency department (also known as accident and emergency, A&E or ED) is at the James Cook University Hospital in Middlesbrough. 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 adjacent to the department. Patients who arrive by helicopter are escorted to the department by a dedicated team of staff. Within the department, there are three distinct areas where patients are treated. The minors department can treat patients with minor injuries such as simple fractures; the paediatric emergency department treats patients under 17 with all types of illnesses and injuries; and the majors department treats patients with more serious illnesses or injuries.

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.

We carried out this inspection on only the 'effective' domain because when we inspected the trust in December 2014 we rated the effectiveness of the department as 'Requires Improvement' whereas the department was rated as 'good' for our four other domains, 'safe', 'caring', 'responsive' and 'well-led'.

During our inspection, we visited the main A&E department.

We spoke with staff including doctors, nursing assistants and nurses of all grades. We also spoke with 19 patients and their relatives. We looked at the records of seven patients and reviewed information about the service provided by external stakeholders and the trust.

According to the trust, between April 2014 and February 2016 the department had 201,499 attendances. Of these, 78% were aged 17 or over (158,100) and 22% (43,399) were aged under 17.

Urgent and emergency services

Summary of findings

At our last inspection in December 2014, we identified concerns about the results of Royal College of Emergency Medicine (RCEM) audits. We also identified that staff had not undergone training about how to restrain patients safely.

At this inspection, we found that the department was effective.

Although RCEM audits had not been repeated, the department had completed local audits based on RCEM guidance to ensure that compliance to the guidance had improved. We identified significant improvement in compliance.

Patients were able to access treatment seven days a week, 24 hours a day delivered by staff from a number of different disciplines such as nurses, doctors and allied health professionals.

Competent staff who followed nationally recognised pathways and guidelines treated patients. Records were audited to make sure that pathways and guidelines were followed correctly.

Overall, patients received pain relief in a timely manner and were able to access food and drinks as required.

Staff understood their responsibilities in relation to the Mental Capacity Act (2005), restraint of patients and the treatment of detained patients.

Are urgent and emergency services effective?
(for example, treatment is effective)

Good

We rated effective as good because:

- There were policies and procedures and these were evidence based. Audits took place to ensure staff were following relevant clinical pathways. The trust was taking part in local and national audits and monitoring patient outcomes. The trust had identified a need to improve some audit results where they had outcomes worse than the England average and action was taken to make this happen.
- Staff were able to access information about clinical guidelines. Information about patients such as test results were readily accessible.
- Patients were offered pain relief on arrival at the department and regularly during their stay.
- Patient nutrition and hydration needs were managed and we saw patients being offered drinks and food whilst we were inspecting the department. Patients also confirmed that they were offered food and drinks.
- There was evidence of multi-disciplinary and multi-agency working throughout the department and the department offered a full seven-day service.

Evidence-based care and treatment

- There was a wide range of departmental policies and guidelines for the treatment of both children and adults.
- Departmental policies were based upon 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.
- A specific consultant has responsibility for ensuring that guidance was assessed and policies updated when necessary.

- We saw evidence that the department followed NICE guidance for a number of conditions such as sepsis, head injury and stroke. Where patients presented to the emergency department with these conditions, pathways were commenced.
- 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 department had also run regular training sessions for staff. These covered areas of non-compliance from audits such as, for example, procedures for conscious sedation within the department.
- Local audit activity demonstrated that re-audit took place in the department, and there was evidence of changes implemented as a result. For example, mandatory fields had been added to the IT system to ensure that patient next of kin details were recorded to assist with appropriate discharge of elderly vulnerable patients from the department.

Pain relief

- We saw that patients were asked if they required pain relief as part of the triage process and it was recorded if patients refused. Patients were checked regularly to see whether they needed further pain relief. Patients we spoke with confirmed that they were offered pain relief.
- We looked at the records of seven patients. Six had a pain score recorded and there was evidence that pain levels were re-evaluated throughout the stay in the department. When patients had identified that they were in pain, pain relief was administered as appropriate.
- We saw nurses giving patients pain relief such as paracetamol and ibuprofen using patient group directives (PGDs).
- CQC's national 'Inpatient survey 2015' showed that the trust performed about the same as other similar trusts for whether staff did all they could to control patients' pain.

Nutrition and hydration

- CQC's national A&E survey 2014 showed that the trust performed 'about the same' as other similar trusts for the ability of patients to access food and drinks whilst in the ED Department.
- CQC's national 'Inpatient survey 2015' showed that the trust performed 'about the same' as other similar trusts for the quality and choice of food available. There was no specific information relating to A&E.
- Staff told us that sandwiches, meals and beverages were available to patients. We overheard staff asking patients if they wanted drinks or snacks and we saw patients being offered drinks and being brought meals.
- There were vending machines present in the department that relatives and carers could access and the hospital had a number of shops, cafes and places to eat.

Patient outcomes

- The department took part in Royal College of Emergency Medicine (RCEM) audits so that it could benchmark its performance against best practice and other A&E departments. The results of some audits showed that the department needed to improve compliance with RCEM guidelines.
- At our last inspection, we identified that the department was not meeting some of the standards identified in RCEM audits. For example, in the recording of vital signs at triage. 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.
- We saw that re-audits had taken place to ensure results had improved because of changes made.
- Staff had undertaken a re-audit of the sepsis standards following the results of the RCEM Sepsis audit. The results for JCUH showed that 11 of the 12 indicators had improved. One indicator had deteriorated. However, the sepsis screening tool and National Early Warning Screening (NEWS) tool had been updated and the critical care outreach team had been introduced at the site. The department had also introduced new documentation as a response to poor sepsis audit compliance. There was also an identified consultant lead for the management of sepsis.

- A further re-audit had not yet taken place to measure whether compliance had improved because of these changes.
- 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 still not being met, compliance had improved from 42% to 67%. A further action plan was being devised at the time of our inspection.
- In the 2012 Renal Colic audit, the department had not met any of the standards. In July 2015, the latest revision of the suspected renal colic pathway was introduced. Audit of compliance was yet to take place.
- We spoke with managers about the department's clinical audit programme and saw that there was a comprehensive programme of clinical audit in place within the department. We saw that some re-audits based on RCEM standards were planned. There were also other prioritised audits in place, such as: Admission of patients aged over 90, Neonatal antibiotic prescribing and Alcohol Related Admissions to A&E in Under-18s.
- Trauma Audit Research Network (TARN) information showed 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 88% of chest injury patients were seen by a consultant compared to the national database figure of 66%.
- National targets say that patients with a severe head injury should have a brain scan within 60 minutes of arrival at the department. The median time patients waited at JCUH was 30 minutes. This is better than the national figure.
- Across the trust, the unplanned re-admission rate to A&E within seven days was better than the England average of 7.5%, however it had increased from 4.6% in July 2015 to 7% in January 2016.

Competent staff

- Recently qualified staff were given preceptorship (mentoring and support) and newly employed staff shadowed existing staff prior to being counted as a member of the team for staffing purposes.
- We saw that there was a local induction in place for all new staff including temporary staff. The senior nurses in charge had to sign to say they were happy with the competencies of any bank staff used. The department very rarely used agency staff (0.2% of shifts) however, the same process applied for agency staff.
- According to information provided by the trust, between April 2015 and March 2016, 72% of registered nursing staff had undergone annual appraisal. Within the medical staff, 28% of medical staff had undergone an annual appraisal. 100% of therapy staff based in A&E had undergone annual appraisal.
- We spoke with staff about whether they were able to access support and supervision. Staff told us that the department managers supported them to develop their roles. Staff felt well supported and able to discuss clinical issues openly with colleagues and managers.
- The senior sisters worked with staff to ensure that they were competent. Senior members of staff informally monitored staff competencies throughout the year and managers told us that action was taken to address any concerns about staff competencies. This applied to both medical and nursing staff.
- All staff were part of the revalidation scheme and we identified no concerns about compliance within the department.

Multidisciplinary working

- The emergency department teams worked effectively with other specialty teams within the trust, for example by seeking advice and discussing patients, as well as making joint decisions about where patients should be admitted. There were close links with the ambulatory care department.
- There was good access to mental health clinicians with 24-hour telephone access to psychiatric liaison staff.
- There was a substance and alcohol misuse liaison team available by telephone to support patients and staff treating them.

- Allied health professionals such as physiotherapists and occupational therapists attended the department. This meant that patients who needed therapy input or assessment prior to discharge could be seen quickly and efficiently.
- The department worked closely with the ambulance trust, local GPs and the out of hours service to ensure that unnecessary attendances and admissions to the department were avoided.
- We saw that medical and nursing staff worked well together and communicated clearly and effectively about patients.

Seven-day services

- The emergency department offered a seven-day service staffed 24 hours a day, seven days a week by medical and nursing staff. Staff could access support from consultants throughout the 24-hour period.
- There was 24-hour seven-day access to diagnostic blood tests. The department had some point of care testing which meant that some blood tests could be carried out in the department. Radiology tests such as x-rays and scans were carried out as and when needed and were available 24 hours every day.

Access to information

- Staff were able to access patient information using the electronic system and using paper records. This included information such as previous clinic letters, test results and x-rays. There was also a link to patient information held by GPs such as past medical history and current medications. Having access to comprehensive information about patients ensured they received the most appropriate care and treatment.
- Patients transferred to other services such as the clinical decision unit had documentation that was completed by the sending department. It included information about whether the patient was being transferred on a specific clinical pathway. This meant that important details about the patient's treatment plan were captured and appropriately transferred to the receiving department.
- Clinical guidelines and policies were available on the trust intranet. Staff were able to access these easily when required.
- Staff were able to access a patient's summary care records.
- The electronic system used by the department automatically printed letters to a patient's GP once the patient was shown as discharged from the department. This meant that GPs received discharge letters in a timely manner and could make any relevant adjustments to medications quickly when appropriate.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- We spoke with staff about the Mental Capacity Act (MCA) 2005 and Deprivation of Liberty Safeguards. Most staff understood the basic principles of the Act and were able to explain how the principles worked in practice in the department.
- Training figures for MCA training were at 100% for nursing staff and 47% for medical staff. The trust target was 90%.
- Staff we spoke with understood the need to obtain consent from patients to carry out tests and treatments. Staff told us they considered implied consent when patients agreed to a procedure. We saw evidence of staff explaining procedures to patients and patients agreeing to them.
- An initial assessment of a patient's capacity was made at triage and where concerns were identified, a more detailed assessment would be made each time such a patient needed to make a decision. Staff were able to access Independent Mental Capacity Advocates (IMCAs) when required. These are independent patient advocates to support patients who were deemed to lack or have fluctuating capacity and had no family members to support them.
- Staff we spoke with about restraint 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 had been used.

Medical care (including older people's care)

Safe	Good
Overall	Good

Information about the service

The South Tees Hospitals NHS Foundation trust provides medical care; including older people's care, across two sites, the James Cook University Hospital (JCUH) in Middlesbrough and the Friarage Hospital in Northallerton.

The trust has made significant changes to its management and governance structures since the last comprehensive inspection. Re-organisation of services and staffing were on-going and during this follow- up inspection the new management team in medical care, as part of the community care centre, were establishing roles and responsibilities.

Medical care was managed under four centres at South Tees Hospitals NHS Foundation Trust. The community care centre included care of the elderly, respiratory, endocrinology, rheumatology and dermatology. The specialist care centre included haematology, cardiology, neurology, spinal injury and stroke care. The planned care centre included gastroenterology and acute medicine was now managed under the urgent and emergency care centre. JCUH delivered all of the specialties on its hospital site.

We carried out an inspection in December 2014 and reported in June 2015. We rated medical care overall as good, with the safe domain as requires improvement with concerns around poor ratios of nurses to patients, especially overnight, inconsistent management of medicines including controlled drugs and poor compliance with mandatory training. We rated effective, caring, responsive and well-led as good and therefore did not inspect these domains at this follow up inspection.

We reviewed 14 care records and 10 medicine prescription charts. We spoke with five patients and 18 staff including ward managers, health care assistants, student nurses, doctors, pharmacists, pharmacy technicians and managers. We reviewed performance data about the trust and listened to stakeholders.

Summary of findings

During this inspection, we inspected safe and rated the domain as good, noting significant improvements since the comprehensive inspection of James Cook University Hospital in December 2014.

There were processes to ensure safe staffing levels on wards and the number of beds had been reduced to support nurse to patient ratios being safely maintained. During this follow-up inspection, we did not find any evidence to suggest that nurse staffing was unsafe or would cause a risk to patients in the wards we visited.

Arrangements for mandatory training were good and significant improvements had been made in order for staff to attend and trust targets were being met or plans were in place to achieve them.

During our inspection we found some inconsistent medicines management, however the trust nursing and pharmacy team acted promptly and issues were addressed with an improvement action plan to ensure out of date drugs were not stored in wards, liquid medications were labelled to identify when they were opened and arrangements for drug fridges and temperature recordings were improved.

Medical care (including older people's care)

Are medical care services safe?

Good

We rated safe as good because:

- A trust-wide nurse staffing review in 2015 had supported improvement in ratios of nurses to patients on the day and night shift.
- Ward sisters and matrons were experienced and knowledgeable about nurse staffing levels and the action plans that had been implemented in 2015. Ward sisters had planned daily meetings, escalation policies were embedded and staff worked as a team to cover any shortfalls in staffing.
- Ward sisters had organised training plans and we reviewed training attendance rates, which were good for 2015/16 with strategies in place to achieve annual mandatory training targets for all staff. Display of training information was consistent and available across all wards as senior nursing staff had good access to ward level data for attendance rates. A new approach to mandatory training had been implemented by the trust since our last inspection, and staff we spoke with told us it was working well to improve attendance and achievement of trust targets.
- CCU had improved systems and processes for managing controlled drugs as part of an action plan from previous inspection findings. Staff we spoke with were aware of the learning and improvements.
- The trust had good systems for reporting incidents. Staff we spoke with understood the processes. Feedback was given in team meetings and through a variety of approaches taken by ward managers. Wards had clear display of safety thermometer data (key performance indicators) as part of monitoring safe and harm free care. Results were positive and closely monitored.
- Wards were visibly clean. Display of information reporting low or improving rates of infection were clear at the entrances to wards. We observed good compliance with infection control policies and hand hygiene audits. We observed equipment to be clean and the resuscitation trolleys to be checked and well stocked.
- Staff completed patients' records, including individualised care plans and risk assessments. The electronic system for recording and escalating Early Warning Scores (EWS) for deteriorating patients and those at risk was also good.

However:

- We noted that the emergency nurse call system was faulty in wards 10 and 12, as on previous inspections. Staff we spoke with could not differentiate between a nurse call to assist a patient and the call to an emergency scenario. This was a risk to patient safety when timely responses would be required in an emergency. This issue was resolved on ward 3 as part of refurbishment. No progress had been made with this issue since our last inspection.
- Pharmacists and pharmacy technicians were assigned to support ward areas, however we found the frequency and level of support was inconsistent across wards and recruitment work was on-going.
- On ward 10 and 12, we found out of date medicines. Bottles of liquid medicines were open with no system to inform staff of the date of opening, increasing a risk that the drug could be administered beyond its expiration date. Inconsistent fridge temperature monitoring was observed and we noted that clinic rooms were very warm with no recording of room temperature. During an unannounced inspection on the 21st June 2016, we found that managers, pharmacy and nursing staff had promptly put an action plan in place across the trust that included the use of a date opened sticker system for bottled liquid medicines and a new system for fridge temperature and room temperature recording. Staff we spoke with had been informed of the changes and communication to staff about the improvements had been shared, actions had been taken and the new system implemented across all wards.
- An audit in March 2016 identified wards in community care had low missed doses of medicines with the exception of ward 9 and this had required further action at ward level with support from the pharmacy team.

Incidents

- The centre reported incidents through an electronic system. Incidents were monitored by each department within the centre and could be broken down further into specialities.

Medical care (including older people's care)

- There was evidence of good reporting systems, consistent monitoring by senior staff and all staff we spoke with were aware of the reporting system. Reports were shared in team meetings and as part of staff briefings. We saw minutes of meetings and display of information on all wards inspected. Staff we spoke with told us that there was a good reporting culture amongst the team. We were informed that that 98% of National Reporting and Learning (NRLS) incidents reported were either low or no harm.
- A total of 5504 incidents were reported at the James Cook University Hospital in 2015/16. Incidents in medical care were reported as proportionate across all specialities. A small proportion at 8% (466) was reported in tertiary care, including cardiology and neurosciences. 23% (1276) were reported in specialty care, including dermatology, gastroenterology, haematology, renal, rheumatology and radiotherapy/oncology. Integrated medical care, the largest directorate within the centre reported the highest proportion at 68% (3763) incidents in acute medical wards, chest medicine, diabetes and endocrinology, elderly and stroke care, and critical care services at JCUH.
- The trust categorised incidents according to severity of harm as per trust policy.
- There had been three never events reported by the trust in 2015/16 with one in medical care. This had been reported as wrong site surgery in dermatology. A never event has the potential to cause serious potential harm or death, harm is not required to have occurred for an incident to be categorised as a never event.
- We reviewed the thorough investigation process in dermatology, actions taken and evidence of shared learning across the trust.
- In accordance with the Serious Incident Framework 2015, the trust reported 60 serious incidents from April 2015 to February 2016, which met the reporting criteria set by NHS England. 32 of those incidents were reported as pressure ulcers and 14 as patient falls with harm or fracture. Medical care reported 22 major incidents across its departments to include pressure ulcers, cardiac arrest, medication errors, falls and safeguarding amongst reporting.
- Across all wards within medicine, there had been 105 moderate graded incidents in 2015/2016. A range of incidents were reported with falls, pressure ulcers and infections being the most common.
- Arrangements for mortality and morbidity review for the centre were good. Each centre held their own meetings to share incidents and learning. Additional meetings were held at trust level to strengthen learning across the organisation. Staff told us that additional meetings were arranged if issues were identified.

Duty of Candour

- The duty of candour is a regulatory duty that relates to openness and transparency and requires providers of health and social care services to notify patients (or other relevant persons) of certain 'notifiable safety incidents' and provide reasonable support to that person.
- Staff we spoke with understood that duty of candour requirements involved being open and honest with patients and staff could describe how to access the trust policy. Ward managers had a good understanding of the duty of candour. They explained that they had been involved in investigating, supporting responses and writing letters of apology to patients and families under this duty.

Safety thermometer

- Safety Thermometer data was clearly and consistently displayed at the entrance of all wards we inspected.
- The rates of pressure ulcers and falls were closely monitored and investigations and action plans were quickly put in place when rates of falls or pressure ulcers increased.
- There were 903 falls reported at JCUH across the whole of medical care specialities in 2015/16. Wards we inspected had a good understanding of their own rates and these were displayed. Falls remained a priority for the trust and work with a falls strategy team had been implemented. Staff were knowledgeable about mitigating risks to patients and used a variety of approaches to prevent incidents. Staff had access to low/high beds, appropriate footwear was supplied to patients and staff would have one to one nursing if required. We saw action plans at ward level for patients at risk and for those that had suffered harm through falls.
- The trust has seen a 24% reduction in avoidable category 3 and 4 pressure ulcers from April to December 2015. A 10% reduction in category 2 pressure ulcers was also reported for inpatients. There has been an

increased focus on the prevention of pressure ulcers across the trust.The trust reported 62 catheter associated urinary tract infections (CAUTI) in medical care in 2015/16. This incidence had increased over 2015/16. Of fifteen records reviewed, we noted staff completed all venous thromboembolism (VTE) risk assessments within the first 24 hours of admission. There was a newly developed VTE care pathway in place across sites. We also observed in all patients who required VTE treatment, staff had prescribed the relevant prophylaxis. The trust reported 31 VTE in medical care in 2015/16.

Cleanliness, infection control and hygiene

- All wards inspected were visibly clean. We spoke with domestic staff and reviewed cleaning schedules for routine ward cleaning. We observed systems to indicate equipment was clean and ready for patient use. There was good waste management systems and poster display information to guide staff. Disposal of sharps was observed as compliant with trust policy.
- We observed staff taking opportunity for washing their hands and using hand sanitising gel between patient contacts. We observed staff comply with uniform and 'bare below the elbows' policies. Hand hygiene compliance was greater than 95% across wards we inspected and a commitment to hand hygiene campaigns continued.
- There was good provision of isolation rooms, however we noted that staff did report frequent occasions in 2015/16 where isolation was not available for patients with suspected or actual infection. Staff used personal protective equipment appropriately and we observed staff apply principles of infection prevention and control.
- Clear signage was present for infection control risks and staff and patient information was observed in ward areas.
- The trust were monitoring and responding to the rates of clostridium difficile to ensure incidence did not continue to breach trust targets. At the end of February 2016, there had been 60 cases against a target of 50 for 2015/16. In medical care, this had been reported as 29 in 2015/16 to time of reporting, an increase from 2014/15 figures (23 recorded cases). There had been no reported Methicillin Resistant Staphylococcus Aureus (MRSA) in 2015-2016.
- Wards displayed the monthly and annual rates of infections as part of a wider display of key performance indicators and 'know how you are doing' (KHYD) information boards on each ward. Staff we spoke with were knowledgeable about their areas and when preventable infections had occurred or rates increased, local action plans were implemented and communicated with staff. We spoke to staff about changes in care pathways to guide care for assessment of patients with diarrhoea. A stool chart had been re-designed and this had been communicated to staff to improve assessment and isolation of patients. All staff had attended commode-cleaning training.
- The trust had a clear approach to advising visitors not to attend the ward if they had been unwell. This was in order to reduce the spread of infection.
- Mandatory training within the trust included an infection control module. Staff accessed training online and in face-to-face sessions with the infection control team. 95% of staff in the centre had completed this training so far this year.

Environment and equipment

- 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.
- We checked 16 items of equipment and found all items to be clean and well maintained with annual checks and labelling in place. Ward staff checked resuscitation equipment daily and we found consistent checks and systems across all wards. In previous inspections, we had found this to be inconsistent across wards.
- Ward matrons performed a regular environmental audit and in wards we inspected, compliance was reported as high (greater than 95%) with the exception of ward 9 with lower compliance (around 60% in 2016). Action plans were developed to improve standards and results against the environmental audit.

Medicines

- 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. Monitoring was planned through the centre quality dashboards.
- We previously reported a 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%.
- Wards we visited had safe central system for key storage and access.
- Controlled drug (CD) storage and checks were good in all wards and CCU. We observed improvement and actions that had been taken after the previous inspection. CCU had established a coded keypad access system to the treatment room and weekly checks were clearly displayed.
- We reviewed 10 prescription charts. Medical and nursing staff completed the charts legibly. All prescription charts had patient allergies recorded and we found no discrepancies or missed doses.
- An updated controlled drugs policy had been ratified by the clinical standards committee and shared with staff on the trust intranet site.
- A monthly programme of medicines audit against trust policy was embedded. This included missed medication audits, antibiotic prescribing and controlled drug audit. Audit results were good and where improvements could be made, an action plan was produced and measures put in place to improve standards. It was noted in May 2016 that patients own CD's should be recorded separately to ward stock and this had been implemented. We observed separate 'patient own' log books during the inspection. Minutes of audits were produced and shared with teams. Community Care achieved 99.4% compliance with acceptable antibiotic regime prescriptions in May 2016.
- A comprehensive trust approach to audit of missed doses of medicines had been taken in March 2016 in order to inform development of future policy, assess the current rate of missed doses and improve compliance and awareness amongst staff.
- In response to the National Patient Safety Agency (NPSA) alert 'reducing harm from omitted and delayed medicines in hospitals' the trust identified a list of critical medicines where timeliness of administration was crucial. Learning from the audit had been shared across the trust. Of wards inspected in community care, ward nine had the highest rates of missed doses (472), with much lower rates on ward 10 (67), 12 (31), 3 (98) and CCU (32). According to the trust report ward 9 had the highest rates of missed doses across all wards and it was recognised that standards had not been met. Work was on-going to improve compliance and further audit planned for 2016.
- 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.
- 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 who acted on the information promptly.
- 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 had been removed from ward 12 and a replacement ordered. New room temperature thermometers had also been 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 the new system implemented across all wards.

Records

- We reviewed 14 patient care records during our inspection. Overall, we found records to be well organised, up to date and clear. We saw good examples of legible daily entries and reviews of patient treatment and care.

- Staff recorded outcomes from reviews and discussions with the multidisciplinary team, patients and their families. We saw good evidence of individualised care plans, appropriate risk assessments and discharge planning for patients.
- Health records were stored securely in all wards inspected.
- The trust had implemented and embedded the use of an electronic system for recording of patient physiological observations. Staff had a good understanding of the use of equipment and how the system supported monitoring and recording changes in patient observations.
- We reviewed specific care pathways for patients with chronic obstructive respiratory disease (COPD) and non-invasive ventilation (NIV) in accordance with best practice and British Thoracic Society (BTS) guidelines. We also noted care pathways for patients with stroke. Pathways were complete in all cases we reviewed.
- We noted good examples of Do Not Attempt Cardio Pulmonary Resuscitation (DNACPR) documentation with evidence of discussion with patients and family.
- Staff attended information governance training as part of the 'Core 7' mandatory programme. Attendance rates across wards were greater than the trust target of 95% at the time of inspection.

Safeguarding

- Provision of safeguarding training was good across the trust and staff could access training for safeguarding adults and children at level one and two through the 'Core 7' mandatory training system. In May 2016 it was reported that 67% of staff overall had attended training. 100% of staff requiring level 3 safeguarding training had attended it.
- During the previous inspection, figures provided by the trust indicated that there was poor and inconsistent attendance by staff to safeguarding courses for adults and children. We found that this had improved. Staff across wards we inspected had achieved or had a clear plan to achieve targets for attendance with greater than 85% attendance rates and targets to achieve the 90% target.
- Staff we spoke with had awareness of their responsibilities and knew whom to contact regarding safeguarding concerns. Policies were available online and staff knew how to access them.

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 at essential training. At the time of inspection, overall compliance was greater than the trust target of 90% in wards inspected. Medical staff had achieved 98% attendance. The trust teams had worked hard to improve planning and achieve compliance in 2015/16.
- The Core 7 mandatory training package included: basic life support, blood transfusion, conflict resolution, dignity at work, fire safety, health and safety and patient well-being, Infection prevention and control, information governance, manual handling, mental capacity act, safeguarding level 1 and 2 for vulnerable children and adults. There was also evidence of training for VTE assessment and a comprehensive medical devices training and competency programme was organised for nursing staff.
- We saw clear and consistent poster displays of attendance and plans for staff attendance on each ward we inspected in senior nursing offices. 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.

Assessing and responding to patient risk

- All wards used an early warning score (EWS) system to help identify and manage patients whose condition deteriorated. An electronic system was embedded to support the recording and monitoring of physiological observations and risks to patients**.** Staff we spoke with knew how to follow escalation policies if they had concerns about patients.
- The critical care outreach team (CCOT) and hospital out of hours team continued to support staff with concerns about patients who were at risk of deteriorating.
- A range of risk assessments were completed for patients on admission and during their hospital stay. Risk assessments we reviewed in care records were thorough and individualised.

Medical care (including older people's care)

- Ward 9 had four beds allocated for enhanced respiratory support for patients. Patients could be monitored more closely in this area.
- The staff had a vision for working towards new models of care for the elderly frail patient. Plans for new ways of working and managing care were to include reconfiguration of the wards across ward 10 and 12, with improved multidisciplinary team working and continued use of the therapeutic support worker role to reduce risk to patients.

Nursing staffing

- The hospital had adopted the Safer Nursing Care Tool (SNCT) to determine the required levels of nurse staffing for each ward. It was reported to us that a further and more comprehensive review of nursing establishments and skill mix, with reference to concerns around nurse to patient ratios and safe staffing levels took place in 2015.
- Because of the review, a number of actions were implemented. These included three nurses on nights if wards had more than 24 beds or patients, improved escalation policies, increased sharing of staffing across wards and regular meetings within the centre to establish any staffing problems early and resolve promptly. The ward manager role was established as supervisory, allowing for greater oversight of ward staffing issues.
- During this inspection, we found much improvement in planned and actual staffing levels and ratios of nurses to patients, with one nurse to six or eight patients during the day and one nurse to a maximum of 12 patients overnight, with good healthcare assistant support and escalation policies in place. Nurses assessed patient acuity levels and planned to staff wards according to demands. There were plans, which had been partly implemented to increase to three registered nurses overnight, which would improve ratios further.
- We reviewed historical and current paper and electronic rotas and establishments on each ward, which corroborated improved nursing staffing levels during day and night shift. We noted that ward 12 had reduced its bed capacity from 32 to 24 beds and ward 10 from 27 to 16 beds to mitigate risks to patients.
- Vacancies had improved across medicine since 2014 although this was reported as a consistent challenge for this service, especially in elderly and acute medical wards. The vacancy rate at the time of reporting was 90 WTE qualified nursing staff across the medicine service; approximately 6% vacancy rate overall against planned establishments. Trust staff covered shortfalls by working additional shifts when required and NHS Professionals was utilised as a nurse bank provider. Nil agency nursing staff were deployed in the wards we visited.
- The trust continued to develop its therapeutic support worker role that had been developed as a new patient care role at the trust since 2014. The team had continued to grow and supported patients in wards that required additional care or supervision. This was also working well across wards to support ward staff and we observed workers caring and closely observing patients.
- Sickness was closely monitored and managed by senior nursing staff and the trust had implemented earlier reviews for staff as part of a new sickness absence management policy.
- Handover was observed to be organised and thorough. Discussion between the nurses in charge, a cascade to staff and board round discussion with the Multidisciplinary Team (MDT) to identify priorities and risk for each patient was observed. Nursing staff communicated well with medical colleagues and members of the MDT.
- Staff displayed planned and actual staffing numbers on whiteboards at the entrance of the ward. All wards inspected were staffed according to planned figures.
- The service was actively recruiting nursing staff and had filled a number of vacancies with nursing staff from outside the UK. Recruitment however was reported as an on-going challenge by staff. Ward managers were knowledgeable about team vacancies, plans for new staff commencing in post and positive ways in which they would be supported on commencement.

Medical staffing

- The ratio of consultants to other medical staff continued to be better than the England average. There were recognised gaps in recruitment to registrar and junior doctor levels. Senior staff told us that all other grades were staffed appropriately.
- There was consistently less than 4% medical locum usage at the JCUH site and a policy clearly outlined processes for the use of locums in the trust.

Medical care (including older people's care)

- At the time of inspection, the team were exploring new ways of working with Advanced Nurse Practitioners (ANPs) with plans to improve weekend cover of appropriately skilled staff.
- The consultant cover and junior doctor availability was appropriate. Consultants were visible and accessible to junior staff. Consultant cover was provided as an on call service. Junior doctors we spoke with during this inspection reinforced previous reported findings around feeling supported by consultant colleagues.
- The risks associated with the trust being able to fill junior medical staff vacancies were included in the corporate risk register as a high priority.
- Overnight cover was provided by medical registrar with support from a team of foundation year one and two doctors. The team was integral to the hospital out of hours team.
- Medical staff were visible and involved in handovers and daily ward rounds and review of patients. We observed good communication amongst staff at handovers and safety briefs.

Major incident awareness and training

- There was a major incident plan in place and staff we spoke with knew how to access policies and support. There was also a winter management plan in place.
- The trust and its partners in the locality had escalation/ resilience plans, which were followed as required. The North East Escalation Plan (NEEP) was known to staff we spoke with.
- We saw that the trust had appropriate policies in place with regard to business continuity and major incident planning.

Services for children and young people

Safe	Good
Overall	Good

Information about the service

James Cook University Hospital ("JCUH") was the largest facility within South Tees Hospitals NHS Foundation Trust. The hospital situated two miles south of Middlesbrough town centre provided district general services and specialist services to the population of Teesside and neighbouring districts.

Paediatric and neonatology care at the hospital primarily sat within the community care centre and provided services for babies, children and young people. Services at the hospital included three wards:

- Ward 21 was a 30 bedded unit for paediatric medical patients (inclusive of an 11 bedded young person's area);
- Ward 22 was a 17 bedded unit for paediatric trauma and surgery patients;
- A Paediatric Day Unit (PDU) with a seven bedded assessment area.

The paediatric intensive care unit (PICU) provided four critical care beds and three high dependency beds. There was also a nine-bedded paediatric surgical day unit and designated children's outpatients.

The neonatal unit had the facility to provide care to 30 babies. Cot allocation was split between intensive care (IC), high dependency (HD) care and special care (SC) areas. From January to March 2016, the unit reported 109 admissions equating to a total of 329 IC bed days, 462 HD bed days and 1141 SC bed days. Cot occupancy during this period was over 85%. The unit transfer 'squad' were involved in a total of 45 transfers. The majority of these, some 24 (53%), were urgent level 3 intensive care transfers. The unit also reported two non-clinical transfers (those cases where babies needed to be moved from their hospital of booking and delivery for non-clinical reasons – lack of capacity and cots (Neonatal Northern Network, Quarterly Report, Q4 2015/16)

The trust reported 9,869 admissions into children's service between September 2014 and August 2015. 8,496 (86%) of all admissions were to JCUH. 84% of these were classified as emergency admissions, 10% elective and 6% recorded as day case spells.

The trust was previously inspected in December 2014 where services for children and young people was rated as 'good' in effective, caring, responsive and well-led. The safe domain was rated as 'requires improvement'. This inspection focussed solely on the safe domain.

During our inspection, we visited the neonatal unit, wards 21 and 22, PDU, PICU and the paediatric surgical day unit at JCUH. We observed care, staff working, ward rounds and ward meetings. We spoke with 19 members of staff, including consultants, specialist doctors, trainee doctors, managers, nursing staff and pharmacists. We introduced ourselves to nine parents and four children. We reviewed 14 sets of care records and 13 prescription charts.

Services for children and young people

Summary of findings

Overall, services for children and young people at JCUH were safe.

Staff were aware of the importance of ensuring their practices kept children and young people free from harm.

Staff ensured the ward environment and clinical areas were 'child-friendly', secure, clean and well maintained. Equipment was checked, labelled and safely stored.

Medicines and clinical records were stored securely. Documentation was good with each child and young person having an individualised plan of care.

The service had good local procedures to monitor changes in a child's condition and robust arrangements with network colleagues in the event of the need to escalate care due to a child's deterioration.

Staff followed trust mandatory training requirements and additional core training relevant to their specific clinical area. Managers were working to ensure all staff completed necessary training and to meet trust target.

There had been an improvement in staffing levels in all paediatric areas since the inspection in December 2014. Additional recruitment was planned to re-enforce staffing in the neonatal unit to ensure compliance with national staffing guidelines.

Staff reported concerns and incidents where they felt this compromised a child's safety and wellbeing. Managers investigated concerns and incidents thoroughly. Outcomes and lessons learnt from investigation findings were shared with all staff. Changes to practices following lessons learnt needed to be embedded and monitored.

Are services for children and young people safe?

Good

We rated safe as good because:

Staff were confident reporting incidents of harm or risk of harm using the trust's reporting system.

We saw thorough investigations of incidents and discussions of the same being held at all levels of the service. Outcomes and learning from incidents was cascaded to staff on the wards using a variety of media such as emails, bulletins and at face-to-face meetings. We saw evidence how shared learning had brought about changes in clinical areas.

Staff had an awareness of their responsibilities regarding the duty of candour.

All clinical areas were visibly clean and regularly monitored for standards of cleanliness. Infection prevention and control (IPC) procedures were embedded and there were audit processes to monitor compliance. Overall, audit results were good.

Equipment checks were complied with and some staff had additional skills in using wider equipment functions.

Medicines were safely stored in accordance with policy or in line with agreed risk assessments.

Documentation was good with care plans individualised to the needs of each individual child and baby.

The trust had a designated safeguarding team and staff were aware of their roles and responsibilities in the safeguarding process. The unit had good working relationships with community colleagues and there were good communication channels for the sharing of relevant information to ensure child safety and wellbeing.

There were local and regional procedures and partnership working agreements in place to respond to changes or deterioration in a child's condition.

Services for children and young people

Nurse staffing rates in PICU were in accordance with Paediatric Intensive Care Society (PICS) standards. There were marked improvements in neonatal recruitment with a number of staff currently progressing through their preceptorship or induction period.

Overall, medical staffing was good with strong consultant presence and support for junior grades.

Staff were aware of major incident and business continuity plans and how these affected their areas of work.

However,

Some mandatory training compliance figures were below trust target. Managers planned further training to ensure the trust targets were met by year-end.

The agreed 'do not disturb' procedure for staff completing medication rounds was not fully complied with therefore the risk of distraction still applied.

Some areas had limited space to store necessary stock.

Establishment planned nurse staffing figures were not met on general children's wards however, there was evidence of good cross-unit support and escalation procedures to address shortfalls.

Nurse staffing in neonates did not fully comply with British Association of Perinatal Medicine (BAPM) standards. There had however been a period of sustained improvement in recruitment and increased staffing compliance rates since April 2016.

The medical rota did not fully comply with BAPM standards due to a shortfall in tier two medical staff numbers however, the rota was always covered. Managers planned additional staff training to progress staff from the tier one rota.

Incidents

- The service followed the trust incident reporting and investigation policy.
- Staff reported incidents of harm and concerns using the trust web-based risk management reporting system. Staff we spoke with told us they felt confident reporting incidents and near misses. Managers actively encouraged incident reporting.
- Staff told us they received feedback from submitted incident reports on an individual basis and at team meetings. A consultant published and circulated a 'lessons of the week' paper reviewing an incident, actions and lessons learnt.
- We reviewed the minutes from paediatric and neonatal group meetings where attendees discussed incidents, actions and learning outcomes. Staff also discussed some incidents at governance groups and clinical standards group. Managers completed a 'tracking and trending report' to monitor incidence and emerging themes and took appropriate action. For example, changes to medication administration practices followed a management review of incidents, which involved the development of a 'safer medication' process and a do not disturb agreement during drug rounds.
- The trust reported over 10,000 incidents in 2015/16 of which 226 (2.3%) related to services for children and young people. Of those reported, 99.1% were classified as no or low harm. There were two reported incidents where harm was graded as 'moderate'. These incidents related to a delay to complete a particular medical investigation and an injury to a staff member.
- The service reported no never events. Never events are incidents defined by the Department of Health as serious, wholly preventable patient safety incidents that should not occur if the available preventative measures have been implemented correctly. There was one serious incident (SI) reported between March 2015 to February 2016 relating to a pressure sore.
- We reviewed the root cause analysis (RCA) investigation reports for the two moderate incidents and one serious incident. We found they contained relevant background information, a chronology of events, an analysis of the facts and action plans to prevent further occurrence. The reports detailed how the learning was shared, namely at ward meetings and the directorate risk meeting. There was evidence in those RCA reports involving patients that staff had informed the family in accordance with duty of candour requirements. Duty of candour is a regulatory duty that relates to openness and transparency and requires providers of health and social care services to notify patients (or other relevant persons) of certain 'notifiable safety incidents' and provide reasonable support to that person.

- Staff we spoke with had a clear understanding of the duty of candour and awareness of their responsibilities to be open, honest and inform patients (and their families) by way of a written apology when harm had occurred because of a shortfall in care.
- The neonatal unit shared learning with colleagues from other trusts as part of the wider Northern Neonatal Network (NNN) at regional meetings held each quarter. The NNN aims to improve outcomes for babies born and cared for across the network region and provides trusts with an opportunity to share good practice. For example, staff told us they had recently audited their old incubators following another network partner identifying growths of pseudomonas (bacteria commonly associated with respiratory infections) within their older equipment.
- The service recorded five pressure ulcers, no falls with harm and two catheter-acquired urinary tract infections (CUTIs) between March 2015 and March 2016.
- The service monitored perinatal mortality and morbidity through the monthly child death overview panel (CDOP) meetings. Medics, nurses and other healthcare practitioners involved in the care of the deceased from paediatric, neonatal and maternity services attended. Attendees shared information and learning from the panel at ward team meetings.

Cleanliness, infection control and hygiene

- All areas we visited were visibly clean.
- There were cleaning schedules and cleaning logs followed by housekeeping staff and these were well maintained.
- Handwashing signage and handwashing facilities were situated at the entrance of each clinical area. Antibacterial hand gel dispensers were also available at various locations within each unit. There were infection prevention and control (IPC) posters and information on display with many designed by children to promote good IPC practice. We observed staff and visitors washing their hands and using hand gel.
- Staff monitored ward cleanliness throughout their shift and completed formal audits on a monthly basis. Wards displayed audit results and relevant IPC quality indicators such as clostridium difficile (C. diff) and methicillin resistant staphylococcus aureus (MRSA) on large information boards for patients and their families to view. The service reported no cases between March 2015 to March 2016.
- All units reported compliance in excess of 95% for handwashing and ward cleanliness from March to May 2016. In neonates, the unit had use of its own UV light box (used to teach staff on appropriate handwashing technique) which was used to do 'spot checks' on staff. The neonatal unit was 100% compliant in hand hygiene and ward cleanliness against local benchmarking criteria In May 2016.
- The service was involved in the trust-wide infection prevention quality improvement audits in December 2015. These audits combined a detailed review of IPC management, IPC staff health, IPC staff training, environmental cleanliness in various clinical areas, equipment cleanliness and management, sharps safety, personal protective equipment and waste management. Ward 22 achieved 89.4% compliance with comments identifying dust at various locations across the unit. PICU recorded 96.4% overall compliance with insufficient storage being highlighted and neonates recorded 91% compliance with some wear and tear to fixtures and fittings noted. The units implemented local plans to address the shortfalls highlighted and we noted the neonatal unit had re-decorated in parts and replaced some furnishings.
- IPC training was mandatory with a trust target of 90%. Staff compliance across the units was 93% in neonates and ranged from 78.4% to 100% on the paediatric wards. Ward managers appointed staff to attend those sessions not fully complied with and all wards were on track to meet target.
- All clinical areas had a named lead nurse for IPC to support local audit, share current IPC information and maintain the trust IPC agenda in their clinical area. Following shared learning from the Northern Neonatal Network, staff in neonates worked with microbiology and IPC colleagues to review the integrity of their incubators. Consequently, the trust replaced a number of old incubators.
- We saw personal protective equipment was readily available to staff to use and we observed staff using it appropriately. We also observed staff adhering to 'bare below the elbow' guidance, in line with national good hygiene practice.
- Toys and play areas within the units were clean and we observed staff cleaning some play equipment with hot soapy water. Staff informed us they followed guidance from the IPC team for cleaning of such items.

- We saw evidence of appropriate waste segregation and clinical waste disposal units. Staff were aware of the importance and risks involved in handling of sharps. We observed staff safely disposing of needles in appropriate sharp bins, which were emptied regularly.
- The unit matron carried out unplanned IPC checks and involved the children to challenge staff who they felt had not followed IPC procedure.

Environment and equipment

- The hospital ensured the environment was safe for the children by using a buzzer entry system. Staff monitored visitors entering and leaving the ward.
- Staff completed environmental and equipment checks as part of their daily work and formally through the audit process. Checks included equipment cleanliness, accessibility, storage and integrity. Staff displayed audits findings on ward noticeboards. All areas in paediatrics reported compliance in excess of 95% from March to May 2016.
- Wards consisted of bays and individual rooms. Individual cot spaces in neonates and PICU were spacious to allow for necessary equipment, staff and family access and unhindered movement. Storage in some areas was limited leading to tighter control on stock rotation and ordering.
- Storage of the camp beds, used by parents who wished to stay with their child, tended to clutter the ward environment but were positioned away from rooms and clinical areas to avoid obstruction or hazard.
- We saw evidence of processes to ensure equipment was safe and we saw documentation for checking and cleaning equipment. Medical and nursing staff worked in partnership with the trust medical devices, electronics and supplies teams to maintain equipment and devices. All equipment we checked was tested and labelled accordingly.
- Staff we spoke with told us they knew who to contact if they needed to report any faults and felt confident the system was robust. Some staff had received additional training to use wider functions of particular pieces of equipment such as the blood gas machine in PICU.
- Resuscitation and emergency equipment was suitable for the needs of the children. Staff completed a daily log to confirm the daily resuscitation equipment check was completed. We reviewed the logs and found no omissions. Staff were trained to use equipment and their competency recorded.
- In the CQC Children and Young People's Inpatient and Day Case Surgery Survey 2014, 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.

Medicines

- The trust had a policy for the administration and storage of medicines and staff we spoke with told us they followed this policy.
- Staff received training on medicines management as part of preceptorship and local induction into the clinical areas. Managers had introduced a number of local medicines based competencies, for example, in administering intravenous medications. Ward managers assessed and monitored competencies against agreed best practice standards.
- Following a thematic review of medicine related incidents, the trust implemented a 'do not disturb' agreement when staff were completing medication rounds. This was put in place to avoid undue distraction and the potential for maladministration or drug calculation errors. We observed two medicine rounds where staff were interrupted when completing this task.
- The units had a designated pharmacist who worked in partnership with staff to ensure all required medications were available for the needs of the children. The pharmacist provided medicine guidance and support to the children and their families on discharge.
- Medicines were stored securely and always in a locked cupboard. The nurse in charge for the respective units held the keys to access the medications. On PICU, staff completed a thorough risk assessment to allow the door to the treatment room (situated directly behind the staff base) to be kept closed but unlocked for ease of access to medications. The unit pharmacist had agreed this.
- Staff checked controlled drugs stock on a daily basis in accordance with local policy. We viewed stock review checks showing completion.
- Staff checked refrigerator temperatures on a daily basis to ensure those medications requiring storage at specific temperature ranges were safe for use. We reviewed daily logs, which were complete. Staff informed us of the procedure they followed if the temperature fell below the lower range or exceeded the

upper range. There were two refrigerators in the neonatal unit which were clearly labelled confirming which was for medicine storage and which was for the storage of milk.
- Staff we spoke with told us they had 24-hour access to pharmacy for information and advice.
- We reviewed 13 paper prescription charts on the neonatal and paediatric wards. Staff completed charts legibly and all entries were signed and dated. Staff recorded the child's weight along with a date of birth. The charts did not provide for age to be recorded. No medications were omitted and antibiotics had been prescribed in accordance with local guidelines. There was one chart where the allergy check was not completed and this was immediately rectified.

Records

- Staff managed, handled and secured records safely on the unit. There were no records left unattended during our inspection.
- We reviewed 14 sets of paper based care records throughout children's services. Staff completed records accurately and timeously. There was evidence of consultant review within 12 hours in all cases. Diagnosis and management plans were well documented and there was evidence of multidisciplinary input. The records included appropriate clinical history, review, risk assessments and noted discussions with family members.
- Nursing documentation was also paper based. This included family history, an age specific assessment of activities of daily living and individualised care plans. Staff kept various documents bedside for ease of reference such as observation and nutritional charts.
- Ward managers completed a weekly trust documentation audit of five sets of records on their respective units. The audit, a 37 point checklist, recorded compliance against key record keeping indicators such as legibility, risk assessment completion, pain assessments and individualised care plans. Managers rated compliance using a red, amber and green scale (RAG).
- During April to June 2016, the paediatric unit was fully compliant against all criteria in 10 of 11 weeks reviewed, securing a green rating (91% equivalent). Managers found some NMC number omissions and illegible names during one week in May with the unit only receiving an 'amber' rating.
- Managers issued good practice or improvement required letters to wards and individual staff members in accordance with their findings. This allowed staff to share best practice across their unit or take steps to address shortfalls.

Safeguarding

- The trust had a safeguarding children policy and a designated safeguarding team, which comprised a named doctor and named nurse. Staff confirmed the safeguarding team to be accessible and supportive in dealing with queries and concerns.
- 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 reinforced the trust's statutory, regulatory and contractual responsibilities to safeguarding children.
- All staff we spoke with had a clear understanding of the processes involved if they had any concerns in and out of hours. The safeguarding team completed a daily walk around within the paediatric unit. The trust held a rota for out of hours advice on safeguarding concerns.
- 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).
- In 2015/16, training records showed 100% of staff in the service had completed level one safeguard training. Level two and level three safeguarding training was delivered by way of initial core training, an annual refresher and a three yearly core update. Compliance varied slightly across the paediatric unit. In neonates, compliance with the initial core training was 80% and 100% for the refresher course. In paediatrics, compliance was recorded at 75% and 100% respectively. Staff also attended joint external regional training events on safeguarding topics. This had improved from 2014 and 2015 figures. Managers planned additional training sessions to ensure trust target was met by year-end.
- Staff confirmed they had good relationships with the Local Safeguarding and Looked After Children Boards along with other community based staff involved in the safeguarding process. Designated trust staff attended the meetings on a regular basis.

- The children's community nursing team had a base on ward 22 from Monday to Friday. This assisted with care transition for those children who required additional support or were subject to safeguarding procedures.
- There were systems to ensure children and young people subject to safeguarding concerns were safe. For example, the local safeguarding team would share daily updates with relevant hospital personnel. Children who attended the hospital from other areas were tracked using their NHS number, which alerted the patient administration system (PAS). PAS also provided a child protection information (CPI) field to allow staff to enter a system alert for a particular child. This enabled the service to identify children who were subject to a child protection plan.
- The safeguarding team had access to a local safeguarding database, which was shared with specialist community colleagues. This allowed timely, accurate and current information exchange to wider professionals involved in the child's care.
- Staff were familiar with the trust's child abduction policy. The trust had designated police personnel with specific responsibility for child safety. Access to all clinical areas was restricted; doors were locked and accessible by a keypad entry code only.

Mandatory training

- The target for mandatory training compliance was 90%. The trust employed a dual responsibility strategy for the management of mandatory training involving ward managers and personal accountability.
- Mandatory training included topics such as equality and diversity, infection prevention and control, fire safety, information governance, mental capacity act and safeguarding.
- Overall, mandatory training figures in neonatology were 92% for nursing staff and 91% for medical staff. There was good compliance across all mandatory topics.
- In paediatrics, overall mandatory training compliance was 79% for nursing staff and 76% for medical staff. Managers had arranged further training dates to address the variance in uptake in some core training and were on track to meet target. In the paediatric surgical day unit, compliance was 98%.
- Staff in children and young people services completed additional mandatory training covering life support and transfusion. Across the service, paediatric immediate life support (PILS) training compliance was 86%, advanced paediatric and neonatal life support training compliance was 94% and transfusion training was recorded at 67%.
- Managers had arranged training for all staff not fully compliant with mandatory requirements. The unit will meet the trust mandatory training target by year-end.

Assessing and responding to patient risk

- Staff promptly assessed their patients and consultants reviewed all children within 12 hours from admission. All children had an accessible and current treatment and management plan in accordance with their needs.
- Staff completed all relevant risk assessments on admission such as nutritional status, skin integrity and, where appropriate, body maps were completed. Staff reviewed risk assessments regularly.
- Staff discussed patients at handovers and during safety huddles. This allowed nursing and medical staff to reinforce plans to monitor deteriorating patients such as increasing observations, 1:1 nursing or care escalation.
- The service benefitted from the 24 hour, seven day a week PDU. The service had evolved into an assessment suite. This allowed children to receive prompt paediatric assessment and treatment 'off-the-ward'. Staff made decisions on the need for on-going care (admission or discharge) without interrupting ward staff and care delivery for those patients already in the ward environment.
- The service used evidence-based documentation to monitor observations and the child's condition when receiving care. The paediatric unit used age specific paediatric early warning scores (PEWS) to monitor condition stability and escalation triggers. This included a clinical observation chart, coma scale and pain score tools. Staff used the assessment table to assist in determining what action would be taken in the event of deterioration, such as increasing the level of care or considering external transfer.
- The service had agreed regional transfer guidelines in place with network colleagues (Northern Neonatal Network) in the event of a baby deteriorating and requiring care at another centre. When the retrieval of a baby was required, the designated team at JCUH prepared the patient and equipment for transfer. Additional staff were requested to stay on the unit (or were called in) so the retrieval team could respond to the deteriorating child whilst the units remained safely

staffed. The service also had links with the North East Children's Transport and Retrieval Service (NECTAR) to ensure critically ill children were rapidly transported to the most appropriate regional centre for on-going care needs.

- The unit transfer 'squad' were involved in 45 transfers between January and March 2016. The majority of these, some 24 (53%), were urgent level three intensive care transfers. The unit also reported two non-clinical transfers (those cases where babies needed to be moved from their hospital of booking and delivery for non-clinical reasons) due to a lack of capacity and cots (Neonatal Northern Network, Quarterly Report, Q4 2015/16).

Nurse staffing

- The trust used the Safer Nursing Care Tool (endorsed by National Institute for Health and Care Excellence) to assess safe staffing levels and had previously trialled a children's acuity measurement tool (SCAMPS).
- Managers informed us there was no validated or recognised tool to ascertain acuity in children's wards. Senior staff referred to guidance provided by Royal College of Nursing (Defining staffing levels for children and young people's services, 2013), considered nurse to patient ratios, used professional judgment to assess staffing requirements on general paediatric areas and utilised data from their new e-rostering system. Managers forward planned nurse rotas to allow for early identification of staffing shortfall.
- Ward managers met with the clinical matron and service manager on a daily basis to discuss staffing across the unit. This included consideration of current patient dependencies, planned admissions, discharges and non-clinical commitments such as training and meetings. Staff were moved to support areas where there was greater need.
- Managers informed us of strong nursing teams across the unit with many staff members having been in post for a number of years.
- Managers confirmed retention was good however all areas suffered attrition and there were vacancies. In 2015, turnover rates across all nursing grades in paediatrics averaged 9.5% with whole time equivalent vacancy (WTE) rates showing a 2.4 WTE deficit. Recent recruitment had seen a number of new and experienced staff appointed across paediatric services.
- Wards displayed planned and actual staffing numbers. Where there were staffing shortfalls, ward managers advised they obtained support from the wider unit, requested existing staff extend or work additional shifts or requested staff from the nurse bank. Where safe staffing levels were not achieved, the service had closed beds.
- The standard for bedside deliverable hands-on care (as defined by Royal College of Nursing defining staffing levels for children and young people's services, 2013) recommends 1:3 registered nurse: child staffing for children under 2 years and 1:4 registered nurse: child for children over 2 years.
- During the week of our inspection, ward 21 had 24 open beds (six closed), ward 22 had 17 open beds and PDU had the facility to accommodate seven. Staffing ratios averaged 1:4 on the wards and 1:2.5 on PDU. These ratios were broadly the same between March to May 2016 and correlated with fill rates. The unit complied with recommended staffing compliment and skill mix to meet patient need.
- Fill rates for ward 21 between March to May 2016 averaged 93% for registered nurses covering days and 139.8% for nights. Healthcare assistants fill rates were 61.1% on days and 96% on nights. Ward 22 figures were better at 104.6% for registered nurses covering days and 99.2% at night with healthcare assistants at 101.3% and 108.3%.
- All wards reported some short and long-term sickness, averaging 5% for nursing staff and 2.4% for health care assistants. Bank and agency staff usage was less than 2% between January and March 2016.
- Staff confirmed it was helpful to have flexibility within the unit to move staff between wards to support at times of increased demand. Staff knew how to escalate concerns when support was required.
- Staff informed us that no child was ever at risk due to nurse staffing levels. Parents we spoke with acknowledged nurses were busy however always attended promptly when requested.

Neonates

- From January to March 2016, the unit reported 109 admissions equating to a total of 329 IC bed days, 462 HD bed days and 1141 SC bed days. Cot occupancy during this period was over 85%.
- Managers in the neonatal unit followed service standards for hospitals providing neonatal care

produced by British Association of Perinatal Medicine (BAPM, 2010). The BAPM standards provided guidance on staffing governance and staffing levels in neonatal units.

- BAPM recommends staffing ratios of neonatal nurse qualified in speciality (QIS) to babies. In intensive care a ratio of 1:1, in high dependency care a ratio of 1:2 and in special care a ratio of 1:4.
- We reviewed staff rotas from April 2016 to June 2016 and were able to compare staffing numbers against the recommended BAPM ratios. We found the neonatal unit complied with BAPM ratios on 70% of shifts in April, 68% in May and 78% in June. In addition, the unit accessed the ward manager, a community nurse, a BLISS nurse (providing practical advice, emotional support and guidance to families of vulnerable babies), the practice development nurse, the breastfeeding nurse and the research nurse who were not included in staffing numbers for benchmarking purposes. These staff complimented BAPM reported compliance figures.
- Managers recorded nurse staffing levels twice daily on Badgernet (a single record of care for all babies within neonatal services).
- Data provided by the trust showed a 6.99 WTE deficit across all nursing grades in neonates. The service had recently appointed 15 nursing staff (10 WTE) being phased into the neonatal unit. These appointments would further enhance performance against QIS and BAPM benchmarking. Managers planned further recruitment. The unit reported sickness rates across all nursing grades of less than 10% and turnover less than 5%.
- Managers worked with their team to cover staffing shortfall. Existing staff worked additional hours and flexed rostered working patterns to cover. The unit reported nurse bank use (of less than 2%) however had a pool of specialist staff to draw upon when required.

Paediatric Intensive Care Unit (PICU)

- Managers in PICU followed Paediatric Intensive Care Society (PICS, 2015) quality standards for nurse staffing in the unit.
- The PICS standards recommended nurse staffing ratios in accordance with defined levels of care. For children classified as requiring level 1 care (children requiring close supervision and monitoring following surgery or with single system problems), a ratio of 0.5:1 nurse to child ratio is advised. For level 2 care (this includes children requiring intubation or ventilation), a ratio of 1:1 and for level 3 (ventilated children requiring vasoactive medicines or with multiple system problems), a ratio of 1.5:1.
- The unit actual nursing staffing whole number was 31 equal to planned nurse establishment figures. The unit reported no current vacancies.
- We reviewed staff rotas from April – June 2016 and were able to compare staffing numbers against PICS standards. Without exception, we found the unit complied 100% with staffing ratios against child dependency during this period.
- The unit reported no nurse bank or agency use during January to March 2016 and sickness rates less than 5%.

Medical staffing

- According to the Health and Social Care Information Centre, medical staffing skill mix varied in comparison to England average. Overall, the service had a higher proportion of consultant, registrar and junior doctor grades. There was a shortfall in middle career grades (doctors with at least three years' experience as senior house officer or at a higher grade). The total whole time equivalent (WTE) for medical staffing was 59.
- The service provided consultant paediatric cover seven days a week. The service operated a consultant of the week rota. During Monday to Thursday, there were four consultants on site, the last until 9pm and often later. Three consultants were onsite until 9pm on Friday and two until 5.30pm at weekends. There was out of hour's consultant on call cover and staff confirmed this to be effective with support easily accessible.
- The consultant paediatrician of the week and on call anaesthetist completed an evening ward round on PICU. Out of hours, the unit was covered by the paediatric rota, the specialist rotas (if a surgical patient for example) and anaesthetic rota.
- The neonatal unit was staffed independently from the general paediatric wards and maintained a three-tier rota in accordance with BAPM standards. The team included consultants, registrars, paediatric specialist trainees and advanced neonatal nurse practitioners (ANNPs).
- The consultant neonatologist of the week remained on site until 7pm (and often later) and covered the tier three on call rota. Senior specialist trainees covered the tier two rota requirements and a combination of specialist trainees and ANNPs covered tier one.

- We reviewed recent neonatal rotas and found the service provided staff numbers to cover the tier one rota above BAPM standards (12 on rota against a minimum of 8 staff) and in line with BAPM standards at tier three with the minimum of seven consultants being available. The service had six staff to cover the tier two rota (below BAPM standards of eight) however the trust were providing additional skills and training to existing ANNPs on the tier one rota in order that the tier two numbers could be improved in line with BAPM.
- Formal medical handovers occurred three times each day, morning, late afternoon and evening. The handovers were well attended by all medical grades. All children were discussed and this combined a detailed review of the child, an update on progress, on-going treatment plans and an opportunity for junior medical staff to learn and ask questions. Each doctor showed they had an in-depth knowledge of each child and their family.
- Junior medical staff told us their senior colleagues were supportive. Consultants and senior paediatric doctors welcomed contact out of hours in the event of concern about a child or for treatment advice and were happy to attend the unit when required.
- Sickness rates for medical staff and locum use across the paediatric and neonatal unit was less than 2% in 2015.

Major incident awareness and training

- The trust had a major incident and escalation plan.
- There were specific business continuity plans for neonatal services and paediatric services in the event of an emergency due to specific internal or external incidents such as loss or damage to key resources.
- The plans detailed roles and responsibilities of key service administrative and clinical personnel, critical business function resilience and priority patient safety issues.
- Staff at all levels demonstrated awareness of the plan. Staff confirmed they received training on the key points within the documents in mandatory training and at ward based meetings.

End of life care

Safe	Good
Effective	Good
Well-led	Good
Overall	Good

Information about the service

Nursing and medical staff throughout the James Cook Hospital delivered end of life care (EOLC). There were no dedicated beds within the hospital for specialist palliative care.

The specialist palliative care team (SPCT) were part of a multidisciplinary team approach to end of life care and covered both James Cook and Friarage Hospital. The team provided information to patients and staff, regarding diagnosis and treatment and offered specialist advice on the management of difficult symptoms at the end of life.

The SPCT delivered a Monday to Friday 8.30am - 4.30pm service, with advice available out of hours and at weekends from the sub-regional (a collaboration of South Tees and North Tees) palliative care consultants. The team were based at the James Cook Hospital.

There were 1866 deaths recorded for the trust between April 2015 and March 2016.

When we inspected the trust in December 2014, we rated the safe and effective domains in EOLC as 'requires improvement'. Therefore, this inspection focussed only on these areas and we decided to review the well-led domain to see if leadership, management and governance assurances were in place.

During this inspection, we visited medicine, surgery, respiratory wards and the accident and emergency department, where end of life care could be delivered.

We spoke with 13 staff including the clinical nurse specialist, ward nurses, porters and mortuary staff. We looked at the records of five patients receiving end of life care and 20 do not attempt cardiopulmonary resuscitation (DNACPR) forms.

Summary of findings

We carried out a comprehensive inspection of this trust in December 2014. During that inspection, we rated safe and effective in EOLC as 'requires improvement'. This was because DNACPR forms were inconsistently completed, syringe driver monitoring was also inconsistent. Within the mortuary, it was found that porters were using an old manual concealment trolley for transfer rather than a height adjustable trolley. It was also found that whilst staff knew how to report incidents they were not always provided with feedback. The assessment of nutrition and hydration had been inconsistent and the National Care of the Dying Audit showed the trust performed below the England average in terms of the review of patients nutritional and hydration needs.

We saw during this inspection that the service had made significant improvements to a number of these areas. Overall we rated end of life care as good because:

- The service had made significant improvements in audit and completion of DNACPR forms.
- Nutrition and hydration assessments were included in an individualised patient assessment tool for patients at the end of life.
- Patients were provided with an end of life care service that was safe and caring.
- The mortuary was clean and well maintained.
- Staff delivering end of life care understood their responsibilities with regard to reporting incidents and ensured information and lessons learnt were shared proactively with other colleagues within the hospital.
- We saw clear, well documented and individualised care of the dying documents.

End of life care

- The referral process was clear and responsive and staff ensured that patients' wishes were central to the care planning process.
- The culture was open and transparent and encouraged effective communication between the SPCT and ward staff.
- Staff were supported to attend mandatory training and in all areas records showed 100% compliance.

However:

- Although there was a clear vision for the service, which specialist palliative care staff had developed, the trust specific strategy for end of life care was due for review which will be undertaken when the new strategic lead for palliative care is appointed and it was not clear when Board approval would be finalised.
- The trust did not have an overall strategic lead for palliative care but this was identified as a future development. There was no action date to implement this role but the Board were keen to ensure that this happened.
- Within the 2015 results of the National Care of the Dying Audit, the trust was above the England average in all five of the clinical indicators but only achieved two of the eight organisational indicators. This was identified as a key area in the work programme for the SPCT in 2016/2017.

Are end of life care services safe?

Good

We rated safe as good because:

- There were systems for reporting actual and near miss incidents across the hospital. We saw examples of lessons learnt following audit.
- There were systems in the mortuary to ensure good hygiene practices and the prevention of the spread of infection.
- There were sufficient numbers of trained clinical, nursing and support staff with an appropriate skill mix to ensure that patients receiving end of life care were well cared for.
- Staff were supported to attend mandatory training and in all areas of training records, showed compliance was 100%.
- There were adult safeguarding procedures in place supported by mandatory staff training. Staff knew how to report and escalate concerns regarding patients who were at risk of neglect and abuse.
- There was sufficient equipment available including syringe drivers and plans were in place to arrange a central store to locate them across the hospital easily.
- Medications were stored correctly and syringe drivers were used in accordance with the National Patient Safety Agency (NPSA) Rapid Response Alert.

Incidents

- Staff understood their responsibilities with regard to reporting incidents and they knew how to report them. They also told us that they received direct feedback relating to incidents.
- Staff told us they were involved in the review of incidents on a trust wide basis if end of life care treatment had been identified. There was weekly contact with the SPCT who verbally shared incident information.
- Between April 2015 and March 2016 there were 20 incidents relating to EOLC all of which were categorised as no harm.
- There were no serious incidents recorded between March 2015 and February 2016.

End of life care

- We saw examples of incident investigations where lessons were learnt. For example, changes to identification procedures for the transfer of patients to the mortuary had been made and guidance amended.
- Incidents relating to palliative care were reviewed by the risk committee and shared at the SPCT directorate meeting. We saw examples of the minutes, which confirmed this process.

Duty of Candour

- Duty of candour is a legal duty on NHS trusts to inform and apologise to patients if there have been mistakes in their care, which led to moderate or significant harm.
- Staff we spoke with understood duty of candour, and their responsibly to be open and transparent. Staff told us that patients and relatives were kept informed when incidents occurred. They gave us an example of when they had used the duty of candour to inform relatives about delays in communication.

Cleanliness, infection control and hygiene

- We visited the wards and found there were infection control and prevention systems in place to keep patients safe with appropriate signage around the wards.
- We visited the mortuary at the James Cook Hospital and found that it was clean and well maintained. Cleaning records were accessible and up to date. We saw appropriate hand washing facilities were available.
- We saw staff had access to personal protective equipment (PPE), such as gloves and aprons.
- We saw there were hand washbasins, liquid soap, paper towels, and hand gels.
- Mortuary protocols were reviewed and we saw that relevant infection control risks were managed with clear reporting procedures in place. We spoke with the mortuary manager who reported that mortuary staff were confident in their role and using the reporting protocol.
- The training data showed that the SPCT including end of life nursing staff achieved 100% compliance for infection control training, against an internal target of 90%.

Environment and equipment

- Staff we spoke to told us that they had no problems accessing equipment for patients at end of life.
- There were height adjustable concealment trollies for patient transfer.
- Syringe drivers were available and although there was no central store, staff told us they had no problems in obtaining the syringe drivers they needed.
- The trust followed the guidelines within the NPSA Rapid Response Report: Safer Ambulatory Syringe Drivers (NPSA/2010/RRR019) published in December 2010, which advised that ambulatory syringe drivers should change over to devices with specific safety features. Staff told us that equipment was accessible within a few hours for patients at the end of life who were being discharged using the fast track route.
- The mortuary staff told us that they had not experienced any difficulties involving capacity but they could access the mortuary at the Friarage Hospital if they experienced problems.

Medicines

- There were guidelines on the trust intranet (NHS North of England Cancer Network) for medical staff to follow when prescribing anticipatory medicines. Medical staff we spoke with were aware of the guidance and how to access the SPCT for advice should, they need it. The guidelines were in the process of being updated at the time of inspection.
- We looked at the files of five patient's Medication Administration Records (MAR's) and we saw they were completed clearly, including administration of medicines prescribed 'as required'.
- We saw that the SPCT worked closely with ward staff to provide daily advice and support.
- We spoke with staff on the wards, who told us the system was effective and staff were confident patients would receive the appropriate medication even at short notice.

Records

- The SPCT had developed a care plan for the last days of life (core care Plan 25), which recorded the care, treatment and wishes of the patient leading up to and at the point of death. We saw these documents were in place and audits completed regularly by the SPCT to ensure that the quality of information was high.
- We viewed five sets of patient records and found that on all occasions these were completed correctly with discussions with the patient and relatives recorded where appropriate.
- The SPCT checked VitalPac (an electronic system which analyses and monitors patients vital signs) twice each

day to proactively check for patients who had been identified as requiring end of life care. We saw from the minutes of the End of Life Steering Group in January 2016 that an additional 110 patients (since August 2015), had been identified who would not previously have been seen.

- The SPCT were moving towards the integration of SystmOne, as a database for patient information. Staff had received a demonstration of the system and work was underway to have the 'agreed template' in place by August 2016. These arrangements would help to keep patients safe as different groups of staff could access the patient's records.
- Information governance training was part of the annual mandatory requirement for all staff. We saw that the SPCT and nursing staff within the end of life team achieved 100% compliance against an internal target of 90%.

Safeguarding

- Staff were knowledgeable about the trust's safeguarding policies and their role and responsibilities. Staff could give examples of what constituted a safeguarding concern and how they could raise an alert.
- The trust had mandatory safeguarding training programmes in place for staff as part of their initial induction. The training data showed that the SPCT including all end of life nursing staff team achieved 100% compliance for safeguarding adults level 1 and safeguarding children level 1, against an internal target of 90%. They also achieved 100% compliance for safeguarding children level 2. These levels of training were appropriate to their role.

Mandatory training

- All staff providing end of life care undertook mandatory training. We were provided with training data by the trust, which showed that the SPCT and end of life nursing staff achieved 100% compliance in modules such as dignity at work, health and safety, safeguarding and information governance.
- All staff we spoke to advised that it was difficult to attend training due to the lack of staff cover on the wards.
- We spoke with the end of life senior management team, who told us that one of the key priorities for end of life care was to 'formalise an education plan and monitor the impact of training within the service'. We saw a specialist palliative care education plan, which showed the development of a formal education plan for all staff but this did not have an agreed action date for completion.
- The SPCT provided education on a formal and informal basis, which included delivery to staff from external organisations, including those working in local nursing homes.

Assessing and responding to patient risk

- We saw that staff were able to identify risks quickly and manage them positively using an individualised plan of care.
- When a patient was deemed to be reaching the end of their life, the ward staff would identify this using the Vitalpac system. This would alert the SPCT that the patient might require their services. Ward staff completed the core care plan 25.
- Staff told us about how they assessed a patient and that managing identified risks was part of that process. We saw records in place covering nutrition and hydration.
- Staff on the wards could contact the SPCT Monday to Friday for a patient referral or telephone advice.
- Ward staff told us the SPCT had a visible presence on the wards. Any changes to patient's conditions triggered a visit by the SPCT. We saw patient's daily notes by nursing, medical and therapy staff with updates on any changes.
- We observed the SPCT weekly patient update meeting. We saw the clear identification of patients reaching their last days of life and risks discussed in relation to hydration, falls and the patient's preferred place of death.

Nursing staffing

- We found staffing levels were sufficient to ensure that patients received safe care and treatment.
- The SPCT delivered a Monday to Friday 8.30am-4.30pm service, outside of these hours and at weekends, ward based staff could access specialist support from the sub-regional palliative care consultant.
- Ward staff provided end of life care all the time, with specialist support from SPCT.
- End of life link nurses were not identified on every ward that we visited. However those that were, had compiled end of life information files for staff which were comprehensive and well organised. Ward staff told us that these files were 'extremely helpful'.

End of life care

- One band 8a lead nurse for end of life care and bereavement managed the team. There was also one band 7 clinical nurse specialist providing in-reach service to the Friarage, and three band 7 CNS's based at James Cook Hospital. Additionally there were two band 6 palliative care support sisters.
- The end of life team did not use agency staff. There was consistency in support from the SPCT.

Medical Staffing

- There were 1.3 WTE SPC consultants, one full time and one part time doctor, and one specialty doctor covering the community and acute areas (mostly Friarage Hospital). Each provided cross-site cover when needed. This was in line with the best practice guidance for the number of patient deaths. On-call consultants completed a written handover, which was faxed to the next consultant on-call.
- Medical staff we spoke with told us that the SPCT were available for specialist advice as needed.
- There was a sub-regional palliative care consultant on call for advice only, which operated from 5pm-9am on weekdays and 24hours at weekends and bank holidays.
- Ward staff told us that they would contact the sub regional on-call consultant when required.

Major incident awareness and training

- Major incident and winter management plans were in place. Senior staff had access to action plans and we saw that these included managers working clinically as appropriate, staff covering from different areas and prioritisation of patient need.

Are end of life care services effective?

Good

We rated effective as good because:

- Care and treatment was delivered in line with national guidance and best practice outcomes.
- We saw the use of nursing assessment tools within the core care plan, which included the assessment of pain, nutrition and hydration. Additional prompts were in place, which included patient choice, comfort and individual's ability to tolerate food and drink.
- The SPCT consisted of a team of doctors and nurses who were skilled and knowledgeable. They were experienced in providing support and training to other staff and provided training slots within the preceptorship programme.
- The service participated in relevant local and national audits, including clinical audits. Results and service development were discussed and shared at monthly end of life steering group meetings.
- Ward staff worked together with the SPCT and end of life teams to understand and meet the range and complexity of patients' needs. They demonstrated joint working in assessing, planning and delivering end of life care to patients.
- Staff providing end of life care were qualified and had the skills to carry out their roles effectively and in line with best practice.

However:

- Results from the National Care of the Dying Audit 2015 showed that the trust achieved only two of the eight organisational indicators but had scores better than the England average for all clinical indicators. This was identified as a key area in the work programme for the SPCT in 2016/2017.
- The SPCT was not currently staffed or funded to provide a seven-day week service although a business case for additional funding had been submitted to the trust commissioners.

Evidence-based care and treatment

- The trust participated in the requirement and 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 needs. The document was created using elements, which worked well from the Liverpool Care Pathway and incorporated existing nursing documentation and updated following comment and consultation with ward staff.
- The document contained guidance on appropriate medication for controlling common symptoms at the end of life and daily recording of patient's and family's needs. The document included national guidance from

sources such as the Leadership Alliance for the Care of Dying People, the Department of Health End of Life Strategy and the National Institute of Health and Care Excellence (NICE).
- The SPCT delivered 4hour training slots based on 'One chance to get it Right' as part of the preceptorship programme for nursing staff and junior doctors. There were also designated educational sessions for medical staff. This approach was developed by the Leadership Alliance for the Care Of the Dying Patient (LACDP 2014) and focused on the needs and wishes of the dying person and those closest to them, in both the planning and delivery of care wherever that may be.

Pain relief

- Palliative medicines (which can alleviate the pain and symptoms associated with end of life) were available at all times. We saw examples that anticipatory prescribing was being managed.
- We saw pain assessments in place as part of the core care plan 25. We looked at the records of three patients and saw that patients were assessed and reviewed regularly.
- Staff told us they could contact the SPCT for advice about appropriate pain relief if required.
- Appropriate medication was available in the ward areas, and there were examples that anticipatory prescribing was being managed.

Nutrition and hydration

- We saw that patients had been assessed using a Malnutrition Universal Screening Tool (MUST), which identified nutritional risks. Records showed that, following MUST, staff had used appropriate nutrition and hydration monitoring tools. These included monitoring charts for food and drink taken. Specialist dietician support was available on all wards and we saw records of their involvement.
- End of life care staff told us as part of initial assessment; nutrition and hydration needs at the end of life were assessed. Patient choice and comfort were included in the prompts for staff to make decisions in the best interests of the patient without the mental capacity to make their own decisions. We saw this with the core care plan.
- Staff told us that those patients identified as being in the last hours or days of life had their nutrition and hydration needs evaluated and appropriate actions followed.
- We saw monthly audits completed by the SPCT, which included documentation checks regarding nutrition and hydration assessments.
- Hydration and nutrition assessments were audited every month. February 2016 showed 78% compliance (hydration) and 86% (nutrition) compliance. All patient documents we audited at the time of inspection were found to be fully completed.

Patient outcomes

- The trust participated in the National Care Of the Dying (NCDAH) audit 2015. The results were published in April 2016. The trust was above the England average in all five of the clinical indicators but only achieved two of the eight organisational indicators. This was identified as a key area in the work programme for the SPCT in 2016/ 2017.
- We viewed audit results of the 'care of the dying patient' documentation checks. This audit also incorporates DNACPR audits. Audit results were mixed with some aspects of the documentation completed to a consistently high standard. For example, DNACPR completion achieved 94% compliance in February 2016. Preferred place of death recording dropped to 50% compliance in January 2016 but increased to 78% in February 2016. Data was not captured to show where a patient actually died compared to their requested place of death.
- Syringe driver monitoring charts were audited each month and showed 67% compliance in February 2016, which was lower than January, at 100%.

Competent staff

- Plans were in place to deliver a formalised education programme for end of life. We saw the SPCT education plan for 2016 but there were no completion dates to achieve the final plan. Within the education directory, a plan was in place to produce a leaflet to inform professionals of how to access education.
- Staff toldus they had received an annual appraisal and compliance figures showed 100% for all end of life staff. SPCT staff told us they had recently accepted student nurses to shadow the team.

End of life care

- The SPCT delivered training to staff as part of their preceptorship period. Four hourly slots were delivered twice a year.
- All ward staff we spoke to told us that it was difficult to release staff to attend training.
- Ward sisters had a good understanding of syringe driver training and this was documented in the medical devices log.
- We saw that the trust had recently held an end of life conference, which was part of the dying matters week.
- The end of life care steering group have agreed to make all forms of advance care planning a priority for 2016/ 2018.

Multidisciplinary working

- The palliative care team had established positive working relationships with community services, including GPs, district nurses and the community palliative care team at the local hospice.
- We observed a weekly multidisciplinary meeting, which included discussions regarding the development of care and treatment plans for patients.
- The service included spiritual support from the chaplaincy team and bereavement support from the bereavement centre.
- The SPCT told us they benefited from good working relationships with staff at the hospital and in the community. For example, there were opportunities to attend ward meetings. There were examples of shared documentation such as the syringe driver monitoring forms.

Seven-day services

- The SPCT was not currently staffed to provide a seven-day service. The service was available Monday – Friday 8.30am-4.30pm
- We saw within the end of life steering group minutes that there had been discussion around the provision of seven-day specialist care service. The senior management team told us that the development of this service was subject to funding and consultant recruitment.
- We spoke with the lead nurse who told us there was a business case in place to provide a seven-day service from the SPCT. Following its submission approval was being awaited from the trust's commissioners.
- All staff told us they felt it would benefit patient care if there was a seven day SPCT service.

Access to information

- We looked at the records of five patients identified at the end of life. We spoke with staff who confirmed risk assessments were available and staff had all of the information they needed to deliver effective care in a timely way.
- We saw documentation available for staff to record patient's decisions around advance decisions, spiritual needs and hydration, which was integral to the core care plan.
- We saw guidance documentation (information booklet) produced by the SPCT that could be accessed by ward staff.
- If a patient was going home at end of life then the GP was informed by telephone handover from the discharging medical team and out of hours services using a faxed form. If the SPCT have been involved, there would also be a discharge letter in addition to an e-discharge notification.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- The trust had a policy regarding consent, which was in line with Department of Health guidelines.
- Mental Capacity Act (MCA) training was part of the annual mandatory requirement for all staff. We saw that the SPCT and nursing staff within the end of life team achieved 100% compliance against an internal target of 90%.
- Staff we spoke with all had an understanding of the MCA and Deprivation of Liberty Safeguards.
- We viewed assessment documents for patients identified as being at end of life. We saw guidance for staff to follow in relation to best interest decisions for patients who did not have capacity to make decisions about care and treatment.
- We viewed 20 DNACPR forms. These were completed appropriately and included the patient and/or their relatives in discussions. We saw evidence of the SPCT addressing DNACPR document completion and improvements made following consultation with ward staff and clinicians. An audit in January 2016 showed similar results or some improvements compared to the previous year.
- We saw mental capacity assessments being completed and clearly recorded. Records showed advanced care plans including the patient's preferred place of death.

End of life care

Are end of life care services well-led?

Good

We rated well-led as good because:

- There were arrangements for monitoring the quality of services. Governance processes gave assurance that systems were regularly reviewed and improvement made. A 2016/2017 SPC work programme measured progress against key quality performance indicators.
- There was positive leadership at a local level. Service leaders were visible and approachable. Staff were proud of the care they were able to give and received positive feedback from patients and families.
- There was effective communication both written and verbal between the SPCT and ward nurses in relation to patient care.
- There were examples of patient engagement including a review of EOLC for patients with learning disabilities.

However

- Although there was a clear vision for the service, which specialist palliative care staff had developed, the trust specific strategy for end of life care was in draft and under review and it was not clear when Board approval would be finalised.
- The trust did not have an overall strategic lead for palliative care but this was identified as a future development. There was no action date to implement this role but the Board were keen to ensure that this happened.

Vision and strategy for this service

- A palliative care strategy development paper was completed in November 2015, which identified a clear vision for the service. The key areas were: to progress to a proactive, 7- day, well-staffed, clinical service integrated across acute/community care settings, delivering needs-based equitable palliative and end of life care regardless of diagnosis or prognosis; a single IT system, carer and referrer feedback through partnership working, and delivering an educational programme with involvement in collaborative research. Minutes of the SPCT meetings showed that strategic priorities were being discussed locally, however, the trust specific strategy for end of life care was in draft and it was not clear when it would receive Board approval.
- The service participated in the Ambitions for Palliative and End of Life Care: a National framework for local action 2015-2020, published September 2015 by the National Palliative and End of Life Care Partnership. Locally the trust's end of life steering group work programme update provided some indication of progress against ambitions arising from some key drivers.

Governance, risk management and quality measurement

- The specialist palliative care team met every month to discuss governance issues. The end of life steering group met every other month to look at clinical issues such as audits, patient feedback, risk, training and work programme reviews.
- Staff told us they were informed verbally of any areas of improvement, for example, DNACPR audit results, during monthly ward meetings and SPCT ward visits.
- The specialist palliative care directorate meetings included a matrons briefing however we saw that matrons were not always available to participate in these discussions each month.
- The SPCT held a weekly MDT meeting to share risks, care and treatment plans for those patients who had been identified as requiring end of life care.
- Patient safety and quality were addressed at a senior management level within the risk management group meetings. We saw examples of investigation reports and learning. This meeting enabled a holistic understanding of performance as safety and quality activity was integrated.
- There was a 2016/2017 work programme for specialist palliative care MDT. This included audit and service improvement.

Leadership of service

- There was a non-executive lead for end of life care at trust board level.
- There was a newly appointed medical director for community care centre, which included palliative care following the trust's re-structure in April 2016.

End of life care

- The trust did not have an overall strategic lead for palliative care but this was identified as a future development. There was no action date to implement this role but the Board were keen to ensure that this happened. An option was for the strategic lead for end of life care to come from the specialties of respiratory or cardiology. The clinical lead for palliative care felt this would be a positive move and would reinforce the end of life care agenda beyond cancer/oncology.
- We saw positive local leadership within the SPCT. The team were visible and we received positive comments from ward areas.

Culture within the service

- Staff we spoke with demonstrated a commitment to the delivery of good quality end of life care. There was evidence that staff felt proud of the care they were able to give and there was positive feedback from nursing and care staff as to the level of support they received from the SPCT.
- All staff we spoke with could provide examples of how the patient's needs were at the centre of end of life care being delivered.
- There was a general feeling of 'openness and honesty' and staff told us they would ask senior staff for advice if they needed it.

Public engagement

- The trust had a patient / carer group, which met several times a year and assisted in the design and development of the patient information booklet for the hospital.
- The trust took part in a survey of bereaved relatives. The survey took place over a 6-month period commencing in October 2015. There were 34 responses across both hospitals and all centres. The majority of which were positive. 91% said that they felt involved as much as they wanted in their relative or friends care. 95% said they had the opportunity to ask questions. 6% of responses said that they were not given information on what to do following death.
- The palliative care consultants had presented information to groups in the trust's geographical area. These have included training sessions and awareness meetings to GPs and local care homes.
- Following specific internal audit questions around learning disability patients and families, a piece of work had been started with the trust learning disabilities liaison nurse and the learning disabilities community to improve EOLC for patients.

Staff engagement

- We observed a SPCT team meeting. All EOLC staff, except community, attended this. We saw the meeting gave the opportunity for all staff to raise items on the agenda. Additionally, every member of staff felt confident to raise issues that were relevant to their role or they could add value to the discussion.
- Staff in the SPCT told us they attended matrons meetings as 'often as possible'.
- All SPCT staff had been involved in the development of the speciality strategy.
- We saw effective communication both written and verbal between the SPCT and ward nurses in relation to patient care.

Innovation, improvement and sustainability

- The SPCT pro-actively identified patients who were at the end of life. This was to review as many patients at end of life as possible. The patients were identified on the Vitalpac system and when their status altered to 'end of life' the SPCT were able to add them to the referral list. Since this service was developed in September 2015, the team have reviewed over 300 patients who would not otherwise have been seen. This has allowed symptoms to be reviewed, documentation to be prompted as well as giving the ward staff support in caring for patients at end of life. It had also given families the opportunity to ask questions and be given the time and support they need.
- The audit process within end of life had been updated to reflect the changes in the core care plan. Following the last CQC inspection, an audit was completed each month which included aspects of end of life care.
- The trust worked closely with local care homes in relation to shared advanced planning documentation.
- Following a conference held as part of the dying matters week, the Lead Nurse for End of Life Care was now leading on a regional piece of work for the South Tees looking at embedding and standardising education around the deciding right tools within the locality.

End of life care

- South Tees had been given the opportunity to work with Southampton University to do action research. The focus was acute patients reaching end of life and the practicalities that families face. The pilot will run until September 2016.

Outpatients and diagnostic imaging

Safe	Good
Overall	Good

Information about the service

The James Cook University Hospital had a main outpatient department and 11 other outpatient departments where specialty-specific clinics were held. There was one main radiology and imaging department and a number of other specialist imaging departments such as neuroradiology. An external provider carried out PET Computerised tomography (CT) scans on-site on behalf of the trust.

There were a total of 675,744 new and review outpatient appointments between September 2014 and August 2015. The outpatient departments ran a wide range of clinics, led by doctors, nurses and allied healthcare professionals. Specialties included urology, gynaecology, orthopaedics, general surgery, breast surgery, orthodontics, ophthalmology, ear, nose and throat (ENT), respiratory medicine, radiotherapy, pain management and neurology. Most imaging services were conducted from one location on the site.

The trust was previously inspected in December 2014 where outpatients at the James Cook Hospital was rated as 'good' overall with the effective, caring, responsive and well-led domains rated as good. However, the safe domain was rated as 'requires improvement'. This inspection focussed solely on the safe domain.

During our inspection, we visited the outpatient department at the James Cook Hospital. We observed care and staff working. We spoke with seven members of staff (including, managers, nursing staff and health care assistants). We spoke with four patients and reviewed nine sets of records.

Summary of findings

At our last inspection in December 2014, we found that resuscitation equipment in outpatient areas was not checked in accordance with trust policies and procedures and that this was not being effectively monitored. Medication in the imaging department was not stored correctly and there was no stock control in place.

At this inspection, we found that action had been taken to address these issues and have rated the safe domain as good because:

- There were processes to ensure that resuscitation equipment was checked each day. Staff had enough personal protective equipment in all the areas and staff knew how to dispose of items safely and within guidelines.
- There were sufficient staff of all specialties and grades to provide a good standard of care in the departments we visited.
- There were processes to ensure medicines were managed safely. Practices were monitored and improvements made where required.
- Staff identified and responded appropriately to changing risks to patients, including deteriorating health and medical emergencies.

Outpatients and diagnostic imaging

Are outpatient and diagnostic imaging services safe?

Good

We rated safe as good because:

- Incidents were reported investigated and lessons learned were shared with all staff.
- The cleanliness and hygiene in the departments was within acceptable standards. Personal protective equipment was readily available for staff and was disposed of appropriately after use.
- Staffing levels were managed effectively. Staff were flexible to ensure clinics were staffed and there was continuing recruitment.
- Medical records were maintained electronically, stored, and transported securely. There were rarely any problems with information not being available for clinics.
- Resuscitation equipment in outpatients and diagnostic imaging areas was checked in accordance with trust policies and procedures and was monitored daily.
- Staff were aware of duty of candour process and practice together with their responsibilities. Medicines were safely stored in accordance with policy.
- Staff in all departments knew the actions they should take in case of a major incident.

Incidents

- The departments had systems to report and learn from incidents to reduce the risk of harm to patients. Staff told us that the culture was one of honest reporting.
- The trust used an electronic system to record incidents and near misses. Staff we spoke with knew how to use the system and said they knew how to report incidents. Staff could give examples of incidents that had occurred and investigations that had resulted in positive changes in practice.
- Managers told us that the incident reporting procedures allowed staff at all levels and across multidisciplinary teams to reflect on practice. The matron gave feedback in monthly safety briefing meetings, which was confirmed by staff. The trust's outpatient and diagnostics department had reported three serious incidents from April 2015 to March 2016. These related to a fall, a diagnostic incident including delay and a screening issue.
- Between April 2015 and March 2016, there were 701 incidents across departments. Seven incidents were graded as moderate or above (1%).
- Staff had a clear understanding of the duty of candour and were aware of their responsibilities to be open, honest and inform patients (and their families) when incidents occurred.

Cleanliness, infection control and hygiene

- There were no MRSA bacteraemia or clostridium difficile reported during 2015/216.
- We saw, and patients reported, that staff washed their hands regularly before attending to each patient.
- Personal protective equipment such as rubber gloves, protective eyeglasses and aprons were available to staff and, once used, were disposed of safely and appropriately.
- The imaging department, outpatient areas and clinic rooms were visibly clean and tidy and we saw staff maintaining the cleanliness of the areas by cleaning equipment in between patient use, reducing the risk of cross-infection or contamination. The imaging and outpatient departments' took part in a regular, rolling programme of hand washing and environment audits. The environmental audit for 2015/2016 showed 100% compliance.
- Staff cleaned and decontaminated rooms and equipment used for diagnostic imaging.

Environment and equipment

- At our last inspection in December 2014, we identified concerns that resuscitation equipment had not been regularly checked in accordance with the trust's policies. During this inspection, we found that resuscitation trolleys for adults and equipment including suction and oxygen lines were checked daily and checklists were signed and up to date.
- Equipment in the departments was calibrated, maintained and serviced in accordance with the trust's procedure and manufacturer's instructions.
- In diagnostic imaging, quality assurance (QA) checks were in place for equipment. These were mandatory checks based on the ionising regulations 1999 and the ionising radiation (medical exposure) regulations

IR(ME)R 2000. These protected patients against unnecessary exposure to harmful radiation. During our observations, we saw that there was clear and appropriate signage regarding radiological hazards in the diagnostic imaging department.

- Staff wore dosimeters and lead aprons in diagnostic imaging areas to ensure that they were not exposed to high levels of radiation and RPAs carried out dosimeter audits to collate and check results. Results were all within the acceptable range.
- Single sex and disabled toilet facilities were available and these areas were at an acceptable standard.

Medicines

- The trust had a policy for the administration and storage of medicines and staff we spoke with understood their responsibilities in the management of medicines.
- We checked the storage of medicines and found staff managed them well. No controlled drugs were stored in the main outpatients departments. Small supplies of regularly prescribed medicines were stored in locked cupboards and where needed, locked fridges. We saw the record charts for the fridges showed staff carried out temperature checks daily and that temperatures stayed within the safe range. All medicines we checked were in date.
- Nursing staff followed standard procedures for the safe use and security of prescription pads. All pads were logged and empty pads destroyed.
- Medicines management training was provided for registered nurses across the outpatients and diagnostic imaging departments.
- In the diagnostic imaging and breast screening departments, some interventional procedures required sedation and pain relief and these included controlled drugs. All medicines we checked were in date.

Records

- Records in the outpatient departments were a mixture of paper based and electronic. Diagnostic imaging department records were digitised and available for doctors across the trust.
- Records contained patient-specific information about the patient's previous medical history, presenting condition, and personal information, medical, nursing, and allied healthcare professional interventions.
- Staff managed records and their preparation for clinics in outpatients. Data showed that 99.5% of full patient notes were available in clinics between June 2015 and February 2016.
- Referral letters and discharge summaries were stored electronically and provided back up when patient's notes were unavailable.
- Records were stored securely at outpatient reception areas in preparation for outpatient clinics. Patient notes were kept on open shelves at each clinic suite but staff assured us that no patients were unaccompanied or waited in clinic areas so staff were confident that records were safe and confidential until the point of need.
- We observed staff checking patient identification against their medical notes when booking in for their appointments at the trauma clinic.
- Within the imaging departments, patient's imaging records and reports were securely available for staff to access electronically.
- Nursing assessments of blood pressure, weight, height and pulse were routinely completed when patients attended the outpatient department.

Safeguarding

- All staff in both outpatients and diagnostic imaging were aware of safeguarding policies and procedures and knew how to report a concern. They knew that support was available if they needed it or required advice and support regarding a safeguarding issue.
- There was a designated safeguarding lead for departments.
- Information provided by the trust showed that 100% of applicable staff in outpatients and 100% in diagnostic imaging had undergone safeguarding adult's level 1 and safeguarding level 2 training as part of their mandatory training.

Mandatory training

- Staff were given sufficient time to attend training and more on-site training was being organised to ensure that staff and service needs were being met.
- The Core 7 mandatory training package included basic life support, blood transfusion, conflict resolution, dignity at work, fire safety, health and safety and patient well-being, Infection prevention and control, information governance, manual handling, mental

capacity act, safeguarding level 1 and 2 for vulnerable children and adults. Data showed that the majority of staff had completed the training or were scheduled to attend before the end of the year.

Assessing and responding to patient risk

- Staff were aware of actions to take if a patient's condition deteriorated while in each department and explained how they could call for help, access the paediatric and adult cardiac arrest teams and the process for transferring a patient to the Accident and Emergency Department. There were also a number of resuscitation trolleys and defibrillators across outpatients and diagnostic imaging departments.
- The radiation protection policy and procedures in the diagnostic imaging department ensured that roles and responsibilities of all staff including clinical leads, medical physics expert and specialist safety advisor were clear and that the risks to patients from exposure to harmful substances were managed and minimised.
- Named and certified radiation protection supervisors (RPS) provided advice when needed to ensure patient safety. The trust had radiation protection supervisors who liaised with the radiation protection advisor (RPA).
- Arrangements were in place for radiation risks and incidents defined within the comprehensive local rules. Local rules are the way diagnostics and diagnostic imaging work to national guidance and vary depending on the setting. Policies and processes were in place to identify and deal with risks. This was in accordance with IR(ME)R 2000.
- Staff asked patients if they were or may be pregnant in the privacy of the x-ray room therefore preserving the privacy and dignity of the patient. This met with the radiation protection requirements and identified risks to an unborn foetus.

Nursing and allied health professional staffing

- We looked at the staffing levels in each of the outpatient departments. There were some vacancies; February 2016 data showed the actual number of qualified nurses (whole time equivalents (WTE)) was 32.84 against planned 41.53 and for nonqualified actual 168.53 against planned 173.11. All department managers told us that staff were flexible to ensure cover was available.
- Managers told us they were able to adjust the number of staff covering clinics to accommodate those that were busy or where patients had greater needs. The managers in the outpatient departments were experienced staff who were very familiar with the clinics running in their departments as well as the dependencies of the patients attending them.
- Within the diagnostic imaging departments, there were sufficient radiography and nursing staff to ensure that patients were treated safely.
- There was liaison across outpatient's services and across sites for staffing with areas supporting each other where possible.
- Managers told us they monitored staff sickness and rates in outpatients were consistently low.

Medical staffing

- Medical staffing was provided to the outpatient departments by the various specialties, which ran clinics.
- Medical staff undertaking clinics were of all grades; however, there were always consultants available to support lower-grade staff when clinics were running.
- In diagnostic imaging, on a weekday there were consultants in the department between 8am and 7pm. After 5pm, a consultant on call could look at images from home using teleradiology. There were also SpRs on site from 5pm to 9am who worked a partial shift system. On a weekend, there was a consultant in the department between (at least) 9am and 5pm, then on call. There was also a SpR on site. As well as the general radiology rota, there were separate neuroradiology and vascular intervention consultants on call.

Major incident awareness and training

- There was a major incident policy and staff were aware of their roles in the case of an incident. Outpatients and diagnostic imaging staff participated in table top exercises and events to test the major incident plan.
- There were business continuity plans to make sure that specific departments were able to continue to provide the best and safest service in the case of a major incident. Staff were aware of these and able to explain how they put them into practice.

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' tool (a North East initiative for making care decisions in advance).

Areas for improvement

Action the hospital SHOULD take to improve

- Ensure that the emergency nurse call system 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 is 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 that staffing levels particularly in the neonatal unit meet the British Association of Perinatal Medicine guidelines.